Understanding, Preventing and Responding to Crises in Africa



Dr Christian Matthew Adetunji

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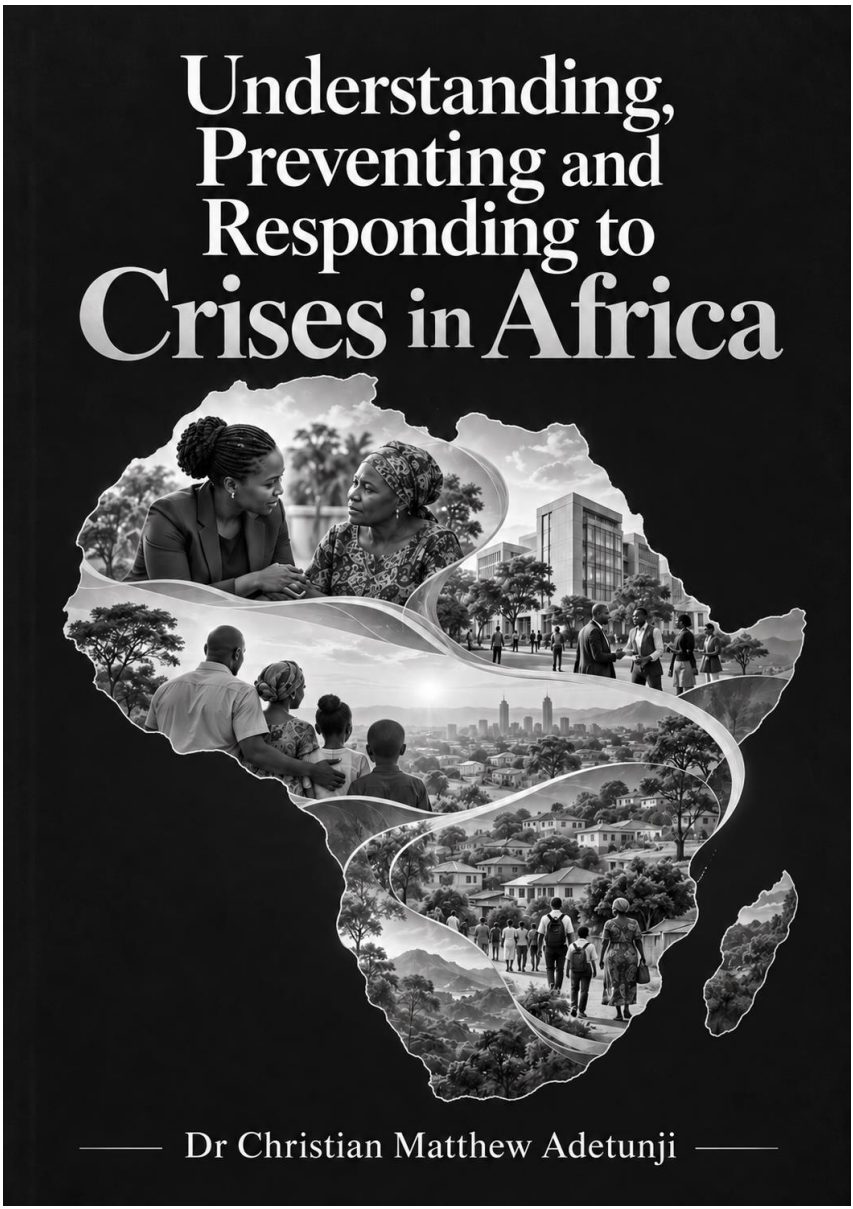
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Dedication

To people whose suffering is heard too late, to families and communities carrying burdens that should be shared, and to those learning to offer help with knowledge, humility, courage, and accountability.

Preface

A crisis may begin with a death, an injury, a threatened relationship, an unpaid salary, a safeguarding concern, or a river rising beyond its banks. Its consequences depend on what the event disrupts and what assistance remains possible. A bereaved person may need companionship and practical support. A family living with violence may need protection. A hospital facing service failure may need an operational response. A displaced community may need water, shelter, access, and continuity of care. The word crisis connects these experiences without making their needs identical.

This book examines crisis prevention and intervention from African settings while engaging international knowledge. Its central argument is that responsible crisis care combines shared commitments with contextual judgement. Human dignity, protection from harm, competent action, and accountability matter across settings. Language, relationships, history, livelihoods, authority, and service arrangements shape how those commitments can be fulfilled. A method becomes useful through an informed assessment of its purpose, assumptions, evidence, and practical requirements.

Africa cannot be represented by a single cultural profile or a single crisis narrative. Nigeria, Sudan, South Sudan, the

Democratic Republic of the Congo, Ethiopia, Kenya, and Rwanda each contain diverse communities. Differences within countries may be as consequential as differences between them. A person's nationality is relevant background, but it does not tell a counsellor what the person believes, whom they trust, whether their family is safe, or what they can afford. The same caution applies when comparing African settings with the United States, Australia, Canada, or countries in Asia.

The book also looks inward at the person offering help. Cultural knowledge cannot compensate for unexamined motives, poor regulation, intrusive self-disclosure, or misuse of professional power. Counsellors may feel drawn to rescue, withdraw, confront, reassure, become indispensable, or defend an institution. Clients may approach them with expectations shaped by earlier relationships and present experiences of authority. These dynamics require attention without turning the client's distress into an explanation for every difficulty in the relationship.

Cultural humility, competence, responsiveness, and safety therefore run through the book alongside transference, countertransference, professional boundaries, embodied awareness, and ethical reasoning. These concerns apply to individual counselling, but they also affect family meetings,

organisational decision making, supervision, training, and public services. A person can be harmed by an insensitive interview or by a system that makes meaningful help inaccessible.

The intended readers include counselling students, professional counsellors, educators, policy makers, organisational leaders, community workers, and people experiencing crisis. Different readers hold different responsibilities. The chapters make those differences explicit. Supportive presence is valuable, but it is not equivalent to clinical assessment, medical care, psychotherapy, investigation, or emergency command. Responsible partnership respects those distinctions while helping people obtain the assistance they need.

Acknowledgements

The intellectual foundations of this book include scholarship on crisis, stress, coping, family adaptation, culture, professional ethics, and disaster risk. The cited authors and institutions are acknowledged through the references accompanying the introduction and chapters. Their inclusion does not imply endorsement of this book or of its contextual applications.

The book also recognises the labour of counsellors, caregivers, community workers, educators, and public servants who support people through difficult conditions. Such recognition should carry practical consequences: fair workloads, supervision, accessible services, and resources for sustained care. Gratitude should not become a substitute for these responsibilities.

How to Use This Book

Students can read the book in sequence, compare theories with cases, and practise under supervision. Reflection activities are intended to reveal assumptions and improve judgement, rather than reward confident answers unsupported by evidence. Practitioners can begin with the assessment and intervention chapters and then consult the relevant setting. Policy makers and organisational leaders should connect those chapters with preparedness, safeguarding, service continuity, and evaluation.

People experiencing crises can use the explanations to understand possible responses and to prepare questions for a helper. They do not need to assess their own condition perfectly before asking for assistance. They can say what has happened, what is becoming difficult, what feels unsafe, and what help they need. The responsibility to make care accessible belongs partly to services and institutions, not solely to the distressed person.

The book distinguishes established findings, professional guidance, theoretical explanations, and its own practical synthesis. A recommendation drawn from another jurisdiction is not automatically a local legal duty. A study conducted in one African population is not evidence of equivalent performance across the continent. Meaning and measurement, rather than mere translation of an assessment tool, must be considered when

assessing the tool in another language. Learning goals, teaching cases, and reflective exercises supplement each chapter. The discussion of cases should not force disclosure of personal trauma from the learners. Role-playing must provide people time-out options. Skill development should be accompanied by feedback on consent, boundaries, language, regulation, and practical feasibility.

During an immediate threat to life, serious injury, poisoning, a suicide attempt, or imminent violence, obtain urgent appropriate assistance. When safe, maintain supportive contact with a person in immediate suicidal danger while arranging a responsible handover. Do not attempt dangerous physical rescue or disarmament without trained support. For ongoing concerns, seek qualified assessment and agree feasible follow-up rather than relying on reassurance alone.

Introduction

The Questions That Shape the Book

People across societies can experience grief, fear, anger, isolation and difficulty managing everyday activities. How they respond depends partly on what the event means to them, what has been disrupted and which resources they can use.

Ask who can offer support, who holds power, what may create danger and what involvement the person freely chooses. Family, community and shared livelihoods may be important to the response, depending on the person's circumstances.

Psychological first aid offers an example of international guidance that explicitly connects humane assistance with respect for culture and ability (World Health Organization et al., 2011). Its existence challenges the claim that international approaches must necessarily ignore context. Its practical use still requires local knowledge and a clear understanding of scope. Shared principles do not organise transport, establish an available referral service, or make an unsafe household protective.

Crisis Within and Beyond the Individual

The book considers crisis at individual, family, organisational and community levels. Suicidal distress may occur in a household facing eviction. A workplace closure can interrupt

access to medication. Flooding can damage water supplies and leave individuals grieving.

Assessment identifies what happened, what is continuing, who may be unsafe and what support is available. The resulting plan may call for emotional support, clinical care, practical assistance or action by an organisation or public authority. Each task needs an identified person or service.

The WHO and UNHCR humanitarian guide addresses a range of mental, neurological, and substance use conditions through appropriately prepared health services (World Health Organization & United Nations High Commissioner for Refugees, 2015). This breadth supports an important distinction: emergency-related distress and conditions requiring clinical care must not be treated as interchangeable. A crisis can require urgent support without establishing a psychiatric diagnosis; a diagnosable condition can require continuing care after a crisis has stabilised.

Four Cultural Responsibilities

Cultural humility involves continuing self-examination. Competence concerns the knowledge and skills needed for a task. Responsiveness changes the way a service is offered, and cultural safety asks how people experience care and the use of

power. Chapter 2 develops these distinctions using Tervalon and Murray-García (1998) and Curtis et al. (2019).

Consider cultural safety alongside immediate physical safety. Chapter 1 also examines how a practitioner's reactions, boundaries and assumptions can shape the encounter.

The Counsellor as Part of the Encounter

The counsellor's values, physical reactions and authority can influence what is noticed and whose explanation takes priority. The client's prior relationships and experiences with services may affect what they feel able to disclose.

Transference concerns how earlier relationships shape expectations and feelings towards the counsellor. Countertransference concerns the counsellor's reactions, including those influenced by personal experience. Hayes et al. (2018) found an association between managing countertransference and psychotherapy outcomes.

Use this evidence to support reflection and supervision. An impression about the client's motives remains a hypothesis to examine.

The terms 'pull' and 'urge' describe a felt pressure to act, such as rescuing, withdrawing or disclosing personal information. Check whether acting on it would serve the client, fit the role and withstand supervision.

Professional ethics require attention to competence, boundaries, power and confidentiality (British Association for Counselling and Psychotherapy, 2018). Explain the limits of the role and follow the legal and professional requirements of the setting.

Structure of the Book

Chapters 1–3 explain crisis, cultural context and theory. Chapters 4–5 cover assessment, intervention, referral and continuity. Chapters 6–9 apply these principles to individuals, families, organisations and communities. Chapter 10 brings prevention, preparedness, policy and evaluation together.

A practical response identifies immediate danger, the person's priorities, available resources and who will act before the next review. It also asks whose needs or account may have been overlooked.

The book cites the BACP's 2018 framework as an ethical reference. BACP set 3 November 2026 as the date its new framework became mandatory for members (British Association for Counselling and Psychotherapy, n.d.-b). Practitioners should also check the requirements that apply where they work.

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Chapter 1: Understanding Crisis and Its Dimensions

Learning Objectives

By the end of this chapter, readers should be able to distinguish a crisis from its precipitating stressor; explain severity, intensity, duration, and functioning; examine differences across individual, family, organisational, and community settings; explain why reactions differ and crises persist; and identify cultural, relational, embodied, and ethical responsibilities in the first encounter. Readers should also be able to describe how the counsellor's internal responses can influence assessment without treating those responses as evidence of a client's intentions.

Opening Perspective

A person may say, "I cannot manage this anymore," after an event that others regard as ordinary. Another person may continue working after a devastating loss and appear unaffected. A family may maintain meals and school attendance while one member lives in fear. An organisation may issue calm public statements while its essential services fail. These differences show why crisis cannot be identified simply by dramatic events, visible emotion, or the passage of time.

A crisis develops when demands exceed a person's or system's capacity to respond. That capacity depends on abilities, reliable

relationships, material resources and access to functioning services.

The counsellor asks what has become unmanageable and what needs action now. Policymakers can also ask which failures made the disruption harder to prevent or address.

Defining Crisis

A crisis is a situation in which an event, threat, or accumulation of pressures exceeds the usual capacity of a person or system to maintain sufficient safety, stability, or effective functioning. Classical crisis theory emphasised disruption of equilibrium and the failure of familiar coping, while later intervention models organised assessment and purposeful action (Caplan, 1964; Roberts & Ottens, 2005). This book applies that broad understanding across several settings, without claiming that a clinical model alone explains every organisational or community emergency.

A stressor and a crisis are related but distinct. Job loss is a stressor. It may become a crisis when it threatens food, housing, treatment, identity, and family relationships while workable support is absent. Another worker may experience the same loss with savings and realistic employment opportunities. Both may suffer. Their immediate needs and ability to manage the situation

may nevertheless differ. The comparison concerns demands and resources, not superior character.

The definition also requires attention to safety. A person should not have to become visibly disorganised before receiving protection from imminent violence. Nor should a service wait until all operations collapse before recognising that an essential function is dangerously compromised. Some crises are apparent through emotional distress; others are identified through threatened life, lost access, coercion, or failure of responsibilities. Asking whether someone looks distressed is therefore only one part of understanding the situation.

Stress, Distress, Trauma and Emergency

Stress refers to demands and the responses associated with them. Distress describes suffering or strain. These terms help explain experience but do not, by themselves, indicate whether urgent action is needed. A student can be distressed about an examination and still retain sleep, support, and effective functioning. A parent can speak calmly while facing an immediate threat to a child's health. The emotional presentation and the practical urgency need separate attention.

A potentially traumatic event involves exposure to serious threat or harm, such as threatened death, severe injury, or sexual violence. Everyday use of trauma is often broader than

diagnostic use. Neither meaning should be allowed to obscure the actual event or need. Calling every disappointment trauma may blur important distinctions. Calling severe violence ordinary stress may minimise its consequences. The counsellor can begin with the person's own language and then clarify relevant clinical terms when their role permits.

An emergency requires urgent action to protect life, health, safety, or essential functions. A crisis may contain an emergency, but crisis intervention can continue after immediate danger is addressed. Conversely, medical assistance may be urgent even where the person remains emotionally organised. The WHO and UNHCR guide distinguishes a range of conditions needing assessment and care in humanitarian health settings (World Health Organization & United Nations High Commissioner for Refugees, 2015). It supports careful differentiation rather than assuming that everyone affected by adversity has the same disorder.

Events, Meanings and Consequences

The same event can threaten different things. Retirement may bring relief to one person and a loss of status, income, and purpose to another. Bereavement may involve grief alongside inheritance disputes, financial insecurity, or the disappearance of a caregiver. A counselling inquiry that identifies only the

event can therefore miss the crisis. The next question is what the event has changed and what the person fears will happen now.

Meaning also shapes the response. A loss can be understood as misfortune, abandonment, failure, punishment, injustice, or a disruption of expected life. These interpretations influence shame, anger, hope, and willingness to seek help. They should be explored respectfully without treating every painful appraisal as distorted thinking. If a family has genuinely lost its home or a survivor remains exposed to an assailant, danger is not resolved by asking the person to think positively.

The consequences may unfold over time. A flood destroys stock today, but debt, school withdrawal, and hunger may appear later. An employer's delayed salary can first create anxiety and then interrupt medication. This changing sequence explains why a crisis assessment should include recent change, accumulated pressure, and likely near-term consequences. The counsellor need not predict the entire future. They do need to identify what may deteriorate before the next contact and who can act if it does.

Categories of Crisis

Developmental crises arise around transitions that require adjustment, such as adolescence, parenthood, retirement, changing roles, or increased dependence in later life. The

transition itself is not necessarily a crisis. It becomes one when demands exceed workable coping and support. A new parent may manage uncertainty with assistance; another may experience exhaustion, isolation, health concerns, and unsafe conflict. The relevant question is how the transition is being lived.

Situational crises follow particular events, including bereavement, serious illness, assault, dismissal, relationship breakdown, or displacement. Some events are sudden; others emerge through repeated incidents. An existential or meaning-related crisis concerns questions of identity, purpose, belonging, or moral direction. These descriptions can overlap with clinical conditions but do not establish diagnoses. They help organise inquiry into what the person has lost and what has become uncertain.

Collective crises may involve disasters, conflict, epidemics, or failure of infrastructure and services. UNDRR terminology describes disaster through disruption involving hazards, exposure, vulnerability, and capacity (United Nations Office for Disaster Risk Reduction, n.d.). That perspective prevents the hazardous event from becoming the whole explanation. A heavy storm has different consequences where drainage, housing, warnings, and evacuation arrangements differ. Categories

should make these relationships easier to examine rather than force every case into a single box.

Individual, Family, Organisational and Community Settings

An individual crisis may threaten safety, self-care, relationships, identity, or daily functioning. The person remains the centre of the encounter, even when wider conditions are important. A counsellor should ask what the person needs now and what support they want involved. The existence of family members does not establish that those relatives are available, trusted, or safe. Individual assessment may reveal a need for health care, protection, practical assistance, or continuing therapeutic support.

A family crisis concerns arrangements through which members maintain care, income, housing, schooling, and relationships. Its effects are distributed unevenly. One member may appear to cope because another has assumed exhausting responsibilities. A family assessment must include who is bearing the load, who has the decision-making powers, and whose needs are concealed. Although a joint meeting may work in some instances, it does not work in situations where a person is worried about being retaliated against or feels that he or she cannot express their views.

An organisational crisis entails a threat to people, processes, obligations, or reputations. Safeguarding allegations, unsafe staffing, information loss, or service interruption can generate

personal crises as well. A community crisis can disrupt shelter, water, access, livelihoods, and shared life. Counselling belongs within an organised response, alongside services and public responsibilities. The appropriate unit of assessment is therefore the actual person or system affected, with attention to its connections to other settings.

Setting	What may be disrupted	Initial questions
Individual	Safety self-care meaning relationships	What is unsafe and what can the person manage today
Family	Care income housing roles	Who is affected who carries the burden and who can speak safely
Organisation	Protection operations obligations	Which functions or users are at risk and who has authority to act
Community	Shelter water access livelihoods	Who is exposed which services have failed and who is being excluded

Severity and Intensity

Severity concerns the seriousness of actual or potential consequences. Intensity concerns the strength of a response at a particular moment. A person crying loudly may be experiencing intense distress while retaining support and immediate safety. A

quiet person may have stopped eating, lost accommodation, or formed an intention to end their life. Visible intensity cannot establish severity. The counsellor should attend to emotion without making it the sole basis of action.

