THE UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH

SKILLS MANUAL FOR HOSPITAL BASED COUNSELLORS

National AIDS Control Programme

June, 1999

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PREFACE

Although counselling service is an important element in health care services, the need has been more urgent since HIV/AIDS started escalaiting in Tanzania. That is why the first serious attempts to develop counselling services in the national health care delivery system was through the National AIDS Control Programme (NACP).

NACP has been instrumental in preparing this manual, that gives an outline of basic skills to support district health service counsellors.

The manual does not only address HIV/AIDS counselling. It has addressed counselling skills that can be applied to any clinical problem. This very progressive undertaking by the NACP is highly commendable. It is a timely development that fits with the goals of the Health Sector Reforms.

Introduction of counselling skills to district health care workers is a challenge to potential users of the manual as well as the managers of health care delivery system at district level.

The health care delivery system managers face the challenge of planning and facilitating implementation of hospital based counselling services. Apart from operational adjustments, the managers, need to have the right attitude and understanding towards the concept of counselling.

It is hoped that district health workers at all levels will be receptive to counselling services. Success of the services is dependent on the level of staff commitment and willingness to adopt to the counselling services.

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INTRODUCTION

The Ministry of Health Tanzania - Mainland is engaged in health sector reforms that aim at accessible and acceptable quality of health care for the majority of the population. Community participation is an important element of district health care planning and implementation. The district health care system will adopt a holistic approach in service delivery. This means management of patients addresses physical, psychological and social aspects of disease and its medical management.

Hospital Based Counselling services have been part of the health care systems in the country for over 10 years. Introduction of counselling was focussed mostly on HIV/AIDS management. Prior to 1990 there were about 600 trained counsellors of which only 2.1% were actively involved in counselling services (Nkya L. and Mhinas, 1990).

The general impression of experts supporting the introduction of counselling services into the health care delivery system is that the service was not taken seriously. Firstly, health managers at all levels of health care delivery were not sensitised or involved in supporting the new service. Secondly, the training was not adequate and there was no follow-up plans. Thirdly, the trained counsellors went back to their traditional hospital duties because their role as counsellors was not recognised.

In 1995, the National AIDS Control Programme trained a total of 16 counsellors from 4 pilot regions. Later, 57 more counsellors were trained to cover most districts in Mainland - Tanzania. A total of 73 counsellors had received in-depth training and there was regular supervision and follow-up of their activities into the regions. Evaluation conducted after one year (Kisesa 1996) recommended that, counsellors are an accepted group of workers and are effective in alleviating social suffering in both patients and their families.

Following the introduction of health sector reforms in Tanzania, vertical programs have to adapt to district essential health packages. It means the activities run by vertical programmes have to be integrated at district level to improve cost effectiveness. Services like counselling at district level will no longer be confined to HIV/AIDS. Patients from all departments will have equal access to counselling if the need arises.

The future of counselling services.

Integration of counselling services into district health caredelivery system is a new development that requires careful planning. Although counselling is highly desired by the service users, district health services are ill prepared to run good quality counselling services. To develop an acceptable hospital-based counselling services, the following basic preparations have to be taken very seriously.

The proposed necessary preparations to develop acceptable quality counselling services are: -

1. Selection of trainees using an established standardised criteria.
2. Sensitisation of DHMT and District Health Boards about counselling.
3. Orientation of health managers in district hospitals like hospital matrons and Heads of departments to counselling needs and practise.
4. Provision of a good quality counselling room that offers privacy.
5. Making provision for in-service support of counsellors.
6. Clinicians should recognise and agree on a system of referrals to the hospital based counsellors.
7. To ensure that counselling standards are followed and reviewed regularly to improve quality of the service.
8. The DHMT should include counselling services in the annual health budget plans.
9. To provide regular refresher courses for hospital based counsellors

The Counsellors Manual

The manual is an outline of counselling skills for trained counsellors in the health care system. It focusses on technical aspects of basic counselling skills. It is up to the hospital based counsellor to apply the skills and adapt to the needs of individual patients, their families and the presenting clinical condition.

Counselling has preventive, developmental and problem management goals. using an educational approach, counselling lends itself to both individual and group training interventions. As far as possible, in addition to managing presenting problems, counsellors assist patients to alter underlying patterns of problematic behaviours. In clinical settings counselling helps patients become active participants in the process of diagnosing, treatment and the aftercare outside the hospital.

Beginners are likely to find that it takes time to become proficient in counselling. The manual introduces skills in stages. It starts with developing a working relationship with patients, identifying problems and clarifying them. This is followed by assessment of problems and redefining in skill terms. Stating goals and interventions comes next, where the patient has to collaborate with the counsellor in setting goals and discussing interventions. There is also an outline of counsellor skills as a trainer followed by the ending of counselling and how to strengthen self-helping skills.

The manual requires counsellors to go beyond offering good relationship skills to offering good assessment and coaching skills. Many beginners find it difficult to move from talking relationships, based on good facilitation skills, to training relationships. It is hoped that counsellors will play a useful role of making health education a cost-effective component of district health services.

CHAPTER 1

ESTABLISHING AN EFFECTIVE COUNSELLING RELATIONSHIP

Introduction

Counsellor - patient relationship is a very important skill in counselling. The relationship building between the counsellor and patient depends on messages sent and received through talking, body movements, touching and action.

