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Field Report

Training Survivors of Gender-Based Violence in the Problem Management Plus Programme in Turkey

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Abstract

Since the beginning of the Syrian conflict, the impact on the local population has rapidly increased, with severe consequent displacement to neighbouring countries (such as Turkey), material losses and psychological damage due to witnessing death, torture, physical and psychological abuse or surviving it, including high levels of gender-based violence. At the same time, available resources to aid impacted communities have not come close to matching need. To respond to this urgent need, the INSAN Psychosocial Support Centre in Istanbul, Turkey initiated the Safety Spark project as a capacity building project with 20 refugee gender-based violence survivors to be trained in Problem Management Plus. This is "a psychological intervention that aims to improve mental health, functioning and psychosocial wellbeing of adults" and thereafter to provide mental health and psychosocial support to other women survivors, thereby increasing the capacity of the community to heal itself. However, right after training, but 2 weeks before implementation sessions began, the onslaught of the coronavirus disease 2019 reached Turkey, making provision of traditional psychological support impossible. With the support of World Health Organization, an online training was added to the programme and survivors were taught to provide support remotely as well. The project is ongoing, and observed results appear to be promising. This field report provides an overview of the target population, procedures, settings and challenges faced during the training and implementation, solutions to overcome them and future recommendations.

Keywords: gender-based violence, Problem Management Plus (PM+), psychological intervention, refugee mental health, traumatic experiences

Introduction

Background

The Syrian crisis began in March 2011. Since that time, the ongoing and ceaseless conflict has become a humanitarian tragedy. Over 6.7 million Syrians of a population of 22 million have been displaced within the country and more than 6.6 million have fled to neighbouring countries (primarily Lebanon, Jordan and Turkey). Turkey is believed to be hosting the largest number of those fleeing the conflict in Syria, with 3.6 million legally registered refugees (UNHCR, 2021).

Those forced into fleeing the crisis in Syria did so because they were confronted daily by death, torture, physical and psychological abuse of loved ones, or experiencing it themselves. For many, it seemed to be the only option for survival, albeit with new challenges related to becoming a refugee, such as difficulties accessing health care (Alawa et al., 2019), discrimination (Demir & Ozgul, 2019) and language barriers (Ekmekci, 2017).

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Additionally, as is often observed in humanitarian crises, women and girls are among the most vulnerable for gender-based violence (GBV; Freedman, 2016). Defined by UNHCR, GBV is any "harmful act directed at an individual based on their gender. It is rooted in gender inequality, the abuse of power and harmful norms". While not always only applied to women and girls, they are disproportionally affected (Sabri & Granger, 2018), and in this field report, GBV is used to refer to women and girls.

The global rate for women experiencing GBV is one of every three, and this number increases within the context of refugees (UNHCR, 2021). Studies with Syrian refugees in Jordan show that most survivors of GBV are unaware of services available or how to find them (UN Women, 2013).

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Although there is no specific data or a research exploring this particular group among refugees in Turkey, the results would be expected to be similar. In addition, during coronavirus disease 2019 (COVID-19) lockdowns, reports have highlighted an increase in GBV in general (UN Women, 2020).

New Challenges

While many NGOs and governmental institutions have tried, and are still trying, to provide basic survival needs, such as food and shelter, psychological needs have often been neglected due to the lack of mental health professionals (Karaman & Ricard, 2016). Other barriers to mental health services include language, lack of information on procedures to reach services, restrictive legal requirements, lack of free service options and different medical and psychological treatment approaches (Giacco & Priebe, 2018; Lindert et al., 2008; Priebe et al., 2013).In response to the lack of mental health professionals, the World Health Organization (WHO), has been working on a task-shifting approach to decrease the mental health gap through developing structured, low-intensity programmes that could be implemented (under supervision) by trained non professionals. This would decrease the pressure on mental health services and create a space to direct specialised care to those who need it, such as survivors of GBV.

The Safety Spark Project

Adopting the same task-shifting approach, the INSAN Psychosocial Support Centre, which provides mental health services in Arabic for refugees in Lebanon, Jordan, Egypt and Turkey, created a project called "Safety Spark" to build the capacities of women who have survived violence through training in one of WHO' s interventions to help other survivors of GBV in their communities. The facilitator training was conducted in Turkey by trainers who were trained and qualified by WHO. All materials, including the training and the intervention manual, assessment tools for inclusion, exclusion and evaluation were provided by WHO, in addition to supportive materials that facilitated adaptation to remote implementation. The project was funded by The Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ).