Severity can be examined through threatened life, injury, loss of essential needs, impaired functioning, continuing violence, and failure of protective arrangements. Intensity can be explored through the person's description, changes in behaviour, and their experience of emotion and bodily activation. A personal rating of distress may help communication or monitoring, but it is not a universal crisis score. Two people using the same number may mean different things.

The distinction has practical consequences. An apparently calmer client may still need urgent assistance. A highly distressed client may benefit from patient support without being treated as incapable of choice. The National Institute for Health and Care Excellence recommends against the use of risk scores or risk categories for predicting suicide and access to treatment (NICE, 2022). Assessment should identify current needs and safety actions, with appropriate clinical involvement, rather than seek reassurance from a label.

Time, Duration and Repeated Exposure

Time has several meanings in a crisis. It includes the speed of onset, the duration of exposure, the frequency of recurrence, and the opportunity for recovery between events. A sudden death differs from an illness that has required years of caregiving. A household displaced once differs from one repeatedly forced to move. These differences shape exhaustion, resources, expectations, and what the next practical step can be.

There is no universal period of difficulty after which crisis inevitably begins. A threat can require action within minutes. A person can also endure substantial hardship for a long time before familiar supports fail. Apparent endurance does not show that conditions were acceptable or harmless. Asking how long the person managed can provide history; it should not become a judgement that they ought to have managed longer.

The passage of time does not establish resolution. Assistance may end, creditors may become more demanding, relatives may withdraw, and delayed consequences may emerge. A temporary shelter can become unavailable while grief remains unchanged. Recovery therefore needs review through actual safety and functioning. Classical descriptions of acute crisis may be useful for understanding episodes, but a fixed timetable should not be imposed on continuing danger or accumulated adversity. The

chapter's descriptive sequence below is a teaching aid, not a validated stage assessment.

Processes Without a Mandatory Sequence

A crisis can be understood as mounting pressure, disruption of familiar coping, attempts to obtain control, stabilisation, and adaptation. These are possible processes rather than steps everyone completes in order. A person may move between them as conditions change. A family may restore income while one member remains distressed. One road might be opened up again by a community, and there is still no clean drinking water. Various elements of restoration happen at different speeds.

Increased pressure could take the form of sleep disturbance, conflict, task disruption, persistent requests for help, or withdrawal. As old coping strategies become ineffective, individuals may look for new forms of assistance, act impulsively, focus only on limited options, and be unable to decide. The above are phenomena worth exploring, but neither diagnose problems nor predict a particular outcome. This is because their significance is relative to the individual's context. The purpose of stabilisation is to reduce danger and pressure. Reconstructing daily life and meaning is the goal of adaptation. The aim is not always a return to the previous situation. That situation may have included violence, unsafe services, or an

unsustainable burden. Responsible recovery may require different roles or institutional arrangements. A counsellor should therefore ask what needs to change, rather than assume that restoring the former equilibrium is automatically desirable.

Why Reactions Differ

Reactions differ because exposure, meaning, previous experiences, development, health, disability, relationships, and opportunities for action differ. Even members of one household may have lived through an event differently. One person saw the injury; another heard about it later. One lost income; another lost a trusted caregiver. Similarity of the event's name does not establish similarity of experience. Counselling begins with the person's account rather than an expected pattern.

People also express distress differently. Silence may reflect fear, exhaustion, numbness, privacy, deference, or a wish to avoid burdening others. Anger may express injustice, helplessness, pain, or a sense of being dismissed. Emotional expression should be explored without assuming that cultural membership supplies the answer. A counsellor can ask what the person notices in themselves and what others may be misunderstanding.

Previous adversity may have helped someone develop practical skills while also increasing exhaustion or vulnerability. Support can strengthen coping, but support that is unreliable, coercive,

or conditional may create further pressure. A person who appears confident may have few options. Another who expresses fear openly may possess a strong and usable network. These differences explain why assessment should investigate the actual operation of resources, rather than count relationships or infer resilience from appearance.

Why Crises Persist

Crises persist when their drivers remain active or when new demands replace the original event. Continuing violence, unstable housing, untreated health needs, debt, discrimination, disrupted services, and repeated loss can maintain danger or overwhelm. Emotional support may help someone think and act, but it cannot by itself repair these conditions. The practical task is to identify which pressures are modifiable, by whom, and within what period.

Some responses can bring short-term relief while increasing later difficulties. Evading debt warnings might help lower stress levels at present while letting the penalty accrue. Excessive consumption of substances may help one distract from their agony while compromising their safety and social interactions. This behaviour absolves individuals with no other option from blame in these scenarios. Instead, they provide a basis for examining the effects, implications, and costs of such a solution, as well as its feasibility and potential alternatives.

Responses within institutions could be causing a crisis too. Unaccompanied refusals, unavailability of application forms, unmanageable disclosure requests, or sudden cessation of support services could further agitate individuals. Calling a person resistant because they cannot afford transport hides a service barrier inside a personal label. Assessment should examine whether the plan can actually be carried out. Policy evaluation should ask whether people become safer and function better, rather than treat the number of sessions delivered as proof of recovery.

Culture and the Actual Person

Culture influences language, explanations of suffering, mourning, help seeking, authority, privacy, and relationships. It also changes over time and varies within communities. A person may draw on faith, extended family, professional services, and digital networks simultaneously. A counsellor should not require them to fit a simplified opposition between African tradition and international practice. The task is to understand the combinations that matter in their life.

Country knowledge can guide questions but should not supply individual answers. Knowing that extended family relationships may be important does not reveal whether a particular uncle is supportive or controlling. Sharing a nationality or language with

the client does not remove differences in gender, class, age, religion, disability, education, or professional status. Familiarity can sometimes increase the risk of assuming that one already understands.

The inquiry should therefore be specific. What does the person call the difficulty? What do they believe caused it? What assistance have they tried? Whom do they want involved? What would make involvement unsafe? Which expectations matter to them, and which create pressure? These questions connect meaning with action. They also allow the person to disagree with the counsellor's assumptions without being judged disloyal to a community or uncooperative with care.

Humility, Competence, Responsiveness and Cultural Safety

At the first encounter, make the cultural responsibilities observable. Ask which language the person wants to use, explain the actual role of the service, and establish how the person can correct an assumption. A question such as "What am I missing about what matters to you?" should lead to a revised understanding or action. The principal definitions and their foundations in Tervalon and Murray-García (1998) are developed in Chapter 2.

Check whether participation is feasible. A person may need interpretation, a private appointment, an accessible format or a

contact arrangement that does not alert an unsafe relative. Record the agreed change and check whether it worked. Sharing a language or background does not establish the skills required for clinical assessment or protection. Obtain assistance when the task exceeds the practitioner's competence.

Ask how the encounter is experienced: can the person refuse an invitation, disagree with advice and raise a concern without losing help? Curtis et al. (2019) connect cultural safety with power and health equity. Its application here is a usable route for participation and correction. Assess immediate danger separately; respectful conversation cannot compensate for an unresolved threat to life or health.

Client Transference and Present Reality

Client transference describes how feelings and expectations shaped by earlier significant relationships can become directed toward the counsellor. A person may anticipate criticism, abandonment, rescue, or special protection. These possibilities can help the practitioner consider relational patterns, but they should be treated as hypotheses. The client's description of dismissal could be an accurate description of the current service. It is important for the counsellor to first look at themselves before interpreting the issue from the client's history.

In crisis, dependence on assistance can intensify expectations. A client may ask the counsellor to make every decision because they feel overwhelmed. Another may distrust a professional who resembles an authority previously associated with harm. A responsible response combines clear explanations with attention to what the encounter is actually producing. It is rarely helpful in an urgent meeting to impose a complex interpretation when the person first needs safety, food, or a reliable referral.

The practitioner can respond to the observable relationship: “It seems difficult to know whether I will follow through. Let us clarify what I can do and when you will hear from me.” This approach acknowledges uncertainty and offers accountable action. It does not promise unlimited availability. Relational insight should increase understanding and reliability, not become a way to dismiss objections, infer hidden motives, or make the client responsible for correcting a poorly organised service.

Counsellor Countertransference

Countertransference concerns the counsellor’s responses to the client, including reactions influenced by personal conflicts, experiences, and vulnerabilities. It can appear as unusually strong sympathy, irritation, fear, helplessness, attraction, protectiveness, or a need to prove competence. According to

Hayes et al. (2018), effective handling of countertransference by a therapist has been linked to positive psychotherapy outcomes, despite some limitations in the studies conducted. This does not establish that every feeling has one psychological cause or that its meaning is self-evident. Narrower psychodynamic definitions emphasise unconscious responses linked to the practitioner's history; broader contemporary usage includes more of the practitioner's reactions. State the meaning used in supervision and examine its effects on care.

Consider a counsellor whose family experienced eviction. A client's housing crisis may prompt a wish to offer personal money immediately. The wish may be compassionate, but its urgency may also reflect the counsellor's unresolved experience. The relevant professional questions concern role, consequences, fairness, alternatives, and supervision. The practitioner should not ask the client to provide reassurance or manage the practitioner's feelings.

Countertransference awareness is useful across theoretical orientations. It means noticing that the helper participates in the encounter and can affect judgement. One's reflection would look at emotions, actions, reasons that support these actions, and possible challenges from a superior or co-worker. The counsellor's emotion can prompt further inquiry; it is not proof

of the client's character. Strong reactions deserve attention especially when they lead to exceptions, secrecy, hostility, or avoidance.

Pull and Urges in Crisis Work

Pull describes the felt pressure of the situation or relationship, while an urge is the impulse to respond in a particular way. These are ordinary reflective terms in this book, not diagnostic categories. Common urges include rescuing, confronting, withdrawing, touching, reassuring, disclosing, contacting relatives, or taking over decisions. Crisis work can produce real urgency, but that urgency does not make every impulse appropriate.

A practical pause asks what is happening, what needs protection, what role the counsellor holds, and whether the proposed action has a feasible benefit. When immediate danger requires action, the pause may be brief and occur alongside arranging assistance. It should not delay emergency care. In less urgent circumstances, consultation can clarify whether a proposed exception serves the person or primarily relieves the counsellor's discomfort.

For example, a counsellor may want to promise that a bereaved client will recover soon because silence feels intolerable. A more responsible action is to acknowledge the loss and help identify the next manageable need. Another practitioner may want to end

contact with an angry client. Before acting, they can distinguish a safety threat from the client's understandable dissatisfaction. Neither compassion nor discomfort should determine the response without consideration of facts, boundaries, and consequences.

Professional Boundaries, Power and Asymmetry

Professional boundaries define the purpose and limits of the helping relationship. They concern roles, contact, time, fees, confidentiality, records, physical interaction, and involvement beyond the service. Crisis may require flexibility, but a change should have an identified purpose and remain reviewable. Boundaries should protect the client and the reliability of care, rather than function as unexplained rules imposed for convenience.

Power asymmetry means that the participants do not hold equal authority or control. The counsellor may control appointments, reports, referrals, and access to information. A client may depend on those decisions and feel unable to disagree. Professional responsibility therefore includes explaining choices and limits and making room for questions. Cultural respect for elders or professionals should not be mistaken for informed agreement.

Overlapping roles deserve particular attention in close communities. A practitioner may also be a lecturer, pastor, mediator, employer, or family acquaintance. A client can then face consequences beyond the counselling room. BACP's boundary guidance places responsibility for maintaining the professional relationship on the therapist (British Association for Counselling and Psychotherapy, n.d.-a). In practice, the counsellor should clarify roles, consider conflicts, seek supervision, and arrange a feasible alternative where the overlap compromises care. Local familiarity does not excuse exploitation or coercion.

Self-Disclosure Intentions

Self-disclosure is the sharing of personal information by the counsellor. It may include experience, beliefs, feelings, or biographical detail. The key question is what the disclosure is intended to accomplish for the client. A brief statement may sometimes clarify a role or reduce misunderstanding. A lengthy account of the counsellor's own suffering can shift attention and burden the client with responding to the helper.

Before disclosing, consider relevance, timing, amount, likely effect, and alternatives. Would the information help the person make a decision or understand the process? Is it being offered because the counsellor wants relief, admiration, closeness, or

proof of shared experience? Can the same purpose be achieved through an empathic response or a clear explanation? These questions examine intention without assuming that good intention guarantees a helpful effect.

In crisis, a client may be especially sensitive to implied obligations. Hearing that the counsellor sacrificed personal time may make the client feel indebted. A story about the counsellor's bereavement may create pressure to recover in the same way. If disclosure has redirected the session, the practitioner should acknowledge this and return attention to the client. Repeated uncertainty about disclosure belongs in supervision, with attention to the client's actual response and the purpose of the service.

Internal State, Embodiment and Regulation

The counsellor's internal state includes attention, emotion, fatigue, beliefs, and bodily responses. Embodiment draws attention to how the encounter is experienced through posture, breathing, muscle tension, movement, and physical presence. A practitioner may notice a tight jaw, hurried speech, shaking hands, or an impulse to move away. These observations can signal stress, but they do not by themselves reveal what the client is experiencing or why.

Somatic and emotional regulation concern maintaining enough steadiness to notice, listen, think, and act responsibly. The practitioner may adjust posture, slow speech, orient to the room, or briefly settle their breathing where comfortable. These are practical options, not a treatment prescription or proof of a particular biological theory. They should support attention rather than become a rigid performance of calmness. A counsellor can feel concern while remaining professionally useful.

The client's bodily symptoms also require care. Chest pain, confusion, fainting, or difficulty breathing should not automatically be interpreted as anxiety; appropriate medical assessment may be needed. Physical exercises should be offered with consent and stopped if uncomfortable. Regulation cannot make an unsafe environment safe. It accompanies protection, practical assistance, and appropriate health care. The counsellor should assess their own capacity to continue and obtain support if fatigue or activation undermines judgement.

Blind Spots, Triggers and Reflective Practice

A blind spot is an aspect of experience or practice that the counsellor does not readily recognise. A trigger is an event or feature that evokes a strong response; it does not necessarily imply trauma or a diagnosis. Blind spots can involve assumptions about gender, marriage, faith, poverty, disability,

education, or the proper way to grieve. They can also concern professional confidence, such as believing that expertise makes mistakes unlikely.

Reflection should be concrete. What information did I overlook? Whose account did I trust immediately? Did I ask about danger privately? Did I interpret inability to attend as resistance? Did I feel unusually invested in a particular outcome? A supervisor can help examine these questions through observable behaviour and decisions. Reflective practice is weakened when it consists only of declaring oneself empathic or culturally aware.

Feedback from clients and colleagues can uncover blind spots, but receiving it requires a level of security to avoid potential backlash. A person who depends on a service may not complain openly. Practitioners should offer understandable ways to question care and should review patterns of missed contact, premature discharge, and unsuccessful referrals. Personal reflection and service evaluation belong together. An individual counsellor may need support, while the organisation may need to change the conditions that repeatedly undermine good work.

Ethical and Systemic Realities

Ethical practice occurs within real constraints: available services, law, regulation, funding, safety, organisational demands, and the person’s ability to choose. The practitioner

should identify these conditions rather than imagine that ethical judgement is a private choice unaffected by context. This discussion includes the competency, supervision, boundaries, and responsible working criteria outlined in BACP's guidelines (British Association for Counselling and Psychotherapy, 2018). However, any relevant local standards that are to be met will have to be determined independently.

Confidentiality is especially important during a crisis situation since there may be repercussions in the form of stigma, revenge, or discrimination against the individual. Clearly define the relevant limitations as soon as possible. Share the information via appropriate means. Avoid vague promises of absolute secrecy. Equally, concern about safety should not become an unrestricted justification for circulating personal information.

Systemic responsibility includes documenting unmet needs and escalating service failures through appropriate arrangements. A counsellor should not present an unavailable referral as completed care. A manager should not expect unlimited availability to compensate for inadequate staffing. Policy makers should examine access, continuity, protection, and equity. Responsibility is distributed, but it must remain identifiable. A plan that relies on unspecified others to provide help may leave the person with no effective support at all.

Teaching Case and Integrated Application

Consider a fictional market trader in Ibadan whose stock is destroyed by flooding. Neighbours provide temporary accommodation and food. A month later, assistance ends, creditors demand payment, and a child stops attending school. The trader says, "I managed the flood, but I cannot manage what followed." The counsellor, reminded of a childhood housing loss, feels an urgent wish to provide personal money and contact the trader's relatives without further discussion.

Assessment distinguishes the event from the sustaining pressures. Flood brings loss, and now that the person is struggling with debts, unstable shelter, interrupted schooling, and dwindling support, things are only getting worse. There is no proof of change in the situation through the calmer story told by the trader. The counsellor should ask questions regarding safety, basic needs, day-to-day functioning, health and assistance currently available. If the suicide risk comes up, proper assessment and assistance will be vital. The counsellor then reviews the impulse to save. Identification can influence the counsellor's judgement. An effective solution will allow one to understand the client's priorities and identify safe, consented support options. Consultation can address whether any material assistance is appropriate within the service's arrangements. The aim is a plan the client can use, with responsibilities and limits made clear. The counsellor's private

experience should not become the organising story of the client's crisis.

From Understanding to a Feasible Response

Understanding should lead to a next action that fits the assessed situation. A useful initial plan identifies the immediate concern, the person responsible for each action, the assistance actually available, and the point of review. A suggestion to seek support remains incomplete until the person knows where to go, whether the service can receive them, and how to reach it. A plan can be modest and still be valuable if its steps are workable and its limits are clear.

Separate what can be done now from what needs another person's authority. A counsellor may help someone explain an urgent health need and arrange contact with a suitable service. They cannot guarantee admission, authorise housing, or remove an organisational hazard through counselling. Recording these distinctions protects the person from false assurances and helps the responsible institution recognise what remains unresolved. Where several services are involved, clarify which one will maintain contact so the person is not repeatedly required to coordinate the entire response.

Review should ask what happened after the plan was agreed. Did the person receive assistance? Did the practical barrier change?

Was the contact safe? Has another pressure emerged? An unsuccessful action provides information for revision; it should not automatically be interpreted as lack of motivation. The counsellor should also consider whether their own expectations, rushed explanations, or unexamined preference for a particular solution contributed to the failure. This links contextual assessment with reflective practice and makes care more accountable over time.

Worked Timeline of Intensity, Disruption and Continuing Risk

This fictional example separates four dimensions often compressed into the word severe. A shopkeeper receives an eviction notice on Monday. The stressor is threatened loss of premises; consequences include income interruption and uncertain debt. Distress rises sharply, but she can arrange childcare and contact a business association. On Tuesday she sounds calmer. The notice remains, stock is exposed and she has stopped eating regularly. Reduced emotional intensity has not resolved the continuing threat or impairment in daily care.