Patients and counsellors are senders and receivers of each other's messages, and they understand the messages they receive with varying degrees of accuracy. The focus of this chapter is on how to develop effective relationships by receiving and showing that you have received your patient's messages accurately. Good and effective listening skills help to facilitate an effective counselling relationship. With effective listening, the counsellor both sends and receives messages, and so is the patient. Communication difficulties may arise in the course of sending and receiving messages. Through communication the patient can learn that the counsellor is genuine accepting and supportive.

The counsellor is expected to establish and maintain rapport, help patients disclose, help patients experience and express feelings, create a knowledge, base, create an influence base and help patients assume responsibility. The counsellor's body messages are important for demonstrating interest and attention, showing responsiveness as patients talk and framing verbal messages.

The counsellor has to send good voice messages by being aware of the effectiveness of his volume, pitch, articulation, emphasis and rate. The way she talks becomes an important communication tool in counselling.

See illustration

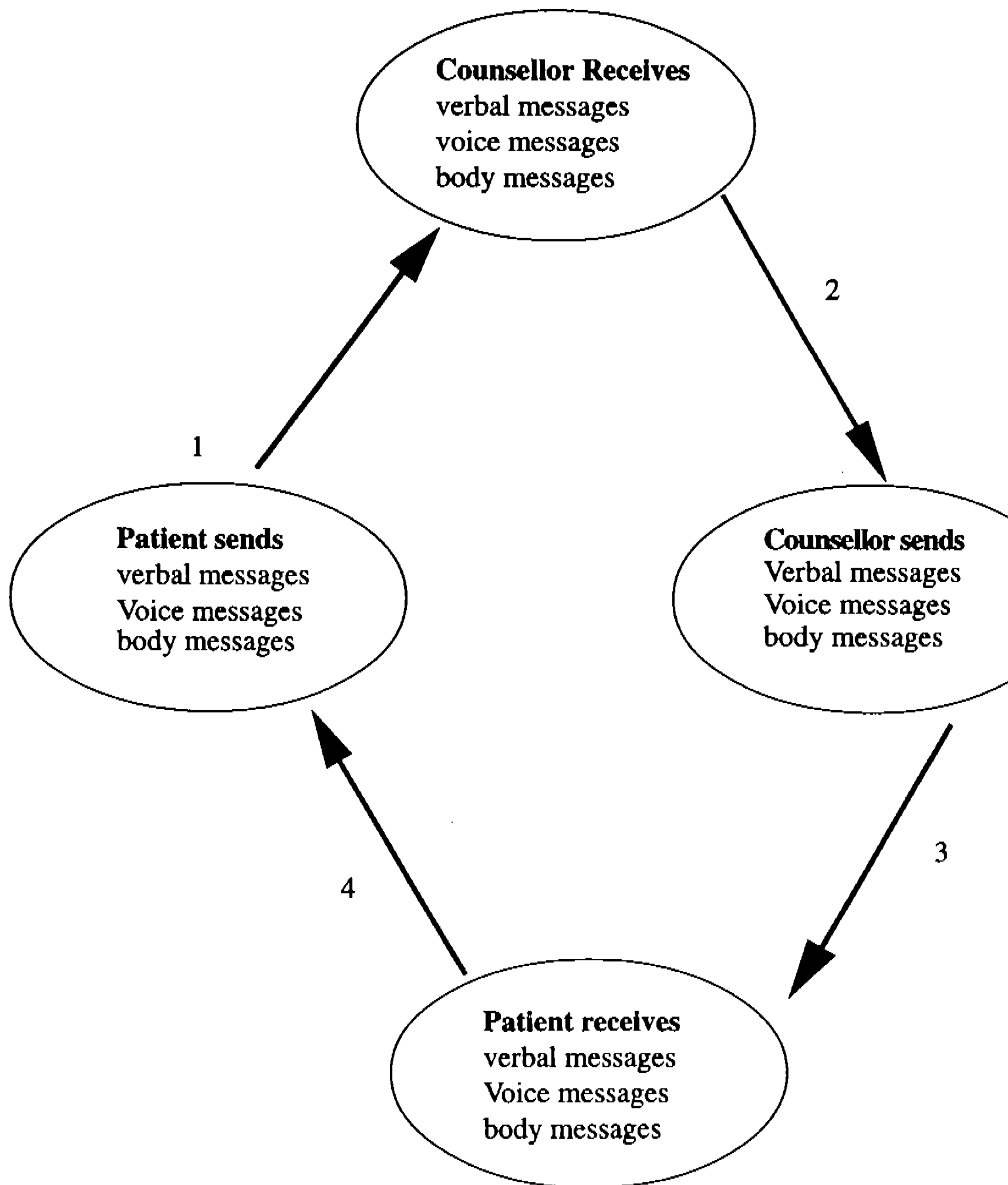


Figure 1: Counsellor - Patient relationship

Verbal techniques of showing you follow what the patient is saying.

1. ***Repeating*** part or the whole of what the patient has just said. This can be a form of a prompt to get the patient to keep explaining himself. It encourages self-disclosure in the patient.

2. ***Paraphrasing*** involves rewording the patient's key words. Good rewording can be clearer to the patient than the patient's original statement. This helps to make the patient feel understood.

3. ***Summarising:*** The counsellor can also summarise what the patient has said. If the summary is accurate the feed back from the patient is usually verbal or by body movements. This also encourages patient's communication because it shows you understand him.

Use of openers, small rewards and open-ended questions

Openers, small rewards and open-ended questions tend to require using a few words as well as sending voice and body messages. They make it easier for the patient to talk.