The project's objectives included raising awareness of GBV through informational lectures on relevant legal rights, protection strategies and services, and to empower (through training and capacity building) a group of GBV survivors to be able, in turn, to provide support to their peers who are also GBV survivors. The lectures included personal legal rights in Turkey, presented by a representative from the Turkish Red Crescent (TRC), and protection strategies presented by professional psychologists. Capacity building to develop a psychosocial support team included providing training to 20 women, including stress management, spiritual and psychological support, and the Problem Management Plus (PM+) programme, which is a low intensity psychological support programme that can be provided by trained lay helpers under supervision (WHO, 2016). Online PM+ training was provided to enable each participant to implement the programme remotely to 10 survivors of GBV. Additionally, self-care training was given to all participants weekly, with each session lasting 4 hours. Supervision sessions were also conducted weekly.

Referral pathways were created for women requiring legal assistance to be referred to the TRC social centres, and for those women in need of more specialised mental health support to be referred to our centre. A screening assessment was conducted with each participant before their enrolment in the programme based on the standards agreed in the manual. Participants with a high risk for suicide, substance or alcohol abuse, or intellectual disabilities were referred to the centre for additional support and excluded from the programme.

A public media awareness campaign on GBV was also launched to coincide with the UN 16-day International Campaign on GBV, using videos and digital magazines in both Arabic and Turkish languages. The campaign raises awareness of GBV within both the refugee and local communities.

PM+ Training

The PM+ programme can help people with depression, anxiety and/or stress, whether or not they have experienced adversity. It can promote feelings of calm and support to better deal with challenges, in addition to teaching them to better manage daily life problems and to make clear decisions.

The PM+ intervention is composed of five sessions : one session each of four different strategies and one on maintaining these newly acquired skills after the intervention. The first strategy is stress management, including psychoeducation on stress, bodily reactions and a breathing technique to relieve stress. The second strategy focuses on a basic cognitive behavioural therapy technique to analyse a problem, differentiate between the solvable and unsolvable aspects of it and create a plan to manage it. The third strategy is known as "Get Going Keep Doing", which educates participants on inactivity cycles during depression and a behavioural activation technique to break the cycle. The fourth strategy is on analysing aspects of trust and planning to establish a healthy social support circle. Finally, each participant learns how to practice these skills after the end of the sessions and how to teach them to others.

This training, therefore, aimed to increase confidence and enable participants to run individual sessions of PM+ wh en maintaining their safety and comfort. Its aims included understanding PM+, learning basic skills required to run the sessions, how to manage challenging and risky situations, and to gain practice and experience of running the programme. One unique aspect of this particular training was that it targeted participants who were survivors of GBV themselves and were trained to help others who had been through similar experiences. Therefore, it also included additional sections to address their psychological needs.

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Methods

Training Setting and Participants

The training lasted 10 days and took place at our psychosocial centre. The chairs were placed in U shape that allowed the trainees to see the trainers clearly, as well as each other. There were 20 trainees who were all females, native Arabic speakers, as well as three trainers. The trainees were, additionally, all survivors of GBV (domestic violence, war, massacres and detention), from a wide range of cultural backgrounds and education levels, and fulfilled the following criteria: attained at least a high school education, had high social and communication skills, as well as the capacity to learn. They all gave informed consent to participate in the training and received information about the training and the project in general.

The Trainers

The training was conducted by three female trainers who were certified by WHO to give the PM+ training and provide supervision sessions. They were chosen from a group of specialised colleagues, where a high sensitivity of working with GBV survivors was taken into account. The first trainer is a Turkish psychologist with experience of working with refugees. She had trained several groups on PM+ and provided supervision. She is fluent in Arabic, which facilitated her work with the Syrian refugees, understanding the situations they went through and gaining their trust easily. The second trainer was a Syrian psychologist who has extended experience of working with women who have been subjected to violence. Being Syrian herself, in addition to her wide experience with complex trauma cases, this gave the training team a crucial strength. The third trainer is an Egyptian psychologist, who has worked frequently with WHO 's projects with extensive experience of training both professional and lay helpers on various programmes.