On Wednesday she reports thoughts of death. A qualified practitioner addresses these directly and arranges assessment and support. The business problem remains relevant, but practical negotiation cannot substitute for the response to

suicidal distress. On Friday, temporary storage protects stock and a trusted person helps with meals. Review asks separately about present safety, functioning, the eviction process and continuing support. None is inferred solely from how composed she appears.

A record can track the event's status, reported intensity, observable disruption and present danger on separate lines. Record time and the source of each observation. Apparent improvement may reflect support, exhaustion, concealment or changed conditions; ask what changed. This timeline is an educational formulation aid, not a validated scale. Chapters 4 and 5 develop the resulting assessment and response decisions.

Chapter Synthesis

Crisis is best understood through the interaction of demands, meaning, resources, safety, and functioning. The precipitating event matters, but it is not the entire situation. Severity differs from visible intensity, and elapsed time does not establish resolution. Personal, relational, organisational, and public conditions can maintain a crisis or make recovery possible. Assessment should remain open to changes in all these dimensions.

The helper's participation also matters. Cultural humility, competence, responsiveness, and safety must be accompanied

by attention to transference, countertransference, urges, boundaries, power, disclosure, regulation, and blind spots. These concerns should improve concrete decisions: what is asked, whose voice is heard, which action is taken, what information is shared, and whether the plan remains feasible. Understanding becomes useful when it leads to accountable care and practical protection.

Reflection and Practice

1. Distinguish the precipitating event, current reactions, sustaining conditions, and service barriers in the teaching case.
2. Explain how extreme anxiety can coexist with a sense of safety in the moment, and how a gentle demeanour can be associated with danger.
3. Contrast an individual crisis with an organisational service failure. Explain what needs to be assessed and what cannot be achieved through counselling alone.
4. Write four questions that explore cultural meaning without assuming a preference from nationality, religion, or family membership.
5. Describe a possible transference hypothesis and a present service failure that could produce similar distrust. Explain why both possibilities require attention.

6. Record a hypothetical counsellor reaction using four headings: what I noticed, what I wanted to do, what evidence I had, and what I would take to supervision. Do not use identifiable client information.
7. Evaluate a proposed self-disclosure for purpose, timing, relevance, possible burden, and alternatives.
8. Identify one personal and one institutional change that would make the teaching case response more useful and accountable.

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Chapter 2: Culture, Geography and the Diversity of African Crises

Learning Objectives

Readers should be able to compare crisis settings without stereotyping; distinguish cultural meaning from material and institutional conditions; apply cultural humility, competence, responsiveness, and safety; examine language, power, faith, and family participation; and recognise how practitioner reactions and professional roles influence contextual care. They should also be able to design an adaptation process that preserves essential protection while making assistance usable.

Shared Humanity and Different Conditions

A parent bereaved in Lagos and a parent bereaved in Toronto may both experience yearning, disbelief, sleeplessness, and difficulty concentrating. A worker in Kigali and a worker in Melbourne may both fear losing income and social standing. Such similarities make international knowledge relevant. They do not tell a practitioner what either person can afford, whom they trust, what their employer permits, or whether the proposed service is reachable. Similar experiences can require different arrangements for assistance.

People may respond similarly to loss while facing different exposures, responsibilities and options for care. Those differences matter when choosing a response.

A national profile can help orient a practitioner. Assessment establishes what changed for this person or community, which resources are available and which barriers need action.

Culture Is More Than Nationality

Culture includes shared and contested ways of interpreting experience, organising relationships, communicating, and making decisions. It is learned and changing rather than a fixed package possessed equally by every member of a group. People participate in several cultural worlds: household, profession, religion, neighbourhood, generation, language, and online networks. Their responses to crisis may draw on these worlds in different combinations.

Nationality does not reveal whether someone wants prayer, prefers individual counselling, trusts a relative, or understands a symptom through a medical explanation. A young adult and an elder from the same household may disagree. A professional counsellor may share the client's language while differing in class, education, gender, migration experience, or institutional authority. Shared background can help communication but can also encourage assumptions that remain untested.

The practitioner should explore meaning through ordinary questions. What do you call this difficulty? What seems to have caused it? What has helped before? What are you concerned others might misunderstand? Who would you like involved? What would make their involvement difficult? The answers should affect assessment and planning. Cultural inquiry has little value if it becomes an introductory courtesy followed by a response that disregards what the person said.

Comparing the United States with African Settings

The United States offers useful examples of organised crisis services, but it should not be treated as one uniform system or a universal standard of delivery. SAMHSA's 2025 guidance describes coordinated arrangements for contact, response, and places where help can be obtained (Substance Abuse and Mental Health Services Administration, 2025). These functions provide a useful planning question: can a person obtain contact, an appropriate response, and continuing support? Their implementation depends on institutions, staff, funding, and local conditions.

An African district should not assume that copying a telephone service reproduces the system around it. A call requires a working device, affordable connectivity, privacy, trained staff, and a feasible next action. If the caller needs transport or

protection, the service must be able to arrange or coordinate it. The same questions are relevant when examining an American service; a national framework does not establish that every person experiences equally accessible care.

Comparison becomes productive when it examines functions and assumptions rather than prestige. Which components have evidence? What resources do they require? Which local agencies can provide them? How will people unable to use the telephone obtain assistance? Who will maintain contact after the initial encounter? A programme should be evaluated through access, safety, and continuity. Its resemblance to a well-known overseas system is not sufficient evidence that it works locally.

Canada, Australia and Indigenous Perspectives

Canada and Australia also contain diverse populations, regions, histories, and service arrangements. They should not be represented simply as societies of individual autonomy opposed to African communal life. A counsellor cannot infer a person's preferred family involvement from the country in which they live. Indigenous communities, migrants, rural residents, and urban populations may have different experiences of authority and access, as may members of each of these groups.

Canadian First Nations guidance offers a particularly useful contribution to thinking about power. The First Nations Health

Authority connects cultural safety with respectful engagement and attention to imbalances within health services (First Nations Health Authority, n.d.). Its origin and leadership should be acknowledged. African practitioners can learn from this attention to institutional relationships without assuming that Indigenous histories in Canada are identical to any African history or that the same implementation requirements apply.

Australia's Royal Commission into National Natural Disaster Arrangements published its report in 2020, drawing on public submissions and hearings to examine prevention, mitigation and response (Royal Commission into National Natural Disaster Arrangements, 2020). This documented example supports comparison of institutional arrangements and learning after disaster. It does not establish that all Australian residents have the same exposure, resources or access. An African planner can compare responsibilities and delivery conditions while checking the functions actually available locally.

Asian Countries and the Limits of Regional Labels

Asia contains countries with widely differing languages, religions, political arrangements, health services, and economic conditions. It cannot serve as a single contrasting model for Africa. Describing an approach as Asian may conceal more than it explains. A crisis affecting a migrant worker, a farming

household, or a displaced community requires attention to their particular location and opportunities for action, wherever they are situated.

Named historical Asian examples are Aceh, Indonesia, and Sri Lanka. WHO's 2013 report includes their mental-health system development after emergencies (World Health Organization, 2013a). These accounts do not establish that a disaster produces improvement automatically or that Asian countries share one model. Comparison should examine actual changes in staffing, service organisation, referral and sustained support. A 2013 account must not be presented as a current operational directory. This approach prevents two errors. One is assuming that international knowledge is unsuitable because it originated elsewhere. The other is treating successful use elsewhere as proof that adaptation is unnecessary. The practitioner should examine what the approach is intended to accomplish and what conditions support its use. Translation, staffing, legal responsibilities, safety, and practical access must be considered. Regional labels can orient discussion, but they do not complete the assessment.

Comparing African Countries Responsibly

Nigeria, Sudan, South Sudan, the Democratic Republic of the Congo, Ethiopia, Kenya, and Rwanda share some exposures and

differ in many conditions. Their populations also experience ordinary personal and family crises alongside collective emergencies. Bereavement, illness, income loss, violence, safeguarding concerns, and service failure occur in different combinations. A country should not be identified only with the crisis that attracts the most international attention.

UNHCR reporting documents displacement and pressures on services in several of these settings (United Nations High Commissioner for Refugees, n.d.-a). Its regional and country information provides background for asking about protection, family separation, shelter, and access. The clinical and planning implications developed here are contextual questions, not conclusions that every resident has the same experience. A dated report should never replace current local assessment.

Country comparison should establish the locality, population, event, and purpose of the response. Is the programme for displaced households, students, employees, bereaved families, or a flood-affected community? Are people living in a camp, a village, an urban neighbourhood, or across several locations? What services currently operate? Who may be excluded? The following country discussions illustrate these questions. They describe selected considerations rather than exhaustive national profiles or rankings of crisis severity.

Nigeria and Variation Within One Country

Nigeria requires attention to locality, language, livelihoods, relationships, and service access. UNHCR's country information describes displacement in affected regions and the consequences of flooding, alongside different groups requiring assistance (United Nations High Commissioner for Refugees, n.d.-d). These conditions should not become a description of every Nigerian client's life. A professional in Ibadan, a displaced household in Borno, and a trader affected by flooding may face different immediate tasks and referral possibilities.

Assessment should distinguish personal priorities from presumed national customs. A client may want help from a sibling but fear an extended-family meeting. Another may depend on a faith community for food and transport while seeking confidential professional support. The counsellor should ask which relationships provide usable assistance and which impose obligations or danger. Linguistic familiarity does not justify disclosing information through informal community contacts.

Policy and organisational responses should also examine actual working arrangements. A school supporting a bereaved student may need attendance flexibility and a reliable referral. A family facing income loss may need practical planning and access to

appropriate financial or social assistance. A displaced community may need protection and basic services before counselling can be useful. These examples require different authority and resources. A single programme labelled culturally appropriate cannot replace the specific assessment each requires.

Sudan and South Sudan as Distinct Settings

Sudan and South Sudan are separate countries. Their histories, languages, institutions, and local conditions should not be merged because their names are related. UNHCR's regional reporting identifies conflict and displacement affecting both (United Nations High Commissioner for Refugees, n.d.-a). For counselling and public planning, the relevant questions include present safety, family separation, repeated losses, movement, and continuity of health care. Current arrangements must be established in the actual location.

Consider a fictional Sudanese family that has moved several times. A referral requiring attendance at the former clinic may be unusable. The response should ask where the family is now, which medicines or records have been lost, and how essential contact can continue. Requiring a detailed trauma narrative before addressing those needs may burden the family without improving the immediate response. Preference and ability matter regardless of disruption. For a hypothetical family from South

Sudan moving back into their community, going back doesn't indicate restoration yet. Shelter, water, livelihoods, education, and trusted relationships may still require rebuilding. The counsellor should explore what return means to the family and what conditions they actually encounter. Planning should include host and receiving communities where shared services are affected. Neither displacement nor return describes a single psychological state, and the same nationality does not establish identical needs.

The Democratic Republic of the Congo

The Democratic Republic of the Congo and the Republic of the Congo are distinct countries. This book's references to eastern conflict and the cited psychotherapy study concern the Democratic Republic of the Congo. Operational work must identify the country and locality explicitly. General references to Congo can otherwise create confusion in service planning, research interpretation, and professional communication.

UNHCR describes displacement associated with insecurity in affected parts of the Democratic Republic of the Congo (United Nations High Commissioner for Refugees, n.d.-a). That background invites questions about safety, access, family contact, and practical support. It does not establish that every Congolese person has experienced violence or needs trauma

treatment. In a fictional service for displaced survivors, the practitioner should first identify current needs and whether the proposed setting permits confidential, safe participation.

African settings also generate intervention evidence. Bass et al. (2013) studied an adapted psychotherapy for women surviving sexual violence in eastern Democratic Republic of the Congo, with beneficial outcomes relative to individual support. Chapter 3 examines the implications. Here the lesson is that contextual adaptation and rigorous evaluation can coexist. The study does not justify offering the intervention to everyone affected by displacement, dispensing with training, or treating psychotherapy as a replacement for protection and material assistance.

Ethiopia and Kenya

Ethiopia and Kenya host refugees and contain diverse local populations and service arrangements, as reflected in UNHCR country information (United Nations High Commissioner for Refugees, n.d.-b, n.d.-c). Refugee hosting should be considered alongside the experiences of receiving communities and people living outside formal settlements. A programme should not assume that camp, rural, and urban populations have the same access or that citizenship reveals who can obtain help.

In a fictional Ethiopian service, a client may use several languages for different parts of their life. The language used for administration may not be the language in which they can describe fear or grief. Assessment should clarify the preferred language and the safety of interpretation. The practical help may come from a relative who is inappropriate as an interpreter due to confidential disclosure. The provision must communicate the management process of the details.

A hypothetical Kenyan client encountering city difficulties would require flexibility in appointments, transportation assistance, childcare, or aid in tasks. Bryant et al. (2017) provide intervention evidence from a defined group of women in urban Kenya, rather than a model of all Kenyan crises. The broader planning lesson is to examine delivery conditions. An intervention that requires attendance may fail when work and caregiving cannot be rearranged, even if its therapeutic components are relevant.

Rwanda and Multiple Forms of Crisis

Rwanda should be understood through present needs as well as historical context. The country's emergency management ministry's reports in 2023 cite floods and landslides that have impacted individuals, properties, and infrastructure (Ministry in Charge of Emergency Management, 2023). UNHCR also

documents refugee hosting (United Nations High Commissioner for Refugees, n.d.-e). These sources establish relevant planning contexts; they do not define the experience of every person living in Rwanda.

A counsellor should not assume that a Rwandan client's current distress is explained by collective history. A student may be responding to a recent family death, a worker to dismissal, or a household to illness. Historical experiences may matter when the person identifies them or assessment indicates a connection. Sensitive inquiry should permit the person to decide what they wish to discuss. Attendance at a service is not consent to public testimony or repeated recounting of painful events.

Displaced families in a fictitious village hit by a landslide will likely need transport, shelter, schooling, and medicine. Students of Kigali with pressure from the community to inherit property may need privacy and thoughtful help. Assistance will need to be culturally sensitive in both cases, but not necessarily the same type of help. The counsellor's familiarity with Rwanda is useful background and remains insufficient without listening to the actual person.

Culture, Material Conditions and Institutions

Some difficulties attributed to culture are better understood through resources or institutions. A client may miss

appointments because transport is unaffordable, not because their community rejects counselling. A parent may decline a group because childcare is unavailable. A worker may avoid a service because the employer requests reports. These barriers can interact with beliefs, but describing them only as cultural reluctance hides the practical changes needed.

Conversely, material assistance does not remove every question of meaning. A person can receive shelter and remain distressed by a loss of belonging or an inability to perform mourning practices. A livelihood programme can improve income while leaving humiliation or relational conflict unresolved. Contextual assessment should therefore examine both conditions and experience. Neither an exclusively psychological explanation nor an exclusively economic explanation is sufficient for every crisis.

Institutions have cultures of their own. Rules about punctuality, forms, disclosure, professional titles, and decision making may seem natural to staff while excluding service users. A policy maker should ask whether procedures are necessary, understandable, and proportionate. A counsellor should examine how institutional expectations shape their interpretation of the client. Cultural responsiveness includes changing avoidable

barriers in the service, not merely asking the client to adapt to the institution.

Cultural Humility as Ongoing Practice

Cultural humility involves continuing self-examination and a willingness to learn from the person rather than claim complete mastery of their background. Tervalon and Murray-García (1998) developed the concept with attention to professional education and power. It is especially relevant when the counsellor's knowledge creates confidence before the person's account has been heard. Humility invites the question of what remains unknown and how assumptions can be corrected.

Its practical expression is specific. A practitioner can ask whether their summary is accurate, acknowledge an incorrect assumption, and revise the plan. If a client says that family involvement feels unsafe, the counsellor should explore that concern rather than defend a general view of family solidarity. Acknowledging uncertainty should lead to further learning and consultation. It should not excuse inadequate preparation for the role.

Humility also concerns authority. The client may find it difficult to correct an older practitioner, a lecturer, or a faith leader. Saying that disagreement is welcome may not remove that difficulty. The counsellor can offer choices, explain why

questions are asked, and check whether consent is freely given. It is important that supervision considers the impact of status on the interactions. A respectful tone is helpful, but power is also exercised through decisions, records, access, and the consequences of refusal.

Competence, Responsiveness and Cultural Safety

Cultural competence concerns the knowledge and skills needed to work responsibly with relevant populations and circumstances. The counsellor may need to learn about language, explanatory meanings, referral options, discrimination, or professional obligations. Competence should be proven through practice rather than implied through identity or goodwill. A novice professional who comes from the same background as his/her clients will require training, supervision, and boundaries.

Responsiveness is about what happens after the needs have been determined. A service may offer interpretation, adjust appointment times, use accessible materials, or support a consented form of family involvement. These changes should have a clear purpose and be reviewed. Adaptation should not remove necessary safety assessment or give an untrained person a clinical role. Delivery can become more usable while essential protection remains intact.

Cultural safety draws attention to the person's experience and to power within the service. Curtis et al. (2019), writing from Aotearoa New Zealand, connect it with scrutiny of provider assumptions and institutional inequity. Applying the concept in Africa requires local participation. People should be able to identify humiliation, coercion, discrimination, and exclusion without risking their access to help. The assertion that a programme is culturally safe must be assessed with regard to actual practice rather than the mere fact that staff members attended language programmes.

Language Interpretation and Explanatory Meaning

Language has implications beyond simple word choice. Language impacts our description of emotions, duties, suffering, and relationships. A client may use a phrase whose literal translation does not convey its significance. The counsellor can ask for an example of what the phrase means in daily life and how the difficulty affects functioning. Such inquiry is preferable to assigning a diagnosis from an unfamiliar expression alone.

The Cultural Formulation Interview provides a recognised structure for exploring cultural dimensions of clinical presentation and care (American Psychiatric Association, n.d.). It can inform attentive questioning within the practitioner's

competence. It does not replace direct assessment of immediate danger, and its use does not establish that every cultural question is clinically necessary. The person should understand why sensitive information is being requested.

Interpretation needs to take into account privacy, accuracy, and power issues. Define the interpreter's status and confidentiality agreements. A relative may filter the account, answer for the client, or be implicated in the concern. For sensitive encounters, consider an appropriate independent interpreter where available. When interpretation is limited, document the limitation and seek workable support rather than pretend that communication was complete. Translation of a questionnaire also requires examination of meaning and measurement; readable wording alone does not establish local validity.

Faith, Spirituality and Community Resources

Faith and spirituality may provide hope, meaning, mourning practices, practical support, and a sense of belonging. They can also be associated with struggle, shame, fear, or pressure. A client may welcome prayer while refusing disclosure to a congregation. Another may prefer no spiritual involvement. The counsellor should explore the person's preferences without treating a particular response as a test of cultural authenticity or moral character.

With consent, a trusted spiritual adviser or community group may assist with meals, transport, companionship, and culturally meaningful activities. Their participation needs a defined purpose and appropriate information limits. Counselling should not assume that shared belief establishes clinical competence. Nor should spiritual support delay medical or protection assistance when needed. A Christian counsellor is free to discuss their faith without compromising the individual's rights and the boundaries of the service.