EXAMPLES

Openers: "You seem upset. Would you care to tell me what is bothering you?"
".... Tell me why you have come to see me."
Openers are permission for patients to talk. They encourage the patient to talk

Small rewards

Small rewards are brief verbal and non-verbal expressions of interest designed to encourage patients to continue speaking. They show your patient that you are with him i.e. you follow what he is saying. Most common small rewards are Uh-hmmm, nodding your head, facial expression or good eye contact. Verbal utterances like "GO ON" or "THEN?" are examples of small rewards. Another common small reward is repeating the last word.

Patient: "I am afraid"

Counsellor: "Afraid?"

This allows or encourages the patient to talk more about his experience of being afraid.

Open ended questions.

Open-ended questions help patients or relatives elaborate their internal viewpoints. A good use of open-ended questions is when, in the first session, you wish to assist patients to tell their stories. In the follow-up sessions too, you are likely to find open-ended questions useful. For example: "Tell me about it" "Please elaborate?"

The opposite of open-ended questions is closed or leading questions.

For example; "Are you sad?" (Closed question) "You are tired aren't you?" (Leading question) Such questions do not encourage the patient to show his viewpoints.

Reflecting feelings

Reflecting feelings usually involves rewording. Feelings are bodily sensations which may then have word labels attached to them. Consequently, rewording alone has distinct limitations. For instance a patient may send voice and body messages that qualify or negate verbal messages. Asha may say, "I am OK," yet speaks softly and has tearful eyes. A good reflection of feelings picks up these other messages as well. You reflect the meaning of what is said, how it is said and what the body messages are saying. Reflecting feelings may be viewed as feeling with the patient's flow of emotions and experiencing and being able to communicate this back to the patient.

Counsellors may just talk about feelings rather than offer an expressive emotional companionship to the feelings. Inadequate distinguishing between thoughts and feelings can be another problem for both patients and counsellors. For example, " I feel gender equality is essential in modern society;" describes a thought rather than a feeling. On the other hand, "I feel angry when I see gender discrimination" labels a feeling. This distinction is important both in reflecting feelings and also when helping patients to influence how they feel by altering how they think.

Receiver Skills

Receiver skills improve the effectiveness of the counselling relationship. Examples are:
- Understanding patient 's, face and body messages.
- Understanding patient s voice messages.
- Understanding patient's verbal messages.
- Being aware of your own emotional reaction to the patient's messages.
- Sensing the surface and underlying meanings of patient 's messages.

Sender Skills

When responding to your patient or relatives the following sender skills are important.
- Responding in ways that pick up patient's feelings words and phrases
- Rewording feelings appropriately using expressive rather than wooden (dry) language.
- Using voice and body messages that neither add to nor subtract from the feelings expressed by the patient.
- Checking the accuracy of your understanding.

Multiple and mixed feelings

Patients may have varying degrees of mixed feelings, for example simple opposites, like "happy and sad." Good rewordings pick up all key elements of feelings messages and reflect them appropriately.

Example

Patient: "I am disappointed but relived that I am not going to marry him."

Counsellor: "You are upset, but feel that a weight has been taken off your shoulders, now that you know you will not marry him."

Reflecting feelings and reasons

A useful variation of reflective responding is to reflect both feelings and the reasons for them. Where patients have already provided reasons for a feeling, you reflect these feelings back in a statement that reflects the patient's internal viewpoint.

Example:

Patient: I have struggled so hard to make sure my family never goes hungry and now I am afraid we will not harvest enough to last us 3 months.

Counsellor: You are worried your family might have very little to eat this year despite your hard work!

Patient: Yes. I get frustrated just thinking of the energy wasted on the farm.'

Avoid unrewarding don'ts:

Some strategies or ways of responding to your patient may make communication with your patient difficult. The way you respond may inhibit your patient's willingness to disclose his inner viewpoints.

The following examples should be avoided:

Directing and leading - e.g. " I would like you to start with what happened to your first wife."
Blaming - e.g. "It is all your fault"
Judging - e.g. "You are a jealous man"
Moralising - e.g. "People who pray regularly can usually avoid most problems"
Labelling - e.g. "You are a difficult woman, are you not?"
Reassuring - e.g. "Don't worry —everything will be alright."
Not accepting patient s feeling: e.g. - "You have got no reason to feel so angry"
Advising or teaching e.g. – "Why don't you stop praying and just depend on hospital medicines?"
Interrogating: - e.g. "Tell me about your sexual habits. I want you to be honest."
Inappropriate self-disclosing: e.g. "You have problems with your irresponsible husband. Let me tell you about my alcoholic husband."
Pretending to be attentive – Insincerely pretending to be more interested than you actually are e.g. "Oh-that's very interesting."

Being inpatient e.g. "You had better hurry up, I have very little time left."

Conclusion: - A positive working relationship between patients or relatives and counsellors is a must. Counsellors have to develop the skills of showing genuine warmth, acceptance and willingness to help to their patients or relatives. Your capacity to help is dependent on your ability to get inside patient's internal viewpoints and showing that you understand and care about what he says. The following chapters will introduce you to more counselling skills

CHAPTER 2

IDENTIFYING AND CLARIFYING PROBLEMS

All human beings have problems from time to time. Most people manage their problems without professional help. They handle their problems either by themselves or are assisted by friends, and family. However, some people who don't manage their problems seek help from professional or paraprofessional counsellors. The professionals include psychologist, professional counsellors and psychiatrists, while the paraprofessionals e.g. teachers, nurses doctors, and social workers with orientation or short training in counselling. Patients come for help when their problems are serious or disturbing. They also seek help if they are serious about managing a problem. Finally they take the problem for counselling if they believe the person can help.