Procedure

To begin the training, facilitators were introduced to the procedure and details of the 10 days, following the training guide provided by WHO to moderate and guide the training (Table 1). The trainers used a variety of teaching techniques, including interactive and adult learning techniques, as outlined below:

(1) Participants were asked to read the relevant material before training to facilitate the learning process.
(2) The trainers provided a theoretical background through a brief lecture assisted by a power point presentation.
(3) Each strategy or skill was taught through games.
(4) Trainers presented each section of the sessions as a demonstration.
(5) The trainees were asked to practice each section in pairs and demonstrate it to the larger group.
(6) Group discussions w ere used as a brain storming method and to answer questions.
(7) Smaller group activities and competitions were used to encourage the creation of a more active atmosphere.
(8) The parking lot strategy was employed, where participants could write their questions on post-its and leave them on a white board so they could be answered later.
(9) At the end of each day, feedback was given to ensure the needs of participants were being met.
(10) Examples taken from real cases in the same community were included in the training to prepare trainees better.
(11) Some videos were used to support some sections from the manual.

Table 1: *Schedule of the 10-day Training*

Training day	Topics covered
Day 1	Welcome, introductions, training logistics, training preassessment, training expectations and group rules Understanding common mental health problems PM+ overview and the role of the helper Basic helping skills
Day 2	Basic helping skills Reluctant participants The counselling setting and physical contact Assessment tools PM+ preassessment including inclusion and exclusion criteria
Day 3	Managing difficulties in assessment Inclusion of family or friends, with role-play What is PM+ and educating clients about PM+ Understanding adversity, managing stress and bringing PM+ session 1 together
Day 4	Session 1 role-play Managing problems
Day 5	Managing problems review Session 2 role-play Difficult case examples for managing problems The impact of adversity on a person's activity Get Going Keep Doing introduction
Day 6	Get Going Keep Doing action planning, with session 3 role-plays Differences between the PM+ managing problems and GGKD strategies Strengthening social support
Day 7	Session 4 role-plays Staying well and looking to the future, with session 5 role-plays When PM+ can and cannot be extended beyond five sessions Logistics and planning for final PM+ role-plays
Day 8	Final PM+ role-plays Competency assessments Review of final PM+ and role-plays
Day 9	Final PM+ role-plays Competency assessments Review of final PM+ role-plays Continuation of eighth day
Day 10	Self-care for PM+ helpers In-field training, supervision and competency assessments Final review of PM+ learnings and posttraining assessment Distribution of certificates

Note. PM+, Problem Management Plus.

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On the last day of the training, the project staff took advantage of the distinguished location of the centre in the Sulaymaniyah district in Istanbul, with a visit to the Sulaymaniyah Mosque and a picnic lunch in the garden.

Anticipated Challenges

Some challenges were anticipated before the training, such as drop-outs and stress, and precautions were taken to minimise their impact. In terms of minimising drop-out rates, aspects such as adjusting training times to account for transportation difficulties and recognising the potential impact a 10-day training might have on those women with family responsibilities were taken into account. Mothers were encouraged to bring their children and a facilitator who was specialised in children's activities worked with them in the children's space at the centre. Additionally, time was allocated within the training to complete homework, so as not to impinge on home time, and the lunch break was shortened to allow the trainees to leave half an hour earlier than originally scheduled.

To mitigate stress and triggers that could potentially cause harm to the trainees, training in stress management and grounding skills was provided. Self-care and support were provided during the training, and supervision was provided wh en trainees were working with the women they were assisting.

Pre- and Postevaluations

Pre- and postevaluations were conducted to measure trainees' understanding and competency on PM+. The results showed a positive result, indicating that the training had had a positive impact on their professional skills in giving support, as well as in their personal lives. Additionally, the trainees expressed that the training was a special experience for them, which touched their hearts.

Online PM+ Training

Rationale for Online Training

During the COVID-19 outbreak maintaining an adequate distance from others was an imperative and necessary precaution to avoid the spread of the virus. The exception was only for frontline workers. However, in such critical times when the need for support is high, but cannot be given face-to-face, having an alternative such as remotely provided services plays an important role. It was therefore necessary to provide the PM+ programme remotely. This meant that conversations took place between service providers and those who were affected through video calls, online media sources, applications and other social media means to maintain social contact.

Online Training Programme

The 20 hours of the training was divided into two sections: the first section took 4 hours and included theoretical knowledge given in a lecture format (including presentation slides, illustrations and supporting documents), the second section took 16 hours (divided into eight 2 –hour sessions) and was given in smaller groups focusing on practical knowledge, including role-plays, brief informative sections, feedback sessions, questions and answers, and homework through an online communication platform, to impart the skills required to provide online mental health and psychosocial support (MHPSS) services. Additionally, times were chosen over weekends or in the evenings to accommodate trainees who had other responsibilities, such as work or studies, or any emergency situations that arose. However, the overall duration and the content w ere preserved within the same frame.