Service provision must take into account individuals with varying beliefs and also those without any religion. The service must not be dependent on worship, conversion, or shared views on suffering. A faith organisation can be a valuable partner without becoming the sole gatekeeper to assistance. People who have experienced harm in a religious setting may need a different pathway and should not be required to justify that choice publicly.

Family Participation, Consent and Unequal Burdens

Families and wider networks can offer care, shelter, financial assistance, and social continuity. The benefits depend on how the particular relationships operate. Involving everyone may overwhelm a client or expose sensitive information. The counsellor should identify the intended contribution of each

participant and obtain appropriate consent. Family membership alone does not establish a right to the person's account or to decisions about care.

Power in the family should be considered privately when safety cannot be assured. There could be an illusion of cohesion since no one is able to speak out. There may be an individual in the household who holds excessive influence, while others perceive the situation as peaceful. The culture will help to make it clear that not all expectations are innocent.

The consent should be reassessed depending on how things change. One may feel at peace with relatives present, while at other times, they may prefer to address the issue privately. In addition, a crisis might affect children, the elderly, and those who have communication issues. Ensure that the arrangements are communicated in simple language. Relational resources are valuable when they improve the affected person's actual protection and ability to act.

Transference, Countertransference and Cultural Assumptions

Transference may shape how a client experiences a counsellor who resembles a previous authority, caregiver, or source of rejection. A client may expect criticism or special protection. These possibilities should remain hypotheses alongside present

realities. If the service has been unreliable, distrust may be a reasonable response to current experience. Cultural difference should not become another reason to dismiss what the person is saying about the encounter.

Countertransference can interact with identity and professional position. A counsellor may feel unusually protective toward someone perceived as similar, impatient with someone associated with a disliked group, or anxious about being judged culturally insensitive. Such reactions may impact questioning and decision-making. Hayes et al. (2018) suggest the link between countertransference management and the results of psychotherapy. The implication here is reflective attention, not the claim that a counsellor's feelings reveal the client's hidden motives.

Supervision should examine the specific action that followed the reaction. Did the counsellor avoid asking about suicidal distress? Did they offer an exception without a clear purpose? Did they interpret disagreement as disrespect? Cultural reflection and relational reflection should inform each other. Shared identity does not remove countertransference, and cultural difference does not establish it. The aim is to recognise possible influences and make decisions that remain accountable to evidence, the person's needs, and professional limits.

Boundaries, Power, Disclosure and Embodied Awareness

Professional boundaries can become complicated when the counsellor is also a lecturer, pastor, employer, mediator, or family acquaintance. The client may feel that refusing a suggestion will affect other relationships. Define the part played and the possible options. Familiarity within a community does not excuse exploitation. The practitioner should seek supervision where overlapping roles interfere with freedom, privacy, or impartial care.

Self-disclosure also needs contextual judgement. Sharing a personal story to demonstrate cultural understanding can shift attention to the counsellor or imply that the client should respond in the same way. Before disclosing, ask what benefit is intended, whether the timing is appropriate, and whether a less intrusive response can serve the purpose. A client's politeness does not establish that the disclosure was helpful. Notice whether they now appear responsible for reassuring the practitioner.

Body awareness refers to awareness of one's own physical and emotional state while at the same time being aware of the client. Tension, tiredness, fast talking, or the desire to escape from the situation might influence the interaction. Relaxing one's body for a few moments might help one make better judgements; however, bodily reactions do not reflect the intentions of the

client. Professional ethics also require attention to competence and capacity to work responsibly (British Association for Counselling and Psychotherapy, 2018). Regulation should support action and consultation, not conceal exhaustion or replace protection.

Age, Gender, Disability and Economic Position

People participate in cultural life from different positions. Age, gender, disability, income, and education can affect who speaks, who controls money, and whose account is taken seriously. These dimensions do not operate independently. An older woman with mobility limitations may depend on a younger relative for transport while retaining considerable household authority. A student may possess educational skills but lack income or freedom to obtain private assistance. Assessment should examine the actual arrangement rather than infer dependence or power from one characteristic.

Accessibility includes the opportunity to understand and express a choice. Materials may need simpler language, larger print, interpretation, or another mode of communication. A person using assistance to communicate should still be addressed as a participant. Enquire about the type of assistance that helps them and check on whether there are any conflicting interests from the helper. Inability to communicate in the manner that the service

requires does not automatically imply lack of preference or inability to consent.

Gender norms may affect care provision, expressions of emotions, and costs of getting help. A man may fear being judged weak; a woman may fear blame for discussing household violence. These are possibilities to explore, not universal descriptions. The practitioner should ask what the person anticipates and what has actually happened. Public planning should examine whether programme hours, locations, staffing, and referral conditions reproduce unequal access. An inclusive invitation is insufficient when the service remains practically unusable for some participants.

African Relational Knowledge and Its Limits

African communities possess varied traditions of mutual assistance, collective deliberation, care, and moral responsibility. Their contribution should be identified through local knowledge rather than reduced to a single continent-wide philosophy. Metz (2011) develops a Southern African interpretation of ubuntu in relation to dignity and human rights. It offers an ethical contribution to thinking about relationships; it is not evidence that one cultural concept describes every African community or constitutes a validated clinical treatment.

For practice, ask which existing arrangements already provide help and how they are sustained. A neighbourhood association may organise food after a death. A savings group may assist with a sudden expense. Relatives may share childcare so that someone can attend a health service. These illustrative resources can reduce the burden on an individual, but their availability and conditions must be checked. Membership can involve obligations, and the person may have reasons for declining participation.

Community knowledge should influence programme design while remaining open to ethical scrutiny. Local authorities might offer elements of trust and cooperation, but some might not feel safe questioning it. Include different accounts and examine who is absent. A practice described as traditional should not automatically be protected from criticism, nor should it be dismissed solely because it is unfamiliar to a professional. Its contribution should be assessed through dignity, consent, protection, and practical benefit in the particular situation.

Cultural Responsibility in Organisations and Policy

An organisation can train individual counsellors and still operate through rules that undermine responsive care. An employer may require a report that exposes personal information. A school may offer counselling only during classes a distressed student cannot

miss. A public service may demand documents lost during displacement. These illustrative problems concern institutional decisions. Expecting a counsellor's empathy to compensate for them leaves the barrier intact.

Policy responsibility begins with identifying who controls the barrier and what change is feasible. Please clarify what information is essential to know, who will have access to it, and if there is an alternative method that could accomplish the task. Look at the facilities, costs, communications, referrals, and complaints. Staff should know how to raise concerns about an unsafe requirement without being treated as obstructive. Accountability needs an identified decision maker and a way to check whether the change improved access.

Evaluation should combine the experiences of service users with practical evidence. Ask whether interpretation was usable, whether people could refuse involvement, whether referrals reached appropriate services, and whether complaints produced a response. Include those who left early or never reached the service. Cultural safety becomes a public responsibility when institutions examine their own exercise of power. It should not be assigned entirely to the client or to a practitioner who lacks authority to alter the system.

A Practical Process for Contextual Adaptation

Adaptation begins by identifying the problem and the people the service is intended to assist. Listen to their priorities and establish practical conditions: language, location, safety, access, staffing, and referral options. Include people who may be unable or unwilling to attend public meetings. A consultation involving only local leaders can miss those who depend on their approval or who have been excluded from their networks.

Next, distinguish the purpose of an intervention from its delivery features. Meaningful safety assessment, knowledgeable participation, proper competence, and reliable follow-up should continue to apply. The use of examples, materials, scheduling, and support arrangements may require modification. Psychological first aid makes it clear that humanitarian care should be consistent with dignity, culture, and competence (World Health Organization et al., 2011). However, the effective application of psychological first aid requires an understanding of the available resources.

Test the revised process and document any changes. Identify who gained from it, who discontinued it, who could not participate, and who was harmed. If there are few complaints, it may indicate that people are afraid to voice their concerns. Evaluation should distinguish an intervention's therapeutic contribution from changes in material conditions. Adaptation is an ongoing process of accountable learning. It is weakened when

the provider announces cultural appropriateness before service users have had a meaningful opportunity to influence or evaluate care.

Teaching Case and Integrated Application

In a fictional Kigali university, a student seeks support after a family death. The counsellor assumes that a whole-family meeting will provide solidarity. The student explains that one relative controls an inheritance discussion and that speaking in front of him feels unsafe. She wants a trusted aunt involved in practical arrangements and a friend available after appointments. She also welcomes prayer privately but does not want the institution's chaplain informed.

The assessment should explore current safety, functioning, grief, practical needs, and the student's preferred support. Nationality and faith do not establish consent to a family meeting or chaplain referral. The counsellor should clarify confidentiality and applicable limits, examine whether their own role within the university creates pressure, and agree an appropriate next step. If a clinical or protection need emerges, arrange suitable assistance without requiring the student to accept unwanted public involvement.

The counsellor notices an urge to persuade the student that reconciliation will help. That urge deserves reflection because it

may reflect a personal or institutional preference. A responsive plan could preserve private counselling, establish consented practical contact with the aunt, and check that the student can use the referral and follow-up arrangements. Review should ask whether the plan improved access and safety. The case demonstrates that cultural knowledge becomes useful through inquiry and action, rather than through a predetermined account of family or religion.

A Comparative Evidence Map for Local Planning

Country comparison must distinguish what a source establishes from what a practitioner still needs to know. UNHCR country and regional pages describe displacement and assistance contexts; intervention studies address defined participants and methods; disaster reports document particular events. None supplies a complete national counselling profile. The matrix uses sources discussed in this chapter. Its planning questions are the book's synthesis, not findings that every resident shares the same need.

Nigeria's humanitarian information should sit alongside ordinary individual and family crises. A university student experiencing depression and a family losing income may need different services in the same city. Sudan and South Sudan require separate records of locality, movement and receiving

services. In the DRC, a psychotherapy trial supplies evidence for a studied population; it cannot establish nationwide treatment availability.

Ethiopia and Kenya should likewise be examined separately. Refugee-hosting information supports enquiry about access and host-community demands. Kenya additionally contributes a defined intervention trial and a dated account of flood-related educational disruption, discussed in Chapters 3 and 9. Rwanda contributes disaster information, community measurement research and family-programme research, each answering different questions.

To use the matrix, choose one locality and crisis pathway. Add current contacts, eligibility, language support, travel cost, operational authority and groups excluded from the initial account. Confirm critical arrangements with responsible local services. Record unknowns. Comparison becomes useful when it changes the plan, such as arranging transport, protecting privacy or confirming a receiving service, rather than ranking countries by presumed resilience.

Setting	Evidence used in this chapter	Local planning question
Nigeria	UNHCR country information	Which services and safe supports can this person reach?

Setting	Evidence used in this chapter	Local planning question
Sudan	UNHCR regional conflict and displacement reporting	How do movement and changing services affect continuity?
South Sudan	UNHCR regional reporting; distinct national setting	What remains unsafe or unavailable in the present or return locality?
Democratic Republic of the Congo	Regional reporting and Bass et al. trial	Does the intervention fit this population and delivery capacity?
Ethiopia	UNHCR refugee-hosting information	Which languages, eligibility rules and barriers need checking?
Kenya	UNHCR information and Bryant et al. trial	Who was studied and which services can receive referrals?
Rwanda	2023 disaster report and refugee-hosting information	How do hazard exposure, access and household roles affect the plan?

Chapter Synthesis

Crises across world regions share human processes while differing in exposure, meaning, resources, and institutional response. Within Africa, country profiles provide selected background and cannot complete an individual assessment. Similar hazards may require different services, and different events may generate similar needs. Care should be organised around the actual person, family, organisation, or community, with attention to who has authority and who may be excluded.

Cultural humility, competence, responsiveness, and safety should lead to observable changes in practice. They belong alongside attention to relational expectations, practitioner reactions, disclosure, regulation, and boundaries. The central test is whether people can obtain appropriate help with dignity, meaningful participation, and practical protection. Contextual adaptation should preserve those purposes while remaining open to correction, supervision, and evaluation.

Reflection and Practice

1. Compare a hypothetical referral pathway in an American setting with one in an African district. Identify assumptions about contact, transport, staffing, privacy, and continuing care.

2. Select two countries discussed in the chapter. Distinguish verified contextual information from questions that still require local assessment.

3. Provide reasons as to why the above factors do not determine the client's preference or the counsellor's competence.

4. Write questions that distinguish cultural meaning, material barriers, and institutional practices in a missed-appointment case.

5. Revise the university case response using humility, competence, responsiveness, cultural safety, and immediate safety as separate considerations.

6. Describe how a transference hypothesis and a current service failure could both explain distrust. Identify what the counsellor should investigate.

7. Examine one proposed family, faith, or community partnership for consent, power, confidentiality, inclusion, and professional scope.

8. Design a small adaptation review that includes people who could not attend the programme, alongside those who completed it.

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Chapter 3: Crisis Theories and Their Contextual Applicability

Learning Objectives

Readers should be able to distinguish explanatory theories, intervention models, ethical perspectives, and service frameworks; explain major approaches relevant to crisis; evaluate their assumptions and evidence; identify adaptations needed in African settings; recognise inappropriate or harmful applications; and connect theoretical judgement with culture, power, practitioner reactions, and professional boundaries. They should also be able to construct a contextual formulation without treating one theory as a complete explanation of every crisis.

What a Theory Can and Cannot Do

A theory helps explain why a stressor becomes overwhelming or how a family adapts. An intervention model helps organise what the practitioner does. Ethical and service frameworks clarify duties and how support should be coordinated.

A counsellor may use stress appraisal to explore meaning, family stress theory to examine accumulated demands, and a structured intervention model to organise immediate contact. A community response may also require an operational plan and coordinated services. Confusing these levels can produce inappropriate expectations. A theory of coping does not provide

evacuation authority. A sequence for counselling does not establish a complete national crisis system. An ethical account of solidarity does not demonstrate that a treatment is effective.

Ask what each approach helps explain and which details it may overlook. Choose a framework that helps answer the question at hand.

Evaluating Applicability in Africa

No major theory should be accepted or rejected solely because its author worked outside Africa. The relevant questions concern the problem it addresses, its assumptions, the supporting evidence, the population and setting, and the requirements for delivery. Conversely, African origin does not establish clinical effectiveness automatically. A locally meaningful concept can enrich an ethical or cultural account while still requiring evaluation if used as an intervention.

Applicability has several dimensions. Conceptual fit concerns whether the explanation helps understand the situation. Empirical support is about the results of studies. Ethical fit concerns consent, dignity, protection, and power. Practical fit concerns staffing, resources, language, privacy, referral, and continuing care. A method can be conceptually useful and practically unavailable; it can be locally acceptable and still lack

evidence for the outcome claimed. These distinctions should remain explicit.

The question of which theories are not applicable should therefore be answered carefully. Some applications are unsuitable because they assume safety that does not exist, require resources that are unavailable, or impose harmful interpretations. That does not always mean the entire theory must be discarded. The task is to identify the useful contribution, the required qualification, and the point at which another approach or service is needed. The judgements in this chapter are contextual interpretations, not findings from trials comparing every theory across African countries.

Classical Crisis Theory

Classical crisis theory drew attention to disruption of familiar coping and the possibility of focused assistance. Lindemann's study of acute grief and Caplan's work in preventive psychiatry helped establish this historical direction (Lindemann, 1944; Caplan, 1964). The value lies in recognising that distress can become a period of impaired functioning requiring timely support. It also places assistance within a wider concern for prevention rather than waiting for every difficulty to become a long-term disorder.

For African practice, a useful application is to identify what has changed and whether ordinary arrangements still provide sufficient safety and functioning. A person who has lost a caregiver may need immediate help with meals, medication, and decisions. The counsellor can identify practical support alongside emotional needs. This application does not depend on treating a particular nationality as psychologically different; it depends on examining the person's actual coping and resources. The limits appear when crisis is treated as a predictable episode in an otherwise stable environment. Continuing violence, displacement, or service failure may prevent stabilisation. Restoring a former equilibrium may also be undesirable if it included coercion or an unreasonable burden. The practitioner should ask what needs to change in the conditions, not only how the person can adjust. A classical framework is useful for an acute disruption but incomplete when used as the sole explanation of prolonged structural adversity.

Grief and the Misuse of Stages

The familiar five-stage account associated with Elisabeth Kübler-Ross is frequently applied as though bereaved people must progress through denial, anger, bargaining, depression and acceptance. Stroebe et al. (2017) review its development from work concerning dying and challenge prescriptive application to

bereavement. A counsellor should not assign a stage from silence or visible composure, or require a universal sequence. Grief-related inquiry is useful when it helps explore loss, meaning, functioning and support.

In African settings, mourning may involve religious practices, extended-family obligations, expenses, travel, inheritance, and community participation. These are contextual possibilities rather than universal customs. A useful formulation asks which practices the person values, which are feasible, and which create pressure. A counsellor should not decide that refusing a ceremony demonstrates unhealthy grief or that maintaining a bond through remembrance prevents recovery.

Fixed stages lose their relevance when used to call for advancement, ascribe blame, or impose a deadline for everyone. This critique focuses on the application of the concept rather than its existence. Severe disability, suicide pain, or health risks have to be evaluated irrespective of what stage people assume.

Ordinary grief also deserves support without automatic diagnosis. The counsellor should help the person manage actual needs while remaining open to clinical consultation when the situation requires it.

Transactional Stress and Coping

Lazarus and Folkman's transactional approach examines the relationship between a person and their environment through appraisal and coping (Lazarus & Folkman, 1984). An event may be experienced as harm already sustained, threat ahead, or a demanding challenge. Their evaluation of the available resources is also important. Coping can involve addressing the problem or managing emotion. These functions can occur together rather than form a simple choice between thinking and action.

This approach helps explain why apparently similar events produce different responses. In a fictional Nigerian household, income loss may threaten food, school fees, identity, and obligations to relatives. It is more beneficial to consider the threat than the person's fear. The counsellor may look into real alternatives, clear up miscommunications, and assist the person in making a practical response to the situation.

It should be approached with caution when the appraisal is a true one. A survivor fearing return to an unsafe home should not be told that the problem is merely negative thinking. A displaced person may reasonably doubt the availability of a service that has repeatedly closed. Emotional regulation may support decision making, but it cannot substitute for protection or restore

an inaccessible resource. The theory is applicable as an inquiry into meaning and options; an application that denies material reality is unsuitable.

Conservation of Resources

Conservation of resources theory centres the threat or loss of valued resources and the difficulty of gaining resources after investment (Hobfoll, 1989). The approach directs attention to what people need to retain, protect, and rebuild. Hobfoll's later discussion explicitly considers culture, community, and the person within social relationships (Hobfoll, 2001). This broadens the question beyond an individual's emotional response to include the conditions that support or obstruct coping.

This highlights the importance of context in understanding the accumulation of losses. For example, consider a hypothetical family affected by floods; the damage to their goods impacts their income generation, putting their ability to pay rent at risk.