The major responsibility of a counsellor is to assist the patient to identify and clarify the problem. The importance of this first stage of the counselling process is based on the fact that patient s cannot manage problem situations unless they identify and clarify the problem.

Helping the patient tell their stories

The patient needs to tell his/her story in order to identify and clarify their problems for action taking. Some people are quite verbal and easily reveal everything that is bothering them while others find it difficult to express themselves especially when there are problems.

The counsellors must also be aware that patients may tend to shift their blame on to others and so they need to help them tell the "real" story.

Factors affecting the process of identifying and clarifying problems

The counsellor while helping the patient in this process or stage of identifying problems needs a number of aspects.

- **Patient expectations and problems.**
  The counsellor needs to find out/consider what the patients expectations and problems are and whether they are realistic.

- **Patients' emotional state.**
  Patients who have serious emotional states may have difficulty in discussing their problems. They may present the problem in an irrational manner making it difficult to understand them.

- **Patient's age**

- The patient's age may determine the individuals ability to present their problems in a systematic manner. For example, children may not present their problems in an organised manner. The patient's' age may also assist the counsellor to know the type of crisis the individual may be going through.

- **Patients' intelligence**
  The patient s' intelligence level will affect the clarity with which they present their problem and thus the ease with which the counsellor can identify and clarify their problem. A patient with low intellectual capacity will in most cases present his/her problems in a disorganised manner. This makes it difficult for the counsellor to identify the problem, and may have very little success or the progress may be very slow. On the other hand, a person with very high level of intellectual functioning may be able to present their case very clearly and logically. However, depending on the problem and the individual some people may be manipulative so the counsellor needs to be alert.

- **Time available for counselling**
  Other factors which affect the counsellors' ability to identify and clarify the problems are: Firstly, the time available and secondly, the situation in which one is functioning or working. The time available affects how well a counsellor can do to identify the problem and clarify it before working out plans of action and closing the counselling session or services. For example, hospital based counselling is done when the patient is in hospital. Since follow-up outside hospital may be difficult and time consuming, if it happens it should be very brief.

  Time available is sometimes limited to one session which greatly limits the counsellor's ability to explore the problem in detail. The importance of identification of the "real" problem should be realised. In addition the counsellor should help the patient identify the most pressing among their problems to be worked on first.

- **The context/environment**
  The environment in which a counsellor has to work is essential because it determines how well they can express their problems and thus proper identification of the problem. For example, the hospital is the best environment to provide counselling services for medical problems.

The Counsellor's role

The Counsellor's role in a counselling relationship is to help the patient identify, explore and clarify their problems. Both the counsellor and the patient must be aware of the fact that it is the patient who makes the final decision on what they eventually do to correct the situation. The role of the counsellor is therefore assisting the patient tell there "real" story. It is from this that the patient can gain self-understanding and work out their problems in a realistic manner.

Establishing Workable Expectations

The counsellor must communicate the reality of things to the patient to ensure the patient has an understanding and expectations which are realistic.

Patients must be made to understand that counselling can assist them identify their problems clarify them and make plans for actions and assist them in implementations of these plans. However they must be made to understand that they have the responsibility for success in implementing the plan of action identified.

Issues of Confidentiality

Confidentiality is the backbone of the counselling service. Issues of confidentiality are very important. During identification of problems and clarifying the patients needs to be open in telling their story, and they need to be assured that what they share with you is confidential. Professional use of information means that no information pertinent to counselling should be used loosely, in social conversations, or in non-professional settings. Confidential information includes information that the patient is ill and the illness he suffers from.

All information arising from a counselling relationship should be kept confidential. This includes keeping confidential all information generated from a counselling interview. The patient should know from the outset that information will be used for professional purposes only and always in the patients' best interest. A counsellor must realise that it is unethical to breach confidence however disturbing or shocking confidences are.

The counsellor - patient partnership in solving the patient s problem

The counselling relationship involves a partnership between the patient and counsellor which is geared towards helping the patient become more effective in solving personal problems. The counsellor works towards equipping the patients with self-help skills which enable them to solve problems. In partnership the counsellor and patient identify the deficits which are present in the self help skills and work towards acquisition of these skills.

Inquiry of the presenting problem

The first step in helping individual solve their problems involves encouraging them to tell their stories. This exercise which involves self-disclosure is essential as it gives both the patient and counsellor an insight into the presenting problem. In addition helping the patient to open up and talk about their problems is the first step in the healing process.

The counsellor uses different skills to encourage the patient to tell their stories

The counsellor has to have proper attending behaviour. This includes appropriate posture, nods and grunts, gestures and eye contact which tell the patient you are attentive and interested in what they have to say.

The counsellor must also exude warmth. Warmth is expressed by facial cues, inflections of the voice and charm. This skill paves way to good relationship between the patient and the counsellor. Such a relationship makes it easier for a patient to open up to the counsellor.

It is very important that counsellor understands problems presented in their context. The culture or social group in which the patient comes from is important to understand before one can be able to assist the patient. For example, what may constitute a normal occurrence in one culture may be unacceptable behaviour in another.

As the counsellor makes inquiry into the presenting problem he/she may need to use focusing skills in order to assist the patient focus on the problem. Focusing skills include rephrasing what the patient has just said and assisting them to own thoughts, feelings and actions.