Some adaptations were made to activities included in the PM+ training to ensure suitability during the pandemic period and encourage everyone involved in the training to follow essential precautions. The agendas of the first section of the training, covering theoretical knowledge, are summarised in Table 2, and the agendas of the second section, covering practical knowledge and role-plays, are summarised in Table 3.

Training Details

It was intended that by making the groups of attendees smaller enabled each of them to have the opportunity to take both the role of helper and the role of participant to facilitate the process of learning and develop their online skills.

In the first session, all the needed information, materials and the distribution of the roles were given. Each training session started with a brief review of the previous session and answering any questions that had arisen over that week. After clarifying any possible confusion and reviewing the materials, a short explanation and reminder of the PM+ session to be practised that day was provided. During these explanation sections of the training, each trainee was asked to have their manuals with them so they could follow

Table 2: *Training Agenda Theoretical Knowledge*

Session	Subject
1	Welcome and introduction (checking the wellbeing of the attendees)
2	Why online PM+
3	Planning for provision of MHPSS remotely
4	Applications that could be used in remote MHPSS sessions
5	Questions and discussions
6	General review of PM+
7	Brief review of basic helping skills
8	Confidentiality
9	Non verbal s kills
10	Difficult participant during practice
11	Challenges that could occur during the implementation (Discussion)
12	Relaxation skills
13	Differences between online PM+ and face-to-face sessions
14	Self-care and peer support
15	Do's and don'ts

Note. MHPSS, mental health and psychosocial support; PM+, Problem Management Plus.

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Table 3: *Training Agenda Practical Section*

Day	Training schedule	Tasks
1	Differences between the face-to-face PM+ sessions and online sessions, with details Online assessment through the online form Inclusion and exclusion criteria Task distribution among the helpers to role-play the PM+ sessions in the coming days of the training Questions Homework	Task distribution among the participants Homework: each trainee is expected to apply the assessment to herself and to a peer-helper to practise skills
2	Brief review Role-plays for the assessment session Feedback Questions Homework	Role-play
3	Brief review Role-plays for the first PM+ session Feedback Questions Homework	Role-play
4	Brief review Role-plays for the second PM+ session Feedback Questions Homework	Role-play
5	Brief review Role-plays for the third PM+ session Feedback Questions Homework	Role-play
6	Brief review Role-plays for the fourth PM+ session Feedback Questions Homework	Role-play
7	Brief review Role-plays for the last PM+ session Feedback Questions Homework	Role-play
8	Review of all the sessions Feedback and improvement suggestions Role play on the postassessment Questions Arrangement of supervision sessions	

Note. PM+, Problem Management Plus.

the trainer's points and take notes, if necessary. In addition, power point presentations were used through the share the screen option to ensure that all the possible learning techniques were used and to have different teaching techniques included.

Immediately following the review, the trainees were ready to practise the role that had been allocated at the beginning of the first session. Two of them were given the chance to role-play without interruption, except if they needed support or if sections were missing. The others had smaller tasks, such as recording the sections where basic helping skills were used or the sections related to online MHPSS rules. At the end of the role-plays, feedback was given to the trainees who were responsible for the role-plays and the recorded information was discussed. The session was finished by answering any questions that had arisen and with the assignment of homework to be completed by the next training session.

Challenges

In the end, lockdowns in Turkey were age-based restrictions, and as all participants were younger than 60 and older than 20 their movements were not restricted. However, people were afraid to leave home and it was, therefore, more convenient to help them remotely.

Other challenges primarily related to technical equipment issues: weak Internet connections, old devices, lack of headphones and lack of knowledge on how to use devices. In addition, there was a general lack of a private environment in the homes of helpers for the online sessions. As a solution, private rooms were allocated within the centre, where any of the trainees could use computers and the Internet connection to conduct any of their online sessions. Additionally, a child friendly area was provided for trainees who needed it.

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Implementation and Supervision

Each of the trained 20 helpers was expected to give the intervention to 10 refugee women, either face-to-face or through online tools. The sessions lasted 90 minutes and were given once a week. The timing of the session was flexible to meet the needs and situations of the participants.

A strong referral system was built before the start of the sessions and a collaboration with the TRC was established to provide a safe base in case of participants were deemed to be at risk, as identified through the risk assessment tools and basic helping skills that were a part of their training. Participants with suicidal tendencies or plans were referred to a professional psychologist, participants with legal issues were referred to the TRC, and any other case was discussed with the supervisors and handled carefully to ensure that both the helpers and the participants were getting the support they needed.