Counselling that examines only the person's feelings may overlook this chain. A resource-informed response asks which loss is generating further losses and what assistance could interrupt the process. A small practical intervention may matter because it preserves several functions at once.

The theory does not determine which resource matters most to a particular person or which agency should provide it. Resources can have costs and conditions: a relative's offer of housing may involve unsafe dependence. Assess their quality and usability rather than merely count them. The approach is applicable to individual, family, organisational, and community planning, but it needs local participation and clear responsibility. It becomes inadequate if resource restoration is discussed abstractly while no one can act on the unmet need.

Family Stress and Adaptation

The Double ABCX model examines family stress through accumulated demands, resources, meanings, and adaptation over time (McCubbin & Patterson, 1983). It extends inquiry beyond one precipitating event to what happens afterward. The later writings of Patterson relate family stress theory to resilience as both ability and process (Patterson, 2002). These contributions help to understand why a response to demands by the family changes when the demands pile up and resources get used up.

A fictitious family experiencing illness may also be struggling with unpaid leave from work, the expense of treatment, school problems, caregiver fatigue, and conflicting responsibility. Family formulation will help to identify the piling up of demands without putting the whole problem on one individual.

The counselor can inquire how responsibilities are shared, what each individual knows, and how practical arrangements can change. Various individuals in the family may attach different meaning to things and have different access to help.

Power has to modify the use. What appears to be family adaptation can be because one individual is carrying the risk or the load. Joint sessions should not be assumed to be the inevitable part of the model. Assessment and protection in private may be needed where there is violence, coercion, or fear. It is useful in working with African families because of its focus on relationships and demands; it is not because all African families are collectivist or the family unity has to be maintained no matter what.

Ecological and Systemic Thinking

Ecological thinking considers people in terms of interconnected environments, such as relationships, organizations, and social systems. Bronfenbrenner's description of the development of humans provides a good basis for considering these nested environments (Bronfenbrenner, 1979). In crisis work, it means to study how the experience of a family is shaped by employment, schooling, healthcare, housing, politics, and the physical environment. Systemic thinking also examines patterns

of interaction and feedback. Fear may increase withdrawal, withdrawal may prompt pursuit, and pursuit may increase fear. In an organisation, staff silence may allow unsafe practice to continue, while continued failure reduces confidence in reporting. This book uses such patterns as explanatory possibilities. They require evidence from the actual situation and do not constitute one validated crisis protocol for Africa.

The strength is a wider account of what maintains the difficulty and where change is possible. The risk is diffusion of responsibility. Understanding a feedback pattern does not make all participants equally responsible, particularly where one uses violence or controls essential resources. A policy that blames communication for abuse may obscure protection needs. Ecological and systemic approaches are applicable when they clarify relationships, authority, and possible action. They become harmful when a concern for complexity prevents the practitioner from naming danger or identifying who must respond.

Attachment and Relational Security

Attachment theories emphasise the significance of secure relationships and their impact on loss and insecurity. Bowlby (1988) posits that supportive relationships that provide safety and exploration form the foundation of a secure base. In crisis

work, this can help the counsellor consider the individuals who provide secure contact and the effects of loss or displacement on the belief that help will be available.

Specific applications of the theory must be made. The child without a carer might require safe contacts and stable routines. A person who has lost a trusted source of support may need assistance in finding a secure source of help. The counsellor can offer clear information and follow-through without promising permanent personal availability. Reliability concerns what the service can actually deliver, not an invitation to unrestricted dependence on one practitioner.

The limits are important. Relational needs should not be interpreted through a single assumed family arrangement or used to blame caregivers without examining poverty, illness, conflict, and service barriers. Shared care by several people is not automatically deficient. Nor does a client's reliance on others establish a pathological attachment pattern. Attachment-informed inquiry can be useful across African settings when it examines actual security and continuity. Classification should remain within competence, relevant assessment, and appropriate evidence rather than become a quick explanation for every difficult relationship.

Cognitive and Behavioural Perspectives

Cognitive and behavioural perspectives examine relationships among interpretations, emotion, behaviour, and functioning. They can help identify patterns such as withdrawal from essential tasks or beliefs that intensify distress. Some structured interventions drawing on these traditions have been studied in African settings, as discussed below. Their relevance should be considered through the specific method and evidence rather than a broad claim that an entire theoretical tradition works equally well everywhere. The African trials discussed below support appraisal of particular interventions and delivery arrangements; they do not validate every technique described as cognitive or behavioural.

A contextual application examines what is modifiable. A person avoiding an important appointment may benefit from breaking the task into manageable steps if transport and safety are available. A survivor experiencing self-blame may need a careful therapeutic approach delivered by a competent practitioner. This is different from informing people that their misfortunes are as a result of their mindset. It is not enough to think about actual dangers and injustices; one needs to act differently too. Behavioural advice must also be realistic. Telling an overworked parent to be more active without considering their

workload may just add to their stress. Asking someone to confront a feared person can be unsafe. The practitioner should clarify the intended benefit, relevant precautions, and professional scope. The approach is applicable where the particular intervention fits assessed needs and can be delivered responsibly. It is unsuitable when techniques are improvised beyond competence or used to shift responsibility for structural harm onto the affected person.

Psychodynamic and Relational Perspectives

Psychodynamic and relational perspectives invite attention to earlier relationships, present expectations, emotional reactions, and what occurs between client and counsellor. Transference may involve expectations of criticism, abandonment, rescue, or special protection. Practitioner reactions influenced by their life experiences encompass countertransference. Hayes et al. (2018) report that effective management of countertransference is associated with psychotherapy outcomes. This supports reflective attention while leaving room for different explanations of an encounter.

In crisis, such awareness should improve immediate care rather than displace it. A client who doubts a promise may be responding to previous abandonment, current service failure, or both. The counsellor should examine the actual facts and clarify

what they can do. A lengthy interpretation of unconscious meaning is not the priority when the person needs urgent health care, shelter, or protection. The relational formulation should remain proportionate to the task.

The practitioner's feelings are information about their own participation, not proof of the client's motives. Feeling helpless does not establish that the client is creating helplessness. Feeling protective does not justify taking over decisions. These perspectives are useful in supervision and continuing care when applied tentatively and ethically. They become inappropriate when interpretation silences criticism, creates dependency, or assigns every service problem to the client's past. Present reality and professional power must remain part of the explanation.

African Relational Ethics and Community Knowledge

African relational perspectives can illuminate responsibilities of care, belonging, mutual assistance, and human dignity. Metz (2011) develops an interpretation of ubuntu grounded in Southern African moral ideas and connected to human rights. Its contribution here is ethical rather than evidence for a specific clinical treatment. The term should not be used as though it names one shared philosophy governing every person or community across Africa.

For practice, relational ethics invites inquiry into who can share practical burdens and how the person can remain connected without surrendering safety or choice. A community network may organise food, transport, or companionship. The counsellor can work with those resources when participation is wanted and appropriate. Their contribution must be explained through practice rather than an idealised version of their solidarity. We still need inclusion, trustworthiness, and information constraints.

The pressure to belong reveals the ethical constraint, leading one to conform, reconcile prematurely, and remain silent. The refusal of a survivor to attend a risky family gathering does not constitute a rejection of communal values. Dignity involves questioning authority and securing protection. Indigenous knowledge must impact care but must be assessed in terms of its impact in the given instance.

The Seven Stage Intervention Model

Roberts and Ottens (2005) organise crisis intervention through assessment, establishment of a working relationship, identification of major problems, attention to feelings, exploration of alternatives, action planning, and follow-up. These tasks provide structure when a distressed consultation could otherwise become unfocused. They should be understood as coordinated activities, with safety addressed whenever

needed, rather than a rigid requirement to complete one conversation before urgent action can occur.

Contextual application asks what each task requires locally. An assessment must directly address danger and needs. In a working relationship, clarity and respect for one's priorities are essential.

Alternatives must be genuinely available. An action plan should identify responsibilities and what happens if the proposed service cannot receive the person. Follow-up should establish whether help occurred, not merely whether a referral was written.

The model is useful for training and organising contact, but it does not solve shortages of staff, transport, or protection services. Nor does a completed sequence establish clinical effectiveness in every population. In African settings, language, family roles, communication methods, and referral arrangements may need adaptation. Essential safety and professional limits should remain clear. It becomes inappropriate when followed blindly in spite of the risks involved or when the successful completion of the steps is reported without assessing the condition of the person and his access to services.

Six-Step Intervention Model

James & Gilliland's six-step formulation is generally stated to include problem definition, safety, support, consideration of

alternatives, planning, and commitment (James & Gilliland, 2013). The model is easy to teach since it combines learning with doing. Listening is always crucial, and the practitioner needs to go back to the previous step whenever new information becomes available. The crisis situation is not static and cannot be defined based on the first description of the problem.

What is meant by commitment? It must refer to the agreement to do reasonable things, not to some guaranteed safety. A person may politely agree to contact a service but have no airtime transport, or privacy. Clarifying these conditions is part of a useful plan. Where suicidal distress or another urgent threat is present, appropriate assessment and support are needed rather than reliance on a pledge.

In a fictional rural setting, the client may identify a trusted contact who can accompany them to a health service. The practitioner needs to ensure availability, get proper consent, and define follow-up. If the contact cannot assist, another arrangement is needed. This illustrates responsive delivery rather than a different moral standard for Africa. The model is applicable as an action structure when it remains grounded in current needs, usable alternatives, professional competence, and the actual operation of local services.

Psychological First Aid and Layered Services

Psychological first aid is an approach to early humane and practical support, not a comprehensive theory of psychotherapy. The WHO guide emphasises respect for dignity, culture, and ability, with attention to immediate needs and connections to assistance (World Health Organization et al., 2011). Its relevance lies in organising supportive contact without assuming that everyone affected by a crisis requires detailed therapeutic processing.

The IASC framework helps organise complementary forms of assistance (Inter-Agency Standing Committee, 2007). Chapter 9 develops the layers and their practical coordination. Its function here is to show that counselling alone cannot answer every material, protection or service need. The framework does not diagnose an individual or establish a clinical protocol.

For African implementation, identify available agencies, actual referral routes, supervision, and continuity. A community worker may provide supportive assistance within training, while a qualified health professional assesses a clinical concern. A counsellor should not assume medical competence because specialist services are scarce. The approach is applicable where roles and resources are coordinated. Its limit is that a framework can remain an attractive diagram while essential services are

absent. Evaluation must examine what people actually received and what needs remain unmet.

Evidence From African Intervention Studies

African studies challenge the claim that approaches developed internationally are inherently unsuitable for African populations. Bass et al. (2013) found benefits from an adapted psychotherapy for female survivors of sexual violence in eastern Democratic Republic of the Congo relative to individual support. Bryant et al. (2017) conducted research on Problem Management Plus for women who had experienced gender-based violence in urban Kenya and found that there were improvements in their psychological distress. In both cases, there is a population and a context for implementation.

Chibanda et al. (2016) found that a primary care intervention delivered by trained lay health workers in Zimbabwe resulted in better symptomatic outcomes compared to the comparison condition. The study demonstrates the value of examining locally organised delivery rather than assuming that only specialist clinic arrangements can contribute. It does not authorise unsupervised practice or establish that every lay worker can manage urgent suicidal danger or complex clinical needs.

Scholte et al. (2011) investigated sociotherapy in Rwanda using a quasi-experimental design. The findings have some relevance

to social bonding and mental well-being. Its design supports different causal conclusions from a randomised trial. Together, these studies show the importance of adaptation, training, supervision, and evaluation. They do not establish a single African protocol, universal suitability, or the sufficiency of psychotherapy in every humanitarian emergency. Evidence should be linked to the actual population, outcome, comparator, and conditions studied.

Approaches That Should Not Be Used Uncritically

Some approaches are inappropriate because of what they require or claim. Fixed emotional stages should not be imposed on grief. Spiritual explanations should not replace medical or protection assessment. Family mediation should not be required where coercion prevents free participation. Imported assessment cut-offs should not be assumed valid in every language or population. These objections concern unsupported or harmful practice, regardless of whether its origin is African or international.

Compulsory retelling of a traumatic event also requires clear distinction from supportive listening. WHO advises against psychological debriefing as an intervention intended to prevent post-traumatic stress, anxiety, or depression after recent trauma (World Health Organization, 2012). This does not prohibit

voluntary support or an operational review of service decisions. The purpose, method, timing, and consent matter. A community meeting should not become a requirement that survivors publicly recount events in order to receive assistance.

Theories of coping and resilience can also be misused to excuse neglect. A person should not be expected to regulate emotion sufficiently to tolerate preventable danger. Professional humility is not a substitute for competence, and cultural respect is not an unrestricted defence of harmful authority. The practitioner should identify which claim is unsupported, which condition is unmet, or which ethical obligation is threatened. A precise critique is more useful than declaring an entire geographical tradition applicable or inapplicable.

Approach	**Useful contribution**	**Qualification for contextual use**
Classical crisis theory	Identifies disrupted coping	Continuing danger may prevent stabilisation
Transactional stress	Explores meaning and options	Accurate danger must not be reframed away
Conservation of resources	Maps loss and restoration	Resources must be usable and responsibilities clear

Approach	Useful contribution	Qualification for contextual use
Family stress models	Examines accumulated demands	Unequal burdens and coercion require attention
Ecological and systemic lenses	Connects settings and feedback	Complexity must preserve accountability
Attachment perspective	Explores dependable relationships	Avoid assumptions about one correct family arrangement
Structured crisis models	Organises immediate action	Adapt delivery and verify follow-up
Relational ethics	Supports dignity and mutual care	Belonging must not override protection or consent
Psychological first aid	Offers early supportive assistance	It does not replace specialised care

The Practitioner Within the Theory

The counsellor can use theory to understand the encounter or to defend a preferred interpretation. A practitioner committed to family harmony may overlook coercion. One favouring cognitive change may minimise resource loss. Another may identify every disagreement as transference. These blind spots

concern how theory is used. Supervision must look at what information was used, what alternatives were overlooked, and whose concerns guided the decision.

Pulls and urges offer useful reflective prompts. Did I want to rescue, confront, withdraw, disclose, persuade, or become indispensable? What would the proposed action accomplish, and for whom? The counsellor should connect these questions with power asymmetry and boundaries. A client in crisis may feel unable to refuse. Apparent agreement can therefore require further clarification rather than be treated as proof that the intervention fits.

Internal and bodily states also influence theoretical judgement. The client or the service provider might be fatigued or stimulated, which could lead to narrowing of focus and a tendency to use labels known to them. Regulated, informed discussion, along with favourable working conditions, may help make more rational decisions. Self-disclosure needs to serve the purpose of the client rather than that of proving one's expertise or similarity to the client.

Constructing a Contextual Formulation

A formulation is a reasoned account connecting the event, its meaning, current danger, maintaining pressures, resources, and possible action. It differs from a diagnosis and from a complete life history. Its purpose is to guide a decision and remain open to revision. The practitioner should distinguish what the person

reported, what was observed, what is inferred, and what still needs investigation. Confidence should match the available evidence.

Begin with the immediate concern and then use theories to generate questions. A resource perspective asks what has been lost and what losses may follow. A family perspective asks how tasks and meanings are distributed. A transactional perspective asks what the event threatens and which options seem possible. A systemic perspective asks how institutions and relationships sustain the difficulty. A relational perspective examines whether the helping encounter is trustworthy and appropriately bounded. The formulation should end in a feasible response. Identify who can act, what support is available, what needs another service, and when review will occur. Do not add several theories simply to make the account sound sophisticated. Each should contribute something relevant. If a theory does not change inquiry, understanding, or action, its inclusion may add language without benefit. The person should be able to recognise their situation in the account and question aspects that do not fit.

Teaching Case and Comparative Application

Consider a fictional family in Kenya after the main income earner develops a serious illness. Income falls, treatment travel becomes costly, and a teenage daughter misses school to provide

care. The father says he has failed the family. The mother appears composed but reports little sleep. A counsellor initially interprets the case as poor coping and wants to encourage positive thinking. The family seeks assistance with the care arrangement and information on the available resources.

Transaction analysis reveals the stakes involved in the illness and the perception of failure. Resource analysis reveals income, transportation, treatment, and schooling. Family stress analysis involves accumulated demands and unequal burden. Ecological analysis involves employers, health care, schools, and social welfare. Relational reflection raises questions about whether the counsellor's need to assure the family diverts attention from concrete issues. None of these theoretical approaches provides a diagnosis or makes the needs of the family equal to all other Kenyan families.

A responsible intervention first attends to urgent health and safety issues, then identifies feasible arrangements and appropriate assistance. The interests of the teenage daughter must be considered rather than ignored because of an assumption of family adaptation. The clinical concerns must be appropriately assessed. The follow-up must determine what happened and whether burdens were reduced. This case highlights the value of combining selected lenses without losing

the clarity of responsibilities. Theory helps the family when it aids understanding and action, but not when it replaces their narrative with jargon.

Consequences for Educational Policy and Research

Students must learn to articulate the contributions and limitations of a theory, not just identify the author or the steps of that theory. Teaching cases must require consideration of safety, resources, culture, power, and professional competence.

Comparing formulations can show what each approach reveals. Supervision should also examine the student's reaction to the case and whether a desire to appear competent has encouraged premature certainty.

Policy makers should distinguish the evidence for a therapeutic intervention from the evidence for an entire service system. A successful trial does not by itself specify national staffing, funding, referral, or legal arrangements. Implementation needs clear roles and examination of reach, continuity, quality, and harm. Research should include populations and outcomes relevant to the local purpose, with consent, appropriate review, and attention to the people excluded from services.

The strongest conclusion is conditional: several major approaches can contribute to African crisis care when their assumptions are examined and delivery is responsible. Some

uses should be rejected because they are unsafe, unsupported, or infeasible. Local knowledge and international research can inform each other. The practical task is to state why an approach fits this need, how it will be delivered, what it cannot accomplish, and what evidence will be used to review its contribution.

Prevention Through Different Theoretical Lenses

Theory can shape prevention before a person reaches the counselling room. Consider a hypothetical settlement where seasonal flooding repeatedly closes a school and interrupts access to a clinic. An appraisal perspective invites enquiry into what residents understand about warnings, whom they trust, and which protective actions appear achievable. A resource perspective directs attention to transport, secure storage, income reserves, medication supplies, and the losses that accumulate after each interruption. An ecological perspective examines drainage, land use, school continuity, and the responsibilities of local authorities. These questions identify different routes into the same preventable harm.

A prevention programme that offers only reassurance would leave these practical conditions unresolved. Conversely, an infrastructure programme that ignores distrust, inaccessible announcements, or family responsibilities may fail to reach

those most exposed. Combining perspectives means assigning concrete responsibilities rather than simply adding theories to a report. A school might prepare accessible continuity arrangements; health services might plan medication access; community representatives might test whether warnings are understandable. Residents should help define the problem and evaluate whether the arrangements work, including people whose voices are usually missing from public meetings.