As patients tell their stories they may have thoughts which are inconsistent or there may be distortions. Usually the counsellor should assist the patient to face these inconstancies and distortions. The patient may also need to be confronted in cases where they ramble moving from problem to problem in a vague manner.

The counsellor needs to use summarising skills in inquiry of presenting problems. As the patient opens up and tells his story the counsellor should use paraphrasing and summarising in order to ensure that he/she understands what the patient is saying to her/ him.

Managing initial resistance

A patient may display resistance in the counselling process. Resistance according to (Egan 1990) refers to the reaction of patient who in some way feels coerced. Resistance is therefore their way of fighting back. Egan (1990) presents the following productive approaches of dealing with resistance and reluctance to focus on the main problems:

- seeing some resistance as normative
- Seeing reluctance as avoidance
- Explore your own reluctance & resistance
- Examine the quality of your intervention
- Accept and work with patient's reluctance and resistance
- Be realistic and flexible
- Establish a "just society" with your patient
- invite participation
- Help patients identify resistance - supporting incentive
- Search for incentives for moving beyond resistance
- Tap significant others as resources or
- Employ patient s as helpers

Thus one needs to deal with the resistance and reluctance. Be careful not to reinforce them.

CHAPTER 3

ASSESSING AND REDEFINING PROBLEMS

Assessment comes at a later stage during the counselling process. It is after the counsellor has practised good listening that he will be in a position to assess the problem(s) and re-define (them). There are specific skills associated with this stage,. A counsellor should use the skills to fruitfully conclude this stage. Most of the skills will be on tactful ways of checking with the patient . The following skills are advised:

Reflecting the patient 's concerns

The skill is associated with a lot of qualities .
- It demonstrates to the other person that you have understood and accepted him
- It shows your good listening skills
- Reflection helps the counsellor to concentrate on what is actually being expressed and not what she is expecting, or would like to hear.

There are five ways of reflecting

1. **Paraphrasing:** This is the skill of telling the person what she has just said in your own words without distorting. It demonstrates good listening and provides breathing space in which the other person can think through what she will say next.

2. **Summarising reflections**
   Brief restatement of idea and feeling that the patient has expressed over a longer period of conversation,
- checks understanding.
- helps the patient to focus on main concerns and helps in movement from one stage to another towards specifying clear goals.

3. **Reflecting feelings**

   Feelings are not always expressed in words but more often conveyed by what the person does such as facial expression, posture, eyes etc.
- These signals are important for reflecting feelings of the patient, making him/her aware.

Reflecting the listener's feelings
The counsellor reflects back her own feelings from what is being expressed such as "I feel confused by what you are saying. This helps the patient towards self-understanding.

Reflecting meaning

This is linking the feelings being expressed to the patient 's experiences, action and understanding. Example: "You feel hopeless, because the doctors are not saying what is wrong with you." "You fear the illness may kill you"

You feel......because...........

Interpretation

This is an attempt to provide the patient with a new way to view the situation. It provides a clear cut alternative perception of reality. The perception may enable a change of view which may result in changes of thoughts, and behaviours.

Logical Consequences

This involves leading patients to understand the possible consequences of their actions.

This provides an alternative frame of reference for the patient . It helps the patient anticipate the consequences or results of their actions.

Patient focus.

e.g. "Mary, you feel confused and lonely. You are unsure of what you want to do,"

Confrontation .

This is a gentle process in which a counsellor points out discrepancies between attitudes, thoughts and behaviours. For example, you may confront a patient as follows e.g. On one hand you think/feel/behave....but on the other hand, you think/feel/ behave.....................unprotected sex with your boyfriend is very risky, but on the other hand you allow him to practise unsafe sex with you.

How is he going to know you are afraid of the possibility of catching AIDS from him?

The above skills if used appropriately can enable both the patient and the counsellor to evaluate/assess the presented problem (s) and redefine them.

CHAPTER 4

WORKING OUT GOALS

Goal setting is an important stage in the process of counselling.
Goals setting has the following advantages:

- helps patients to focus attention and action
- have a new vision of what she/he can direct his/her energy to.
- mobilises the patient 's energy and efforts into action.
- increases patient 's persistence i.e. patient s with clear and realistic goals don't give up as easily as patient s with vague goals or no goals at all.
- motivates patient s to search for strategies to accomplish the goals.

The Counsellor's role is to help the patient at this stage to shape their goals to have the following qualities.

- **Goals should be stated as Accomplishments .**
  This means that if the patient is enabled to state the goal as an outcome or preferred scenario rather than an activity it helps, the patient to visualise each accomplishment. For instance, "I would like to be able to say **NO** to unprotected sex.

- **Goals should be made clear and specific**
  The patient is helped to develop the goal to the level of clarity and specificity needed in order to act. The counsellor uses probing to help clarify the goal. Example: "Do you mean you will makesure the surgeon answers all the disturbing questions you have in relation to the operation?"

- **Outcomes should be measurable or verifiable.**
  This will help in determining progress towards the goal. It has been proved that for many people being able to measure progress is an important incentive. Example: "The patient can record how many times he has asked the doctor to explain the meaning of investigation results compared to times he has feared to do so.

- **Goals should be realistic**
  It is worth noting that a goal is realistic if (a) the resources necessary are available to the patient . (b) the patient is aware of external obstacles that cannot be over come by the use of available resources, c) The cost of accomplishing the goal is not too high i.e. beyond available means or resources.