Supervision sessions were given in the form of online group supervision, in addition to one-to-one calls for trainees who needed additional support or had questions. The 20 trainees were divided into three groups, each with one trainer, to ensure the quality of supervision and provide the opportunity for each trainee to discuss their cases. The supervision sessions were given once a week for the smaller group with each supervisor and once every 2 weeks with the bigger group (all 20 trainees) to enable exchange of experience between the groups.

Before each session, trainees were expected to fill out assessments and supervision forms so the supervisor could follow the process carefully. During these supervision sessions, all trainees had the chance to present the cases they were following and discuss any difficulties that they had been experiencing and suggestions on how they could be overcome. Additional to supervision, self-care and peer support sessions were also conducted whenever the supervisors detected a need for it.

Results

Through both the face-to-face and online training, followed by supervision, the trainees acquired a good understanding of PM+ and their roles as helpers. They also became familiar with the manual, assessment tools and illustrations, and practiced how to use them. Moreover, they learned how to use basic helping skills and respond to potential (personal) questions. They also learned how to identify and deal with common challenges and high-risk situations. A unique addition to the training, as a result of the pandemic, was that they mastered the use of online tools to provide online MHPSS.

It was an advantage to train women who had experienced traumas themselves and were members of the same communities in order to build the trust needed to implement interventions with other women who had experienced GBV, as they were (understandably) mistrustful of anyone from outside their communities. This was especially true for women who had been exposed to torture for a long time. Although an effort was made to avoid matching women with similar traumas, it was useful to have them in the social network to be able to refer cases to each other and to reach a wider population.

On the other hand, as female trainees who had experienced GBV in their lives, it was more challenging to train them and to keep up with the supervision sessions. Additionally, the need for individual sessions and additional support occurred more frequently. However, including stress management early in the training, as well as spiritual and psychological support, played an important role in mitigating any impacts. Throughout the training process, a great improvement was seen in the wellbeing of the trainees. Training and implementing skills for themselves first, followed by implementing and helping others, contributed a lot to their lives, as shown in the trainee case studies below.

Trainee Case 1

Trainee case 1 was a 34-year-old, single, female survivor of arrest and torture in Syrian prisons, who has been facing difficult experiences with her family and was exposed to complex traumas from her childhood. In addition, she has health problems stemming from her time in detention. After her release from prison, she was engaged and developed a strong attachment to her future husband, who died. His death added a new trauma to her experiences. During her training on PM+, she had a dissociative experience where she thought she was back when she was being tortured. This difficult experience made her believe that she would fail the programme. However, her high levels of motivation to help others and to help herself w ere incredible. She continued to learn strategies and helping her friends to master the skills. She stated that seeing that she is not alone with her pain and being able to ease others' pain by teaching coping strategies to the people around her increased her self-esteem and her belief in herself. The programme was a new start for her in her life.

Trainee Case 2

Trainee case 2 was a 43-year-old, married female survivor of arrest and torture in Syrian prisons. She was in therapy previously, and there was good progress before the programme began. However, she still had work to do; she used to repeatedly talk about her difficult experiences and was unable to separate other's problems from her own. During the PM+ training, she learnt how to use basic helping skills with others and shift her focus to today, rather than remaining in the past. She particularly mentioned that problem management skills were the most beneficial for her, which she taught to her children and husband. Her dream was to become a helper to help others. Through the trainings, she became a very good listener and the first to successfully complete the PM+ sessions.

Trainee Case 3

Trainee case 3 was a 38-year-old married mother of two children. She was a survivor of war and her husband is still in Syria. She has been subjected to more than one traumatic

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event, before and after her escape to Turkey, where she was arrested with her children and was detained for almost a week until it was proven that her detention was due to racism. Although she had had several trainings in providing psychological help before PM+, this training specifically helped her in being able to listen without giving direct advice and without judging others. She also mentioned that the breathing exercise has been very helpful to calm both herself and her children, in addition to problem management skills.

Recommendations for Future Training and Implementation

Trainees reported benefiting greatly from role-plays and suggested to have more during face-to-face trainings. One common suggestion was to have a break in the middle of the training. Additionally, some recommendations were made in terms of the illustrations and the translated words used in the manual that could be altered to suit the target population better.

Special sections and some techniques could also be better targeted and added when trainees are part of the community and have experienced similar traumas. Additionally, having a structured training manual for online training on how to improve trainees' skills to give sessions remotely could be a very useful tool. Especially, knowing that there are many populations such as those in Syria where there is no possible way to make the sessions face-to-face, or during pandemic periods, an unknown future for all societies.

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Conflicts of interest

There are no conflicts of interest.

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