Prevention also requires attention to the distribution of costs. A suggestion for moving may offer physical safety while endangering livelihood, caregiving, education, or job security. These kinds of dilemmas need open discussion and help. Counsellors may be able to add information about suffering and coping, although they must be aware of their limitations in decision-making. They cannot resolve land rights or allocate public funds through therapeutic interpretation. The theoretical contribution is to make interdependent needs visible and support accountable planning, with specialist advice where necessary.

Choosing an Approach Under Resource Constraints

Limited resources change delivery options without removing the need for sound reasoning. A district service might have a small counselling team, several trained community workers, unreliable transport, and a distant specialist facility. The task is

to identify which needs can be addressed safely within available competence, which require consultation, and which require urgent coordination. A model that assumes immediate specialist access needs a realistic referral pathway. Writing a referral that the person cannot use is not continuity of care. Services must examine transport, cost, communication, and responsibility while the transfer is being arranged.

The simplest feasible intervention is not automatically the best matched intervention. Practical assistance and supportive contact may address an immediate disruption, while continuing symptoms or complex difficulties warrant further assessment and appropriately trained care. A resource shortage should not become a theoretical claim that a population needs less. Nor should a prestigious model justify training workers beyond what supervision and safeguards can sustain. Decisions should record the assessed need, the rationale for the selected response, the service limitations, and the arrangements for reviewing progress or deterioration.

The counsellor's own reactions can distort these choices. Helplessness may produce premature referral; a wish to be indispensable may encourage work outside competence; organisational pressure may reward rapid closure. Supervision should examine these pressures alongside the case formulation.

A responsible plan specifies achievable next actions, clear professional limits, and who will remain in contact. The quality of theoretical selection is demonstrated through this disciplined judgement, rather than through the number of named approaches used.

Four Questions Before Selecting a Theory or Protocol

First ask whether the framework helps explain this difficulty. A systemic formulation may identify unsafe dependency; conservation of resources may clarify overlapping losses; an attachment perspective may direct attention to disrupted dependable care. Second ask what evidence supports the proposed intervention with a population and outcome close enough to the present need. Evidence for one programme cannot be assigned to an entire theoretical school.

Third ask what delivery requires: competence, supervision, privacy, interpretation, attendance, protection and a receiving pathway when needs exceed the programme. Fourth ask what makes this application unsafe or ineffective. Exposure work must consider actual danger; cognitive work must not dismiss accurate perceptions of threat; a crisis sequence must not assume unavailable services. Record unmet conditions and alternative action. The conclusion concerns a specified use under specified

conditions, not acceptance or rejection of a continent's knowledge.

Chapter Synthesis

Crisis theory should support precise judgement rather than geographical acceptance or rejection. Classical theory, stress appraisal, resource theory, family adaptation, ecological and relational perspectives each illuminate different dimensions. Structured models organise contact, while service frameworks coordinate levels of assistance. African interventions research provides valuable information without proving universal applicability. At all levels, we still need ethics and practicality.

The practitioner must also consider the relationship between theory and personal response to authority. Cultural humility, competence, responsiveness, and safety belong alongside reflection on transference, countertransference, urges, boundaries, disclosure, and regulation. A useful formulation connects these responsibilities to a feasible response. Its adequacy is assessed through what it helps people understand and do, and through whether care becomes safer, more accessible, and accountable.

Reflection and Practice

1. Define and differentiate between an explanatory theory, an intervention model, an ethical perspective, and a service framework based on examples from the chapter.

2. Contrast classical crisis theory, transactional stress, and conservation of resources in the teaching case. What do they tell us? What do they fail to address?

3. Why would a common African background be a poor indicator of efficacy and an international background a poor indicator of inapplicability?

4. Evaluate one model on the basis of conceptual fit, empirical fit, ethical fit, and practical feasibility.

5. Explain how family adaptation and systemic formulation could mask coercive responsibility. Reformulate the formulation to retain accountability.

6. Explain the significance of commitment in a crisis intervention plan. How is an agreement about a feasible action different from a promise that erroneously guarantees safety?

7. Choose one study from Africa referred to in this chapter and discuss its population, intervention, comparator, design, outcome, and transferability limitations.

8. Write a supervision reflection on the counsellor’s need to reassure in the teaching case. Consider the bodily state, assumptions, boundaries, and priorities of the family.

9. Develop a short contextual formulation that uses no more than three theoretical lenses and ends with responsibilities, referral, and review.

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Chapter 4: Assessing Crisis Risk, Needs and Resources

Learning Objectives

Readers should be able to distinguish screening, assessment, diagnosis, and formulation; conduct an assessment linked to a practical decision; select instruments with attention to purpose and local evidence; identify urgent health and protection concerns; assess individuals, families, organisations, and communities without confusing their needs; and document uncertainty, action, and review. They should also recognise how culture, professional authority, relational expectations, and the counsellor's internal state influence what becomes visible during assessment.

Assessment Begins with a Decision

Begin with the decision the assessment must support. Immediate questions may concern danger, medical care or safe accommodation. Later assessment can address longer-term needs and resources.

Consider a fictional employee whose anxiety questionnaire suggests few symptoms. He then explains that he has nowhere to sleep and has been thinking about ending his life. The score describes one symptom domain; it does not answer whether he is safe tonight. Conversely, a person who cries throughout an interview may have secure accommodation, dependable support,

and no current suicidal thoughts. Visible intensity, functioning, and danger need separate enquiry. Neither composure nor emotional expression should close the assessment.

For each question, ask how the answer would change the plan, who can act on it and what needs to happen before the person leaves.

Screening, Assessment, Diagnosis and Formulation

Screening identifies possible concerns that require further attention. Assessment examines those concerns through relevant history, observation, dialogue, and additional information. Diagnosis, where appropriate, requires qualified judgement about a defined condition and alternative explanations. Formulation connects the event, meanings, threats, resources, and maintaining pressures to a response. These activities overlap but serve different purposes. A positive screen is not a complete diagnosis, and a diagnosis does not describe every practical need of someone experiencing a crisis.

A formulation might describe how repeated displacement, interrupted medication access, and uncertainty about family whereabouts are sustaining distress. That account can guide practical coordination without pretending to establish a psychiatric condition. Another person may need both a diagnostic assessment and help with housing. The question is

what information is necessary for the present task and which professional should obtain it. A community volunteer's role in recognising concern does not become permission to make clinical determinations.

Policy makers should preserve these distinctions in reporting systems. The number screening positive is not automatically the number with confirmed disorders. Service users with diagnoses are not equivalent to everyone affected by an emergency. Reports should specify the population, measure, timeframe, and method. Otherwise, administrative categories may inflate certainty or make people whose needs are primarily practical disappear from planning. Clear definitions support better allocation and more honest evaluation of what the service actually provides.

Preparing the Assessment Setting

Before beginning, establish whether the setting permits safe communication. Is an alleged perpetrator nearby? Can others overhear? Is the person able to sit, communicate, and take a pause? Does an interpreter understand the confidentiality arrangement? In a busy clinic, school, church, or evacuation centre, perfect privacy may be unavailable. The practitioner should identify the limitations and arrange the safest feasible alternative. Sensitive questioning should not occur publicly

merely because the registration desk is the only available surface.

Introduce the role accurately. A counsellor should not imply authority over public benefits, immigration decisions, disciplinary proceedings, or medical admission unless that authority exists. Explain what the conversation can accomplish and how information will be used. Practical honesty improves the person's ability to decide what to share. It also reduces the chance that apparent agreement reflects a mistaken belief that refusal will cost access to food, employment, grades, or another essential resource.

Preparation includes knowing the response pathway before asking questions that may reveal urgent danger. A service should identify qualified contacts, after-hours arrangements, transport options, and protection procedures. Staff also need a way to seek consultation without abandoning the person. These arrangements require organisational responsibility. It is unreasonable to train workers to identify concerns while giving them no reliable means to respond. Assessment capacity and response capacity should be planned together.

Consent, Confidentiality and Participation

Explain the purpose of assessment in language the person understands. Discuss who ordinarily sees the record, whether

coordination may be useful, and circumstances in which information may need to be shared under applicable duties. Do not promise absolute secrecy. Equally, do not describe confidentiality so vaguely that any disclosure appears permissible. Where sharing is necessary, explain the reason where safe and practicable, involve the person as far as possible, and disclose only information relevant to the protective task.

Consent is a continuing conversation. Someone may agree to a counselling interview but refuse a family meeting or research questionnaire. Distress does not automatically remove the ability to make decisions. Communication, time, or a quiet environment might allow participation. Issues surrounding competence in decision-making require professional assessment and adherence to relevant legal guidelines; they should not be resolved merely due to disagreement, as such a resolution indicates incompetence. Students must learn to tell the difference between a difficult choice and being unable to make one.

Guidelines on consent, protection, documentation, and compulsory intervention for each country need to be checked using the latest local guidelines. The information provided here is intended as teaching guidelines and not legal protocols for the continent. A visiting practitioner must not import duties from a previous jurisdiction without checking their applicability. Uncertainty should prompt consultation and careful

documentation while necessary protection continues; it should not become a reason to postpone all assistance.

Establishing the Event and Its Time Course

Ask what happened, when it happened, what changed, and whether the exposure continues. A single bereavement differs from repeated threats at home; a flood that has receded differs from continuing unsafe shelter. The initial event may no longer be the main source of danger. Debt, interrupted treatment, loss of schooling, and family separation can become sustaining pressures. A useful chronology therefore includes the onset of symptoms and the sequence of changes in resources, relationships, and everyday demands.

Invite a concise account rather than require detailed narration of every distressing experience. Someone may be uncertain about dates or describe events out of order. Clarify information necessary for decisions without treating imperfect recall as proof of dishonesty. If exact timing matters for medical or protection assessment, arrange the appropriate qualified service. The counsellor should not conduct an improvised forensic interview while presenting it as supportive care.

Distinguish accumulated stress from sudden escalation. Ask what made help necessary now, what previously kept the situation manageable, and what has recently failed. A household

may have endured hardship for months before transport money disappears or a caregiver becomes ill. There is no universal duration after which difficulty becomes crisis. The threshold concerns the relationship between demands, danger, functioning, and usable support at the present time. This prevents calendar-based assumptions about who should already have recovered.

Identifying Immediate Health and Protection Needs

Urgent action can precede completion of assessment. Serious injury, suspected poisoning, altered consciousness, sudden marked confusion, or another possible medical emergency requires prompt medical attention. An immediate threat from another person requires protection arrangements. Current suicidal danger requires urgent qualified assessment and safe support. The task is to recognise when the counselling interview is insufficient and activate help within the practitioner's role. Asking more questions must not delay a necessary response.

The WHO and UNHCR humanitarian intervention guide provides guidance for appropriately trained non-specialist health providers managing specified mental, neurological, and substance use conditions in humanitarian settings (World Health Organization & United Nations High Commissioner for Refugees, 2015). Its availability does not establish that every

counsellor or volunteer has medical competence. Symptoms that appear emotional may coexist with illness, intoxication, medication interruption, or injury. Physical and mental health pathways should therefore communicate when both are relevant. Assessment should include dependants. Who is caring for children, an older relative, or someone requiring assistance while the person attends the service? A referral may solve one concern while leaving another person unattended. The counsellor should coordinate suitable support rather than assume family arrangements exist. Record unresolved practical questions so the receiving service knows what remains necessary. Protecting the immediate client and examining the surrounding care responsibilities belong in the same plan.

Direct Enquiry About Suicidal Distress

When indicated, ask about suicide directly and calmly. Clarify current thoughts, intent, any plan, access to means, and recent or past attempts. Ask about changes in distress, substance use, agitation and available support. Use the findings to decide how urgently the person needs qualified help and what can make the immediate period safer.

The NIMH adult outpatient brief suicide safety assessment guide distinguishes screening from further assessment and identifies current suicidal thoughts as requiring urgent evaluation within

its clinical pathway (National Institute of Mental Health, n.d.-a). A lay helper should connect the person to qualified assistance, not attempt to reproduce specialist evaluation independently. Where immediate danger is suspected, maintain safe support and activate the local emergency or health response; do not leave the person unsupported while seeking help.

Listen without moral judgement. Statements about family duty, sin, gratitude, or shame can discourage disclosure. A person may fear punishment, loss of work, or disclosure to relatives. Explain the purpose of direct questions and the protective steps being considered. Do not seek a promise as proof that safety is established. Uncertainty, conflicting accounts, or communication barriers need further attention, especially when credible information suggests urgent danger despite a reassuring answer.

Risk Factors, Protective Factors and Their Limits

Risk factors guide enquiry into vulnerabilities and current pressures. Previous attempts, severe distress, recent loss, social isolation, violence, and disrupted care may be relevant, but they do not combine into a simple arithmetic prediction. Protective factors concern what supports life and help-seeking: dependable relationships, meaningful commitments, accessible care, and

coping that the person can actually use. Their presence should be explored rather than merely checked off a list.

A person who names children as a reason for living can still experience suicidal intent. A person who belongs to a religious community may be afraid to disclose distress there. A relative listed as support may live far away or be the source of danger. Ask how each proposed protection operates now, whether it is safe, and whether the other person is willing and able to help. A nominal resource is not necessarily a functioning resource.

NICE advises against using scales or global low, medium, and high categories to predict suicide or repeat self-harm, or to determine treatment and discharge decisions (National Institute for Health and Care Excellence, 2022). The practical alternative is an individual account of needs, current safety concerns, uncertainties, and actions. Administrative urgency categories for organising service response should not be misrepresented as probabilities of suicide. Record the required response and its rationale rather than attach confidence to an unsupported forecast.

Functioning, Basic Needs and Daily Responsibilities

Assess what the person can currently do and what prevents ordinary activities. Enquire about eating, sleep, essential medication, self-care, movement, work, schooling, and caring

responsibilities. Distinguish inability caused by distress from lack of opportunity. A person may not attend school because the school is closed, not because motivation has disappeared. Another may struggle to organise a task despite resources being available. Both situations deserve attention, but the intervention differs.

Basic needs should be explicit. Where will the person sleep? Is food available? Can they reach care? What happens when today's assistance ends? Questions should avoid implying that poverty reflects poor coping. They should identify practical gaps, urgency, and appropriate services. A counselling plan that assumes meals, private space, or reliable electricity may be unusable without those conditions. Functioning therefore needs to be understood through the interaction between personal difficulties and the environment.

Ask how responsibilities are distributed. A household that appears to function may depend on a child missing school or an exhausted caregiver carrying every task. Assessment should examine who pays the cost of apparent stability. The person's own priorities may include restoring schooling or reducing a relative's burden rather than changing a symptom score. Such priorities can become meaningful outcome indicators alongside qualified assessment of health concerns.

Meaning, Culture and Spiritual Experience

Ask how the person names the difficulty, what they believe contributed to it, and what kind of help they expect. The Cultural Formulation Interview offers a recognised structure for exploring cultural dimensions of presentation and care (American Psychiatric Association, n.d.). It supports enquiry into meaning; it is not a suicide screen, diagnostic shortcut, or substitute for urgent action. Nationality, ethnic identity, and religion provide possible context, not a complete explanation of an individual.

Explore spiritual experience with permission. Prayer, lament, belonging, and ritual may support someone; spiritual fear, exclusion, or perceived punishment may increase distress. Another person may prefer no religious discussion. Clarify what involvement is wanted and who may be contacted. Do not classify a belief as pathological simply because it is unfamiliar, or dismiss a concerning experience as culturally normal without assessing functioning, distress, and safety through appropriate professional judgement.

Cultural safety asks how the encounter itself affects participation. Does the person feel respected and able to disagree? Has an explanation led to a plan they recognise? The counsellor should invite correction and notice whether

institutional routines restrict choice. Cultural competence involves relevant knowledge and skill; humility sustains enquiry; responsiveness changes delivery where needed. These responsibilities become visible through the assessment decisions, not through a statement that the practitioner values diversity.

Language, Interpretation and Accessibility

Establish the language and communication method the person prefers. Fluency in everyday conversation does not guarantee comfort discussing suicide, coercion, grief, or spiritual struggle. The interpreter needs to know the importance of the job and the need to maintain accuracy. When a sensitive issue arises, do not rely on your relatives, as they may have control over the account. Where appropriate interpretation is unavailable, record the limitation and seek a safer arrangement rather than silently assume understanding.

Accessible assessment may require more time, plain language, large print, sign language support, or another communication aid. A support person should not automatically answer for an adult who can participate. Address the person directly and establish what assistance they want. Disability does not establish incapacity. An inaccessible instrument can produce missing or misleading responses that are then incorrectly attributed to the

person. The organisation itself needs to analyse its barriers to cooperation before drawing any conclusions.

A translation involves more than just word substitution. Practitioners must consider whether an item has the same meaning, whether the response options are understandable, and whether the administration method matches the validated version. Document departures from standard administration. A verbally explained questionnaire may be useful, but scores should not be presented as equivalent to published norms when equivalence has not been established. Honest limitations improve interpretation and protect against exaggerated certainty.

Severity, Intensity, and Change Over Time

Severity refers to the consequences and threats of the situation, such as impairment and lack of basic needs. Intensity refers to the strength of the response. Duration refers to the time difficulties have been ongoing, while timing refers to the time changes have taken place. These elements need to be documented separately. A person can talk in a soft voice despite being in grave danger. The aim is accurate description rather than a single number that compresses different concerns.

Ask what a typical day has become, what the worst periods are like, and what has changed recently. Distress may peak at night, after contact with a threatening person, or when temporary

assistance ends. These patterns help identify when support must be available. They also show why an office interview cannot represent every period of the person's life. A helpful question is whether the plan remains usable during the circumstances in which difficulty increases.

Review should track meaningful changes rather than simply count elapsed days. Has exposure stopped? Is accommodation more secure? Can the person reach care? Has a trusted supporter become unavailable? Continued distress may reflect continuing threat or cumulative loss rather than failure to accept assistance. Conversely, reduced visible distress should prompt enquiry into its meaning rather than automatic closure. The relevant outcome is a safer and more manageable situation, understood through the person's account and appropriate professional assessment.

More Sources and Contradictions

Information from other sources may help clarify care arrangements, changes that have recently occurred, or worries that the client may not be able to express at the time. Explain the need for it, obtain the appropriate permission, and state its purpose within the context of any protective obligations. A husband, teacher, manager, or community leader is a source of information, not an absolute authority figure. The information provided may be useful, incomplete, wrong, or biased. The

practitioner should record its origin and avoid merging it silently with the client's report.

Conflicting information requires careful enquiry. A parent may describe laziness while a young person reports threats at school. A manager may describe absenteeism while an employee describes an unsafe workplace. The assessor should clarify the relevant facts and consequences without turning the support interview into an adversarial hearing. If specialist investigation is necessary, arrange it through the appropriate process. Immediate assistance can continue while unresolved questions remain visible.