- **Goals should be substantive**
  This means the goal is adequate if its accomplishment is relevant to the original problem. The solution contributes in a substantial way to manage the problem or some part of it. If unrealistic goals are not challenged the outcome of interventions will be unsatisfactory.

- **Goals should be consistent with the patient ' values**
  Values are criteria we use to make decision and this is mainly personal.

Counsellors are to help the patients set realistic time frames for the accomplishments of the goals:

The different types of goals should be differentiated into:
- The now goal
- The soon goal
- The mid-term goal
- the long - term goal

It is also important to help patients explore the consequences of their goals.
The following questions can provide guidance on how:

- What would life be like if this goal were to be accomplished
- What satisfactions would accomplishing this goal give me.
- To what degree would it take care of the concerns I am feeling right now
- To what degree would it conform with the values I hold dear.
- What would life be like if this goal is not accomplished.

Example: "If you stop going out to drink every night how are you going to spend your time in the evening?

OR

Will your wife cope with you being at home most evenings when she is already used to be without you?

CHAPTER 5

PLANNING INTERVENTIONS

Once identification an clarification of problems has been accomplished and the goals for the counselling relationship worked out interventions are planned.

Several steps are involved in reaching the final plans for intervention and implementing these plans. The steps are as follows:

- **Brainstorming strategies for Action**
  This step involves brainstorming of all the strategies possible in reaching the identified goals. In cases where the strategies may be complex the goal may be divided into sub-goals that can be easily achieved. This step involves identifying all possible strategies without evaluating or criticising them.

- **Choosing the best strategy**
  The next step in planning interventions involves critically evaluating all the strategies which were identified in the previous stage. The strategies must be evaluated in terms of which ones make the most sense and be turned into plans of action.

- Choosing the best option involves taking into account the patient 's needs, preferences and resources and what is least likely to be blocked by factors of the patient 's environment. For intervention to be viable it has to have the following qualities.
  - have clear and specific outcomes
  - have to be realistic in terms of environment and resources
  - have to be in keeping with patient 's values
  - capable of being accomplished within a reasonable time frame.

- **Commitment to the chosen intervention**. Patient need to be committed to the intervention strategies/plans he chooses. There is need to evaluate the reinforcing or facilitating factors which can lead to the success of the plan.

How to help patient s in their immediate preparation for action.

First the counsellor can assist the patient to foresee the difficulties that might arise during the implementation of the plans. This type of assistance will reduce the chances of patient 's going to either extreme, i.e. by either being too optimistic and believing that nothing can go wrong. The other extreme involves being too pessimistic and wasting of time anticipating obstacles and day dreaming about ways to handle them.

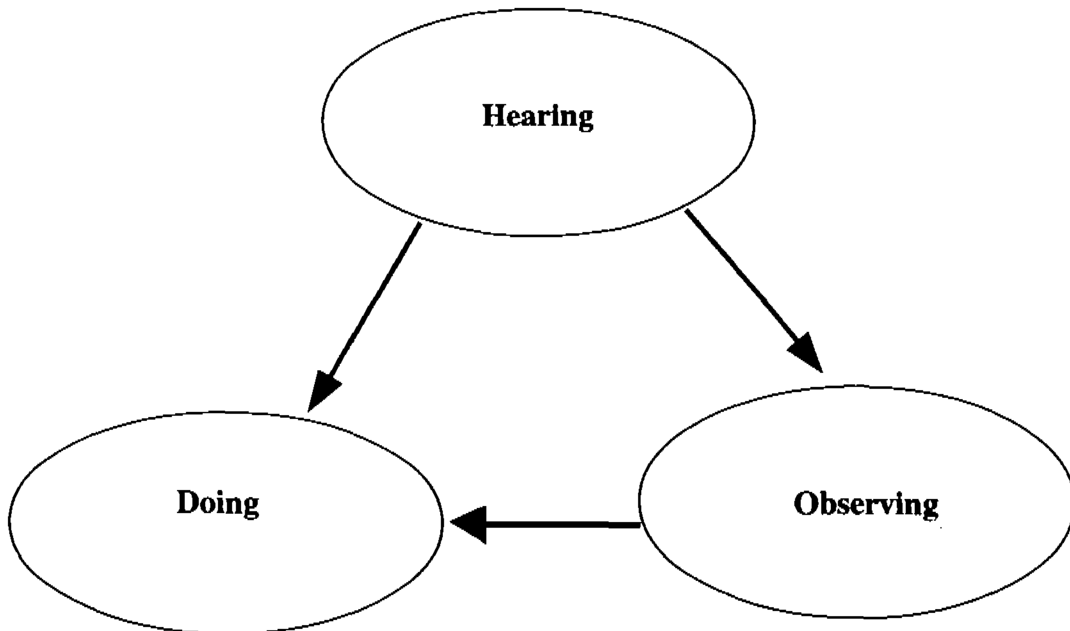
The Counsellor should assist by helping the patient identify the principal facilitating forces and the principal restraining forces that will most likely be operative in the patient s environment in terms of patient s inner thoughts, feelings, imaginations and attitudes.

The second way a counsellor can help patient s in implementing intervention plans is by providing support and challenge for patient s as they act. The counsellor should challenge the patient to mobilise whatever resources are needed for them to stick to the program. Support can improve the determination of the patient or relatives to succeed.

CHAPTER 6

THE COUNSELLOR AS A TRAINER

What are training skills?
A broad definition of training skills includes how to facilitate, assess and design programmes as well as how to intervene. Patients as learners need counsellors who are competent trainers to guide learning. Counsellors require not only knowledge of what interventions to provide, but also skills of how to intervene. The what of intervening needs to be supplemented by the how of intervening. Counsellors are therefore expected to have training skills in three broad areas, i.e. speaking, showing and doing. Patients will learn from hearing, observing and doing.



Interrelationship between learning from hearing observing and doing.

Speaking skills

Whether you facilitate or train you need to have effective speaking skills. The emphasis is on using speaking skills when you first intervene to train patients in specific life skills. Speaking skills for training are somewhat different from those for facilitating. Providing skills information requires you to be more active. This means you will have to communicate vital information in a clear and simple manner. This will make it easier for the patient to understand.

If material or information is presented poorly your patients will find it difficult to follow. They will therefore not learn the new information or skills you would want them to use to help themselves. The following are some counsellor skills for preparing clear presentations.

1. ***Know your material***
   To be an effective teacher you must understand what you will teach more thoroughly than when you are a student. It is unethical not to have a reasonable knowledge of accurate information you want to pass on to a patient. For example you need to know the way HIV is transmitted, the time it may take to form antibodies, how to interpret negative results and how to interpret positive results. With this knowledge you can clear a lot of misunderstanding the patient may have about HIV infectionduring the pre-test counselling. Therefore if you think there is vital information that you want topass on to the patient, prepare before the session. If you are asked something you don't know admit that you are not sure but you will try to get the correct information and present it in the next session.

2. ***Outline your presentation***
   To simplify things for your patient you can outline your presentation so that it becomes systematic. For example in teaching your HIV positivepatient the ways to avoid infecting others you can first discuss risky sexual behaviour in general, then techniques of reducing risks, the non-sexual risk behaviours and how to reduce risk. Your ultimate aim is for your patient to have thorough understanding of your presentation.

3. ***Use repetition***
   Repetition helps to reinforce vital information. When concluding your presentation you can repeat the key idea. At the end of the session you can again repeat the major areas of new information that the patient has learned.

4. ***Summarising***
   Summarising is another useful techniques to improve you patient s chances of having acquired accurate new information or skills.

Why should counsellors have training skills?

Effective counsellors require both good relationship skills and good training skills. Training skills enable them to give clear information and do it efficiently. Having training skills is very useful for some patients who may need to learn new behaviours. The majority of patients is stuck and requires more active help to provide skills to move forward.

Effective voice and body messages

When delivering information to your patient, you need to be aware of your voices as a tool. The loudness of your voice, clear pronunciations, pitch, emphasis and rate; all influence the effectiveness of your presentation.

Sending effective body messages when describing a life skill is partly a matter of avoiding bad messages and partly a matter of sending good messages. The counsellor should be conscious of her body messages when delivering information to patients. For example a relaxed body posture, sensitivity to physical proximity, clothing, grooming and appropriate facial expression all improve the effectiveness of delivering life skills.

Use gestures economically to help explain what is being said. Your gestures also need to be socially and culturally acceptable. Some gestures like scratching your nose or repeatedly adjusting your uniform may distract your patient s attention. Learn to use gestures to work for rather than against your training messages.

Eye contact

Culture and social group/educational level usually influence eye contact. Despite individual differences when presenting make sure you haveadequate gaze level to read your patients' reactions. Your use of gaze and eye contact is a most important way of relating directly to patients when making learning points.

Put content and delivery together

Use speaking skills to help patients develop self-helping skills. Ideally, when learning new skills, patients start by being receptive to your voice in their heads. However, they then need to replace your voice with their voices. Your public talk becomes their private speech. That is why accuracy of content and effectiveness of your delivery are very important.

Demonstration skills

Demonstrating may be used to initiate new skills, develop existing skills and weaken or overcome existing weaknesses. Goals for demonstrating and observational learning can be in the form of thinking skills or action skills.

Thinking skills

Thinking skills include possessing realistic rules using coping self-talk and perceiving accurately. The counsellor can provide handouts, or leaflets demonstrating a specific medical information. Alternatively she can teach the patient self-talk techniques to cope with fears of catching HIV/AIDS through handshake. An example of self-talk would be, "Calm down. Shaking hands will not make you catch HIV/AIDS."

Action skills

Action skill demonstrations focus on observable behaviours. In action skill demonstrations, counsellors need to pay attention to their voice, body and verbal messages. Counsellors may demonstrate skills both initially and when coaching and rehearsing patients. For example a counsellor, with the use of simple diagrams can demonstrate how to use a condom effectively. Another example is demonstration of how to position a patient following an epileptic fit to avoid aspiration problems.

The use of pre-recorded tapes for demonstrations.

Some health education videotapes may be very useful in training patients and their relatives. It is the role of the counsellor to choose videotapes that are relevant in relation to the individual or group of patient's needs. Where these facilities are available they can be very useful in training patients.

Assigning homework

After presenting, demonstrating and coaching patients in new skills counsellors can assign relevant home work. Setting homeworks can speed up the learning process, encourage patient to rehearse and practice skills, helping the transfer of trained skills to outside life. This increases the patient's sense of self-control and personal responsibility for developing targeted skills. {For example a diabeticpatient may learn how to collect and test his own urine for sugar if the appropriate reagents are available. It is very appropriate that such a patient is given homework and he can later report his success or difficulties to his counsellor.}

Conclusion

Training skills are an additional useful tool for the effective counsellor. In everyday medical practice you will meet situations that require your speaking skills, demonstrating skills, coaching skills and setting homework skills. You start from the level of skills that your patients have and use training skills to help them get to where they want to be. Always remember that, after helping patients through counselling. Patients need to retain and develop trained skills as self-helping skills. All counsellors should train themselves in training skills. Once they have mastered the training skill they can apply them to most counselling situations.