Do not ask someone implicated in harm to verify the survivor's account as a condition of care. Contact itself may disclose help-seeking and increase danger. Assessment quality includes deciding whom it is safe to approach, what can be shared, and when. Document the reasoning where coordination is withheld or limited. A complete network diagram is less important than preserving safe participation and obtaining information necessary for a responsible next decision.

Selecting Instruments for a Defined Purpose

Select an instrument by asking what construct it measures, for whom it was developed, and what decision it will inform. Examine age range, language, recall period, administration

requirements, training, permissions, scoring instructions, and available evidence. Consider whether the person is able and willing to complete it now. The best-known instrument may be unsuitable for the current setting. Several questionnaires can create workload without adding information necessary for the next action.

Sensitivity concerns identifying people with the target condition; specificity concerns distinguishing those without it. Predictive values also depend on how common the condition is in the assessed population. Reliability concerns consistency, while validity concerns whether the intended interpretation is supported. These properties do not establish that an instrument predicts individual behaviour or provides a complete explanation of crisis. Students should learn to describe the intended use rather than simply say that a tool is validated.

The table below compares purposes and limits. It is a teaching aid, not a standard battery, scoring manual, or instruction to administer every instrument. Use current official materials and relevant local protocols. Brief screening should be linked to competent follow-up and appropriate care. Collecting sensitive information without a response pathway can identify need while leaving the affected person with additional anxiety and no practical assistance.

Tool or approach	Main purpose	Essential limitation
Contextual interview	Understand events needs and functioning	Quality depends on skill and bias awareness
ASQ	Brief suicide screening	Requires an appropriate follow-up pathway
C-SSRS	Structure enquiry about suicidal thoughts and behaviour	Does not predict an individual's future action
PHQ-9	Depressive symptoms	Does not measure the whole crisis
GAD-7	Anxiety symptoms	Current danger and illness require consideration
PCL-5	PTSD symptoms	Exposure timing and qualified interpretation matter
SRQ-20	Common mental health symptoms	Local language and population evidence matter
WHODAS 2.0	Functioning and disability	Interpret alongside barriers and daily context
Cultural Formulation Interview	Cultural meaning and care expectations	Does not replace immediate safety assessment

Tool or approach	Main purpose	Essential limitation
Genogram and support map	Relationships and available help	A mapped relationship may be unsafe or unavailable
Vulnerability and capacity assessment	Community hazards and resources	Provides planning information rather than diagnosis
Risk register and impact analysis	Organisational threats and dependencies	Cannot establish an individual's clinical needs

Suicide Screening Instruments

The ASQ toolkit provides brief screening materials and pathways for further assessment, with age-specific resources (National Institute of Mental Health, n.d.-b). Services considering it should establish who will screen, who will assess a positive result, and how urgent responses will occur. Age and setting matter. The presence of translated materials does not establish validation in every local population. Practitioners should use the correct current version rather than reconstruct questions from memory.

The Columbia Suicide Severity Rating Scale structures enquiry about suicidal ideation and behaviour (Columbia University Department of Psychiatry, n.d.). Its role should be distinguished from predicting whether an individual will die by suicide. Use

an appropriate version, relevant training, and a defined response protocol. A tool can improve the consistency of questions while still requiring contextual judgement. Programme leaders should avoid turning a response category into an automatic discharge decision.

Screening results need to be integrated with the encounter. If the person declines, cannot understand the questions, or answers inconsistently, record what occurred and obtain the information required for safety through appropriate assessment. A negative screen should not override a recent attempt, credible collateral concern, or present statements indicating danger. Nor should a positive screen be used to shame the person or automatically impose a response unrelated to their assessed circumstances and applicable procedures.

Depression and Anxiety Measures

The PHQ-9 assesses depressive symptoms, while the GAD-7 assesses anxiety symptoms within their specified timeframes. Foundational studies support their intended symptom domains (Kroenke et al., 2001; Spitzer et al., 2006). Neither measures every form of crisis. A person can face urgent violence, hunger, or suicidal danger without a high total score. Conversely, a high score requires interpretation of the symptoms, functioning, context, and possible need for further qualified assessment.

Somatic symptoms need careful enquiry. Sleep and appetite may be affected by unsafe shelter, physical illness, caregiving, or emotional distress. Assessment should not erase either psychological or practical explanations. Ask what has changed and how the person understands it. An indication of self-harm or suicide on a depression measure requires direct follow-up regardless of the total score; a reassuring total must not become a reason to ignore a concerning individual response.

Use repeated scores thoughtfully. The same language, version, time period, and mode of administration allow for comparison, although a change in exposure may influence interpretation. A low score following improvements in housing cannot be taken to mean that counselling was responsible.

A worsening score during new displacement does not necessarily establish poor treatment. Link measurement to the person's account and actual functioning. Explain the result in understandable terms and ask whether it reflects their experience.

Trauma Symptoms and Functioning Measures

The PCL-5 is a self-report measure of PTSD symptoms. The National Center for PTSD describes uses including screening and monitoring, while emphasising qualified interpretation and the importance of the assessment purpose (National Center for

PTSD, n.d.). Immediate distress after an event must not automatically become a confirmed PTSD diagnosis. Timing, relevant exposure, symptom patterns, impairment, and alternative explanations require appropriate clinical consideration. The questionnaire does not require the counsellor to solicit an unnecessary detailed trauma narrative.

WHODAS 2.0 measures functioning and disability across several areas of daily life (Üstün et al., 2010). It adds information about daily functioning alongside symptom measures. Check which version is appropriate and how environmental barriers contribute. Mobility difficulties, lack of transport and fear of travel may all affect attendance, but each calls for a different response.

The SRQ-20 concerns common mental health symptoms. Its use requires evidence relevant to the language and population. It should not be treated as a diagnosis of every positive respondent or an assessment of all emergency needs. A service may choose a broad symptom measure to support planning, but should be clear about what it estimates. The choice should reduce uncertainty relevant to care rather than simply produce a number for a report.

Learning From Nigerian and Rwandan Validation Studies

Adewuya et al. (2006) evaluated the PHQ-9 among Nigerian university students, comparing it with other assessment information. Their findings support consideration of the measure in that population and illustrate that African validation work exists. The study does not establish identical performance among displaced adults, younger children, or every Nigerian language group. Students should read the population and methods before transferring a published threshold into a different programme.

Scholte et al. (2011) evaluated a Kinyarwanda version of the SRQ-20 in a Rwandan community setting. The study illustrates the importance of translation and local validation. Its findings apply to the setting and participants studied.

Local adaptation should include consultation on comprehensibility, pilot testing, and appropriate psychometric investigation when scores are intended to support formal decisions. Back-translation can reveal wording problems but cannot by itself establish validity. Programmes should also examine whether the tool changes access or introduces harms. A perfectly administered measure is of limited practical value if a positive result leads to an unaffordable service or public

disclosure. Measurement quality and service quality require separate attention.

Family Assessment and Relational Power

Family assessment should identify care responsibilities, livelihood, communication, health needs, housing, and the distribution of authority. Ask who controls money, movement, documents, and access to assistance. A joint interview may reveal shared concerns but suppress experiences that cannot safely be voiced in front of others. Offer private opportunities where relevant. The family's public account should not be assumed to represent each member's needs, especially those of children or dependent adults.

Map relationships through a genogram or support map when useful, explaining that these are aids to understanding rather than prediction instruments. Ask which relationships provide comfort, practical help, or pressure. Establish willingness and availability rather than assuming a line on the diagram means dependable support. Family solidarity may be valuable, but a plan can become unsafe when it assigns protection to someone implicated in violence or reinforces unequal caregiving demands.

Assessment should not treat coercion as a symmetrical communication problem. The person using threats remains

responsible for that conduct. A family formulation can explain patterns without distributing responsibility equally. Where violence or fear is present, protection and specialist advice may take precedence over a joint counselling conversation. The counsellor should resist an urge to produce reconciliation simply because family unity is a valued professional or cultural ideal.

Violence Safeguarding and Sensitive Information

Sensitive enquiry should occur in a setting where answers do not increase danger. Ask about safety and the person's concerns without pressing for unnecessary details or demanding immediate decisions about relationships. WHO guidance on intimate partner and sexual violence provides a basis for health-service responses that attend to support, privacy, and care needs (World Health Organization, 2013b). A counselling assessment should connect to qualified protection and health pathways rather than substitute for them.

Children need developmentally appropriate communication and safeguarding arrangements. WHO's clinical handbook addresses recognition and response to child maltreatment for health professionals (World Health Organization, 2022a). Counsellors should learn the procedures relevant to their role, avoid suggestive interrogation, and seek appropriate expertise. Do not assume that the accompanying adult is safe, or promise

a child that all information will remain secret. Explain protective action in terms the child can understand.

Keep therapeutic support distinct from investigation. A safeguarding allegation in an organisation may require an independent process, evidence protection, and formal reporting under applicable procedures. The counsellor should record the information necessary for care and referral, without taking on an unauthorised investigative role. Repeated interviews can burden a survivor and create confusing records. Coordination should reduce avoidable repetition while preserving consent, confidentiality, and the responsibilities of each service.

Assessing Organisations and Communities

Organisational assessment examines who may be harmed, whether the threat continues, which services are affected, and who can authorise protective action. A risk register describes operational concerns; an impact analysis examines dependencies and consequences of interruption. Neither is a mental health assessment of staff. A service failure may require technical correction, safeguarding action, or leadership decisions alongside support for affected people. Offering counselling cannot repair an unsafe system by itself.

The WHO–UNHCR toolkit helps teams assess mental health and psychosocial needs and resources for humanitarian planning

(World Health Organization & United Nations High Commissioner for Refugees, 2012). IFRC guidance adds a participatory way to examine local hazards, capacities and possible action (International Federation of Red Cross and Red Crescent Societies, n.d.). These approaches inform collective planning.

Consult beyond visible leaders. People with disabilities, minority language groups, adolescents, informal residents, and those unable to attend public meetings may experience different barriers. Combine available records with safe, purposeful enquiry, identifying gaps and conflicting information. Do not publish identifiable survivor histories merely to make a report vivid. Community participation should influence priorities and feedback, while personal clinical records remain protected through appropriate systems.

Transference Countertransference and Assessment Bias

Transference may shape how the client experiences the assessor: as a judging authority, a rescuer, or someone expected to abandon them. Such possibilities are hypotheses, not explanations to impose. Distrust may reflect the service's actual behaviour. Examine expectations and previous experiences when addressing current problems. It is possible to make a valuable

concept ineffective when dealing with reluctance as transference without considering cost, confidentiality, and coercion.

Countertransference has to do with how the counsellor reacts, including reactions due to past and present vulnerabilities.

Hayes et al. (2018) report associations between countertransference management and psychotherapy outcomes. This supports reflective practice without making the practitioner's feelings evidence about the client. An assessor who feels unusually protective may ask leading questions; one who feels irritated may stop exploring. Supervision should examine how the reaction affected attention, interpretation, and decisions.

Notice pulls and urges in concrete terms. Did I want to rescue, reassure, confront, withdraw, disclose, or prove that I understood? Did that urge change the questions I asked? A familiar story may encourage premature agreement, while an unfamiliar account may receive excessive scrutiny. The practitioner should actively consider alternative explanations and seek correction. Professional self-awareness belongs within assessment quality because it affects which information is collected and which concerns receive action.

Embodied Awareness Boundaries and Professional Power

The counsellor's internal state can affect judgement. Fatigue, tension, shallow breathing, or emotional flooding may narrow attention and encourage rushed conclusions. Notice these changes without assuming they reveal the client's hidden feelings. Brief regulation, consultation, and a suitable pause may help, provided urgent safety needs remain supported. Institutions should address excessive workload and unsafe conditions rather than assign all responsibility for clear judgement to individual self-care.

Power asymmetry requires attention to choices that appear voluntary. A counsellor who also teaches, supervises, employs, or leads a congregation should explain overlapping roles and arrange alternatives where necessary. The ethical framework of BACP emphasises competence, boundaries, and supervision (British Association for Counselling and Psychotherapy, 2018). Its guidance informs professional reflection here; applicable local professional duties must still be established. The client should not have to protect the counsellor from a conflict of interest.

Before self-disclosure, ask what benefit is intended, whether the timing fits, and whether a less intrusive response would serve the purpose. Sharing personal suffering can shift the assessment

toward reassurance of the practitioner. Emotional closeness does not justify unrestricted messaging, financial dependence, or disclosure outside professional limits. Boundary decisions should be explained and reviewed in supervision, particularly when urgency creates pressure to make exceptions that the counsellor cannot safely sustain.

Documentation Reassessment and a Teaching Case

Document what was reported, what was observed, what was inferred, and what remains uncertain. Record relevant concerns, protective actions, consultation, consent, referrals, and review arrangements. Use language that provides context: missing an appointment due to lack of transportation is different from missing an appointment without reason. The documentation must enable care without imposing any undue judgement. Reassessment is needed where there have been changes to the threats, symptoms, resources, and accessibility, particularly following a failure of referral.

In a fictional Kigali school case, a student reports few anxiety symptoms and repeated threats from an adult relative. The counsellor notices an impulse to reassure her about the relative's intentions. They speak privately, explain confidentiality and its safeguarding limits, and follow local protection procedures. The questionnaire score is one part of the record.

The counsellor checks immediate needs, identifies the appropriate protection service and documents the next steps.

Follow-up should establish whether the student received support and whether the plan needs to change.

Worked Assessment and Instrument Selection

Consider a fictional university student in Nigeria reporting two weeks of low mood after a family death, missed lectures and difficulty paying for food. She sometimes wishes she would not wake up. The first decision concerns safety and further assessment. A qualified practitioner asks directly about suicidal thoughts and the present situation, checks urgent health and protection concerns, and follows the service's assessed-risk pathway. Neither grief nor financial hardship explains away the statement.

The formulation separates reported facts from hypotheses. The precipitant is a death, followed by disrupted sleep, attendance and meals. Maintaining pressures may include isolation and lack of money; enquire about their contributions. A classmate may help, but consent and reliability need checking. Record assessed safety, usable resources, unresolved questions and actions that cannot wait. An urge to reassure quickly belongs in supervision; it is not evidence of low risk.

The PHQ-9 may support depression assessment when its version, language and administration fit. Its standard recall period is the preceding two weeks (Kroenke et al., 2001).

Adewuya et al. (2006) studied Nigerian university students, but the study does not determine this student's diagnosis. Bereavement, physical health, functioning and clinical enquiry remain important. A concerning self-harm response requires enquiry and action through the safety pathway regardless of the total score.

An ASQ screen has a different purpose. Consult current instructions, preparation requirements and follow-up pathways for the intended population and setting. A positive screen calls for further suicide safety assessment; acute concerns require urgent evaluation within the clinical pathway. The NIMH adult outpatient guide is designed for clinical use and does not authorise an untrained volunteer to practise independently (National Institute of Mental Health, n.d.-a, n.d.-b).

An instrument-selection note records its decision purpose, population and setting; version, language and recall period; training and administration; validation and uncertainty; and action after a concerning result. Add consent, storage and accessibility. Resolve inability to provide required follow-up before routine screening. Appendix A keeps the wider practical and relational formulation visible alongside scores.

Reflection and Practice

1. Explain the difference between screening, diagnosis, contextual formulation, and operational risk assessment.
2. Choose three instruments from the table. Identify their purposes, intended populations, and questions they cannot answer.
3. Write a formulation for the employee described at the start of the chapter without using a global suicide risk label.
4. Compare the Nigerian PHQ-9 and Rwandan SRQ-20 studies. State what additional evidence would be needed before use in another population.
5. Design a safe assessment setting for a person accompanied by someone who may be controlling their answers.
6. Examine one of your own urges in a fictional case. Describe its possible effect on questioning and how supervision could help.
7. Develop a referral pathway before introducing a screening programme. Include responsibilities, unavailable services, and urgent response arrangements.
8. Separate information needed for a community report from information appropriate to a protected individual clinical record.
9. Write a concise assessment note that distinguishes report, observation, inference, uncertainty, action, and review.

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Chapter 5: Immediate Intervention and Continuity of Care

Learning Objectives

Readers should be able to organise an initial response around current safety and feasible next actions; distinguish supportive assistance from clinical treatment; use psychological first aid within its scope; arrange collaborative safety planning and appropriate referral; respond to violence, displacement, and service disruption; and establish follow-up that verifies whether assistance occurred. They should also examine cultural responsiveness, transference, countertransference, practitioner urges, embodiment, boundaries, and power throughout intervention rather than treat them as separate ethical additions.

The Immediate Aim Is a Safer Next Period

Immediate intervention aims to reduce danger, meet urgent needs and agree on a manageable next step. Longer-term concerns can be reviewed once the immediate situation is safer. A technique can be sound but poorly timed. In a fictional case, a mother arrives with two children after leaving an unsafe home. A counsellor begins explaining stress regulation, while the children have not eaten and the mother fears being found. Revise the above response: establish personal contact, assess danger and health concerns, and ensure protection, proper food, and shelter for

the affected individual. Supportive conversation can accompany these steps without becoming a substitute for them.

Students, pastoral workers, teachers, community workers and clinical practitioners can contribute within their roles. Explain who will take responsibility for needs that require other expertise or authority.

Before Making Contact

Preparing means being aware of potential risks, services available, ways to communicate, and what can be committed to. A counsellor should not enter an unsafe scene or attempt a dangerous rescue outside training. Emergency responders and authorised services may need to establish physical safety first. In a clinic, school, workplace, or temporary shelter, identify where private conversation is possible and how to obtain assistance without leaving a vulnerable person unsupported.

Know the referral pathway in practical terms. Does the receiving service operate today? Can it receive the person? Is transport safe and affordable? What happens outside ordinary hours? A list of institutions is insufficient when numbers are unanswered or eligibility is unclear. Teams should maintain verified contact arrangements and a way to consult when the usual route fails. Preparedness is a continuing responsibility because services, staff, and access conditions can change.

Prepare emotionally as well. Notice whether fatigue, fear, urgency, or a wish to prove usefulness is affecting attention. A quick moment of reflection can assist the practitioner in speaking effectively and prioritising. This does not mean that there should be a delay. Work arrangements should include backup, consultation, and relief when a worker's capacity is compromised. A response system should not depend on one person remaining indefinitely available or emotionally unaffected.

A Practical Sequence with Repeated Review

This chapter uses six tasks as an educational synthesis: establish safety, make respectful contact, clarify urgent needs, support manageable coping, agree feasible actions, and arrange continuity. These tasks are informed by recognised crisis intervention models, including the structured approach discussed by Roberts and Ottens (2005). They are not a newly validated protocol or a fixed staircase. New information can require returning to safety assessment at any point, and practical action may occur alongside listening.

For example, a person may become more able to speak after receiving water and private space. Later disclosure of suicidal intent changes the response. An agreed referral may reveal that the service has closed, requiring renewed planning. The sequence should therefore organise attention without requiring

completion of every conversational stage before help is activated. Document the response to changing conditions rather than treating movement through a checklist as the main evidence of competence.