CHAPTER 7

CLOSING AND CONSOLIDATING SELF HELPING SKILLS: -

Termination of counselling is an important step of the helping relationship. It is right to assume that the helping relationship requires skills not just for managing current problems but also for coping with future similar problems. Problems tend to repeat themselves if people don't change their characteristic style of responding to their environment. In treatment helping process the counsellor should recognise the reality of ending. Systematically, she should help develop the patient's life-skills for afterwards. Planned last session or sessions can be used to consolidate trained self-helping skills.

Consolidating self-helping skills: -

After patients end counselling they assume responsibility for maintaining and developing life skills worked on during sessions with the counsellor. To consolidate trained skills, four overlapping terms are used i.e. generalisation, maintenance, transfer and development.

Generalisation: -

Generalisation signifies that targeted thinking skills and action skills carry over or generalise to conditions other than those included in counselling. For example, fears based on superstition may be confronted and challenged in relation to a problem of obstructed labour. Such fears may reoccur at a later date when faced with another medical problem. Skills gained from the earlier counselling experience can be generalised to the new challenge.

Maintenance: -

Maintenance, or resistance to extinction, refers to the extension of behaviour changes after counselling. It means new knowledge and skills gained in counselling persist in the person's everyday behaviour. For example new learning about ways to avoid anemia caused by poor nutritional habits

Transfer: -

Transfer or transfer training contains elements of both generalisation and maintenance. Patients not only maintain new behaviour changes but also extend them to new situations and settings.

Development: -

When counselling ends, some patients not only maintain, but also develop targeted skills to higher levels. Such patients assume responsibility for shifting the balance of strengths

and weaknesses in one or more skill areas still further in the direction of strengths.

Skills for Enhancing Consolidation of what is gained in Counselling: -

1. Develop the Relationship, identify and Clarify Problems

When starting counselling, be aware of the patient's need to consolidate trained skills as self-helping skills. If you provide a good helping relationship you will both lessen the likelihood of premature termination and increase the likelihood that patients will learn skills well and hence will continue to use them.

Structure for Maintenance: -

Ideas to incorporate in structuring for maintenance includes using skill language, focusing on self-helping and letting patients know that they can sharpen and develop skills after counselling. You can deliberately make comments that encourage the patient learn new skills that they can apply in future similar situations. For example you could say the following. "The things you learn in counselling are basically self- helping skills for you to maintain and use on your own.

2. Access Problems and Redefine in Skill terms: -

You can develop the patient's self-assessment if you remind him that counselling is a working partnership. It is a joint enterprise with patients to assess how they feel, think and act. They will probably develop better self-assessment skills than if you fail to involve them in the process. Ongoing assessment is an integral part of life skills counselling. It is insufficient for patients to only monitor how they think and act; they also need to make accurate assessments of the significance of the information for maintaining or altering behaviour.

3. State Working Goals and Plan Interventions: -

Develop patient's skills at redefining problems in skills terms. If you negotiate clear initial statements of working goals with patients or relatives, you make it easier for them to maintain targeted skills. Such goals are relevant for after as well as during counselling. During counselling goals assist learning and hence maintaining skills by providing focus and motivating patients. When counselling is over, clear goals both remind patients of skills to retain and also provide a yard stick for assessing progress.

4. Intervene to Develop Self-helping Skills:-

Counsellors who offer both supportive relationships and good training skills enhance patient's likelihood of maintaining kills after finishing. For instance, keep developing self-monitoring and self-assessment skills. Also, where possible, carry out those aspects of your plans that enhance maintenance. You can emphasise homework assignments for example in the proper preparation of nutritious diet for toddlers. You can also encourage patients to summarise what they have learned. This makes it easier to use the skills after counselling is finished.

In some cases of health education you can provide patients with handouts, leaflets and books with skills relevant to the presenting problems. For example leaflets on drug abuse may be handed to patients with substance abuses disorders during counselling. Such materials can be used by the patient after they end counselling.

5. The End of Counselling:-

When to end counselling depends on the type of problem or problems. As implied in the previous discussion on consolidating what is learned, counselling has its ending built into its beginning. In another sense, the ending of formal counselling is the beginning of independent self-helping.

It is important for the counsellor to determine how long it will take tofinish (how many sessions) and make this known to the patient during the process of counselling. It is important for both of you to prepare for an agreed ending. That way the patient knows what to expect and prepares to carry on with self-helping in his life outside the hospital environment.

REFERENCES

Dryden, W. and Throne, B.(Eds), 1991. Training and Supervision for Counselling in Action. London: Sage Publications Ltd.

Egan, G. (1990). The Skilled Helper: S systematic. Approach to Effective Helping Pacific Grove CA: Brook/Cole Publishing Company.

Ive, A.E., Ivey, M.B. and Simek Morgan L. (1993). Counseling and Psychotherapy A Mulitcultural Perspective (3rd Edition) London: Allyn and Bacon.

Storr, A. (1990). The Art of Psychotherapy Oxford: Butter worth - Heinmann Ltd.

Swain, L. (1995). The use of Counselling Skills A guide for therapists. Oxford Butterworth-Heinmann Ltd.