Intervention quality depends on the relationship between needs and actions. Each task should end in something understandable: who is responsible, what can occur, where help will be obtained, and how the next contact will happen. A person in crisis may struggle to retain a long explanation. Offer information in manageable portions and check understanding respectfully. Invite correction, since a plan that sounds reasonable to the counsellor may be impossible in the person's daily circumstances.

Establishing Safety and Urgent Care

Serious injury, suspected poisoning, altered consciousness, or another possible medical emergency requires prompt medical attention. Current suicidal danger requires urgent qualified assessment and safe support. An immediate threat from another person requires an appropriate protective response. Do not ask someone to complete a questionnaire or recount a full history before activating necessary help. Safety includes the practitioner and others present; a helper should seek trained assistance when the scene cannot be managed safely.

While assistance is being arranged, explain what is happening in plain language and preserve dignity. Maintain safe supportive contact where feasible, and identify who will remain responsible until the receiving service takes over. Do not leave a person facing immediate suicidal danger unsupported. Physical intervention, restraint, medication, and compulsory measures belong within authorised qualified services and applicable procedures. Counselling urgency does not create competence or lawful authority that the practitioner does not otherwise possess. Dependants and practical circumstances remain relevant. If an adult needs emergency care, who is looking after the children? Is the home still unsafe? Does the receiving team know about interrupted medication access or essential communication needs? Share relevant information through appropriate consent and protection arrangements. Successful arrival at a facility is an important transition, but surrounding care needs should not disappear simply because the immediate client has entered another service.

Respectful Contact and Cultural Safety

Introduce yourself and your role, explain why you are approaching, and ask whether assistance is wanted where possible. Use the person's preferred language and address them respectfully without assuming that age, nationality, or religion

determines the correct form of contact. Offer a quieter place if it is safe and acceptable. One might need a reliable companion while another could require time alone. Define the individual's preference instead of assuming that group participation is the standard approach.

Cultural humility is about re-examining one's interpretation and being willing to have it corrected. Competence is about knowledge and skills. Responsiveness alters delivery based on requirements. Safety is about whether the encounter is dignifying, participatory, and free of humiliation or coercion. This principle should translate into behaviour. If disclosure in a public setting is necessary for gaining assistance, then polite language is not enough to make the interaction safe. Practitioners should identify institutional barriers and seek appropriate alternatives.

Respect includes the ability to decline a non-essential activity. A person may accept food and transport while declining prayer, a group discussion, or a relaxation exercise. Help should not depend on matching the counsellor's preferred expression of gratitude or recovery. Where necessary protective action cannot be optional under applicable procedures, explain its purpose and limits as clearly as possible. Professional authority should be

exercised transparently rather than hidden inside a friendly invitation.

Listening Without Requiring a Trauma Narrative

Invite the person to explain what matters now. Listen for present danger, practical priorities, and what they hope assistance will accomplish. They do not need to describe every distressing detail to deserve care. A pause, an incomplete account, or a decision not to speak may reflect overload, privacy concerns, or preference. Do not turn supportive contact into an informal test of whether the person is a credible survivor.

WHO advises against psychological debriefing as an intervention intended to prevent post-traumatic stress, anxiety, or depressive symptoms after recent trauma (World Health Organization, 2012). This is distinct from allowing voluntary conversation, offering supportive listening, or conducting an operational review of service decisions. The objection concerns a specific intervention and its claimed preventive purpose. It should not be used to imply that all talking about experience is harmful or that evidence-based trauma treatment is unnecessary. Respond to what is shared without making promises about recovery. Acknowledge uncertainty and name available action. Saying that a clinic can be contacted together is more credible than assuring someone that everything will soon be fine. Ask

before moving toward sensitive detail. If an account raises concerns requiring specialist assessment or investigation, explain the pathway and arrange appropriate help. The supportive relationship should preserve choice and reduce avoidable repetition of painful information.

Psychological First Aid and Its Scope

The WHO psychological first aid guide describes humane, practical, and supportive assistance organised through looking, listening, and linking (World Health Organization et al., 2011). Looking concerns safety and urgent needs; listening concerns respectful engagement; linking concerns information, practical resources, services, and safe support. It offers an approach for people in a position to help after distressing events, while retaining attention to dignity, culture, and abilities.

Its scope should be stated honestly. Psychological first aid is not a comprehensive psychotherapy, diagnosis, or guarantee that a person will not develop PTSD. It does not replace emergency medical care, protection, or qualified mental health assessment. Helpers need relevant orientation and clear pathways when concerns exceed their role. A programme should not use the approach as a reason to provide brief support to everyone regardless of continuing symptoms, danger, or unmet needs.

The practical lesson is to integrate emotional and material assistance. A worker can listen while helping someone locate a safe service; a community volunteer can offer accurate information and connect people to authorised assistance. Delivery depends on the setting. Public venues, displacement, language differences, and unreliable communications can affect privacy and access. Local adaptation should improve usability while preserving the limits of the role and the person's ability to choose acceptable support.

Supporting Orientation and Manageable Regulation

Some people benefit from simple support to notice their present surroundings, sit comfortably, or take a short pause. Ask whether a practice would help rather than instruct everyone to use the same technique. An outward focus, such as noticing the room or speaking with a trusted person, may be preferable to inward attention. Another person may want practical information before trying anything. The aim is to support participation in the next step, not produce a required display of calm.

Breathing or grounding suggestions should remain optional supportive practices within competence. Avoid assuming anxiety when bodily distress needs to be assessed medically. Cease or alter the approach if there is an increase in discomfort, dizziness, fear, or

disconnect. Touch without consent and without professional justification should be avoided. The comfort gesture will seem intruding to someone who has been through a violent episode and does not understand the importance of the touch.

The regulation of the counsellor is another issue that needs to be considered. The helper's voice needs to have a more steady tone and pace. Notice tension, emotional flooding, or withdrawal and obtain support where needed. Bodily awareness is information about the practitioner's state, not proof about the client's intentions. The professional should remain able to think, explain, and seek consultation. Where there is a substantial weakening of this ability, organise assisted movement instead of struggling on to prove your reliability.

Prioritising Issues and Gaining Empowerment

Identify which issue seems more important to you, then analyse the safety and health issues that might need immediate resolution. The impacted individual may perceive a primary issue that the counsellor did not initially assume. Someone distressed after a death may want help informing an employer or arranging care for a child. Someone displaced may first want to locate a relative. These priorities can organise assistance without requiring the practitioner to overlook danger or work outside competence.

Offer a small number of meaningful choices. Too many options can burden someone who is overwhelmed, while a single unexplained instruction can reinforce helplessness. Explain what each option entails, including costs, privacy implications, and limits. A choice is not meaningful if the only apparently voluntary route requires unaffordable travel. The counsellor should distinguish what is genuinely available from what is desirable but not currently accessible, recording unresolved needs honestly.

Agency is supported through participation, not merely by handing responsibility back to the person. Help can include making a call together, clarifying instructions, arranging interpretation, or identifying a trusted companion. Ask what the person can reasonably do and what the service must organise. Avoid defining willingness to accept the counsellor's plan as motivation. Disagreement may reveal a practical barrier or an unsafe assumption that improves the plan when taken seriously.

Matching Assistance to the Presenting Need

Several needs may occur at once. Medical urgency can coexist with grief; violence can coexist with depressive symptoms; organisational service failure can threaten individuals while disrupting community access. A useful response identifies which actions cannot wait and which can be coordinated over

time. The table below is a comparison for learning. It does not establish diagnostic categories, a triage scale, or authority to perform actions outside training and applicable procedures.

Presenting need	Immediate response	Continuity requirement
Possible medical emergency	Activate qualified urgent care	Confirm handover and dependent care
Current suicidal danger	Maintain safe support and arrange urgent assessment	Individual safety planning and active review
Violence or coercion	Enable private contact and suitable protection	Survivor-led support within safeguarding duties
Loss of essentials	Connect to food shelter and essential care	Address recurring access and practical barriers
Distress with manageable safety	Listen and agree feasible support	Review functioning symptoms and changing needs
Service failure	Protect affected users and activate responsible procedures	Verify correction and restore safe access

A person should not be directed into a single pathway simply because one problem is easiest to label. Coordinate responsibilities when several services are necessary, and explain who is handling each need. Prioritisation means ordering action according to current consequences, not ranking whose suffering is most legitimate. If available capacity cannot meet an urgent need, escalate through established arrangements and retain the gap in the record. An unmet need should remain visible rather than be converted into apparent resolution.

Responding to Suicidal Distress

When suicidal distress is identified, direct assessment and a proportionate response are essential. Current suicidal thoughts, recent action, intent, planning, access to means, or other credible concern require appropriate qualified attention. Maintain safe support while activating urgent help when danger is immediate. The NIMH adult assessment pathway describes the need for urgent evaluation when current suicidal thoughts are present and distinguishes safety planning from an ineffective safety contract (National Institute of Mental Health, n.d.-a).

Do not rely on a promise, religious commitment, family attachment, or a reassuring questionnaire total to establish safety. Ask what the person can use now and what might prevent help-seeking. The intervention should reduce isolation and

connect to appropriate care without implying that the counsellor can predict future behaviour. Follow applicable local procedures and consult when uncertain. Protection should preserve dignity and participation as far as possible rather than use shame as a means of control.

For family members and community helpers, the priority is connection to qualified assistance and safe companionship within their capacity. They should not be expected to act as continuous clinical monitors or manage dangerous situations alone. Explain the agreed role, when urgent assistance is needed, and whom to contact. The presence of a relative is not sufficient evidence that the environment is safe. Family support requires willingness, availability, and freedom from coercion or involvement in the threat.

Collaborative Safety Planning

A suicide safety plan is developed with the person, using their own warning signs, feasible coping, safe social contacts, people who can provide direct help, professional services, and steps to reduce access to lethal means. The Stanley-Brown approach offers a recognised structure for this work (Stanley-Brown Safety Planning Intervention, n.d.). A plan should be accessible and understandable, with contact information checked. It is a

practical intervention, not a guarantee or a replacement for urgent assessment.

Rehearse usability. If a person becomes distressed at night, which listed resource is available then? If the phone has no airtime, what is the alternative? If a relative is named, does that person understand and accept the role? Appropriate discussion of means safety should identify who can safely arrange the agreed environmental changes, rather than assume that writing them down makes them happen. Avoid asking an untrained helper to undertake a dangerous confrontation.

A US cohort comparison found better outcomes for safety planning with structured follow-up than usual care among suicidal patients treated in Veterans Health Administration emergency departments (Stanley et al., 2018). This supports attention to planning and continuity without establishing identical effects in every African population. Local implementation needs appropriate training, clinical pathways, privacy, and reachable support. Evaluate whether the plan is used and whether its resources remain available, rather than count completed forms as successful prevention.

Violence and Survivor Led Assistance

Respond privately where possible, listen without blame, and clarify the person's immediate safety and health concerns.

WHO's clinical handbook describes first-line support for women subjected to intimate partner or sexual violence through attention to listening, needs, validation, safety, and support (World Health Organization, 2014). Its defined population and health-service context should be acknowledged. The wider practice principle is to connect respectful support with qualified protection and medical care where required.

Do not require reconciliation, confrontation, or family disclosure as a condition of assistance. Leaving or seeking help may involve danger, financial dependence, children, housing, and fear of retaliation. A survivor may need time and specialist advice. Respectful planning explores safe options while following applicable safeguarding and reporting duties. The counsellor should not contact an alleged perpetrator simply to hear both sides during supportive crisis care. Such contact can disclose help-seeking and increase exposure.

After recent sexual violence, appropriate medical care can be time-sensitive even when no injury is visible. Arrange prompt qualified assessment rather than attempt clinical management outside competence. Counselling support should not depend on completing a police process before care is sought. The local legal and service requirements need verification. Document the support offered and the person's choices through protected

records, avoiding language that assigns responsibility for the violence to the survivor.

Children Families and Dependent Adults

Children need communication suited to age, development, and circumstances. Speak in understandable language, allow questions, and avoid unnecessary repeated interviews. Identify a safe caregiver rather than assume the accompanying adult can protect the child. Safeguarding duties and appropriate consent arrangements apply. A child should not be asked to carry messages between agencies, supervise an adult in suicidal distress, or sacrifice schooling indefinitely to preserve the appearance of family stability.

Family involvement can provide practical care and belonging. Ask whom the person wants involved and what each participant can safely contribute. Some information may be shared for coordination without disclosing the entire counselling account. Explain these boundaries before a meeting. If a family member controls money, movement, or communication, private enquiry may be necessary. Joint participation should be evaluated by its effects on safety and agency rather than assumed to be inherently culturally appropriate.

Dependent adults and older people may need help with mobility, medication, communication, or daily care while retaining

substantial decision-making ability. Address them directly and establish preferences. A disability should not automatically transfer authority to another person. Support arrangements should examine continuity: who will assist after temporary volunteers leave or relatives resume work? A workable plan identifies both immediate care and the longer-term responsibility for maintaining it.

Practical Assistance and Case Coordination

Practical assistance can include connecting someone to verified accommodation, food, transport, legal advice, schooling, or essential health services. The counsellor need not personally provide every resource. The role may be to clarify needs, coordinate with permission, and reduce barriers. Explain eligibility and uncertainty honestly. Avoid promising benefits that another agency controls. A person should not be told that help is guaranteed simply because a referral has been written.

Coordinate when needs cross services. With appropriate consent, agree which worker is the main contact, what each agency will do, and how updates will occur. Do not circulate an entire history when a service needs only transport requirements or appointment information. Coordination should reduce repeated disclosure and confusing instructions. It should also identify unresolved needs, especially when agencies assume

another provider is arranging housing, dependent care, or follow-up.

Record whether action occurred. A resource list given to a person differs from a service contacted, an appointment confirmed, or assistance received. These distinctions matter for evaluation and future decisions. Practical barriers should not be relabelled as non-compliance. Ask what prevented access and revise the plan where feasible. When no adequate option exists, document and escalate the gap rather than create an account that suggests the person simply chose not to use help.

De Escalation and Difficult Communication

Agitation may arise from fear, pain, confusion, shame, delay, or feeling ignored. Use calm, understandable language, reduce unnecessary stimulation where feasible, allow space, and explain what is being done. Offer limited choices that preserve dignity. Avoid public humiliation, argument about whether distress is justified, or abrupt touching. Maintain safety for everyone and seek trained assistance when violence is possible. The counsellor should not attempt to manage a dangerous confrontation alone.

De-escalation does not mean withholding care until the person becomes calm. Adapt the conversation to what they can manage and examine possible medical concerns. Distress that disrupts

communication may require qualified assessment rather than firmer persuasion. Describe limits respectfully, including conduct that would place others in danger. Boundaries should be clear and consistent, with an available response pathway, rather than improvised threats intended to secure immediate compliance.

The practitioner's reaction matters. Fear can lead to unnecessary confrontation or sudden withdrawal; irritation can make an explanation sound punitive. Notice these states and seek support. After the immediate situation, supervision should examine what happened and whether the setting increased distress. Long waiting times, unclear instructions, and public questioning can create preventable escalation. Improving the system may be more useful than teaching staff to tolerate the same avoidable conflict repeatedly.

Referral as a Supported Transition

A referral should describe the relevant need and connect the person to a service able to address it. Confirm availability, eligibility, communication requirements, and practical access. Explain what will happen at the receiving service and obtain appropriate permission to share necessary information. A supported handover may involve calling while the person is present, arranging interpretation, or coordinating safe transport.

The aim is to reduce the gap between recommendation and actual care.

Clarify responsibility during the transition. Who remains in contact while the appointment is pending? What should happen if symptoms worsen or the person cannot attend? Has the receiving provider accepted the referral? A message sent is not the same as responsibility transferred. Urgent situations require arrangements proportionate to the concern. Document outstanding needs and confirmed actions so providers do not assume that someone else is maintaining support.

Respect the person's questions about referral. Previous care may have been humiliating, costly, or ineffective. Ask about those experiences and explain what can realistically differ. Avoid presenting reluctance as resistance before checking practical and relational barriers. Where the person declines and no compulsory protective duty applies, discuss alternatives within professional scope and record the decision. Where urgent danger requires further action, seek appropriate consultation and follow applicable procedures while preserving participation as far as possible.

When the Referral Pathway Fails

A failed referral requires renewed assessment. The service may be closed, unaffordable, inaccessible, unsuitable, or unable to

receive additional people. The client may have encountered discrimination or feared disclosure. Ask what happened and whether safety or functioning has changed. An old plan should not remain in place merely because it was once reasonable. Identify the next feasible option and the responsibility for pursuing it.

Scarcity does not remove professional limits. The WHO-UNHCR humanitarian guide supports trained non-specialist health providers within defined health settings and conditions (World Health Organization & United Nations High Commissioner for Refugees, 2015). It does not authorise any available helper to diagnose or prescribe. Established supervised arrangements, consultation, and appropriate coordination are preferable to improvising specialist practice. The plan should make limitations explicit while continuing assistance that can safely be provided.

Institutions should learn from repeated failures. Record patterns such as unanswered urgent calls, transport gaps, or exclusion based on documentation. Escalation should protect individual confidentiality while identifying operational problems. Programme success cannot be assessed solely by the number of referrals issued. The relevant question is how many people reached suitable care and what happened to those who did not.

Persistent gaps need leadership action rather than repeated instructions to workers to be more resourceful.

Continuity and Reassessment

Follow-up should verify present safety, whether assistance occurred, and what has changed. Agree its purpose, timing, method, and responsible person according to assessed need and local protocol. A routine future appointment is insufficient when instability requires earlier attention. Conversely, unnecessary contact can burden someone or reveal their help-seeking. Ask which channel and wording are safe, and explain what to do if needs become urgent before the planned review.

Revisit the formulation rather than merely repeat a questionnaire. Has the threat ended? Is the person able to eat, sleep, care for dependants, or reach treatment? Have resources changed? Which part of the plan was helpful and which was unusable? Symptom measures can contribute where appropriate, but continuity concerns the whole situation. A person who reports fewer symptoms may still face unsafe housing or a renewed protection threat.

Endings should be planned. Explain when the current service's role will finish and which support remains available. Avoid abrupt disappearance after an intense helping relationship. Equally, do not extend dependency through vague promises of

indefinite personal availability. A clear transition can acknowledge attachment and gratitude while preserving professional limits. Confirm that the person understands the next arrangement and that the receiving service has the information necessary for its role.

Remote Contact and Shared Devices

Remote intervention requires knowing the person's current location, a safe contact method, and a local response pathway. Establish what to do if the connection fails or urgent help is required. Emergency arrangements where the practitioner lives may not serve the client's location. Confirm relevant services before relying on them. Ask whether conversation is private, whether someone can overhear, and whether the person can safely receive a call or visible message.

Shared devices, monitoring, unreliable connectivity, and airtime costs can affect disclosure and follow-up. Agree acceptable wording and contact times without assuming that a coded message will eliminate danger. Recording or storing sensitive material creates additional considerations and should follow consent, security, and applicable requirements. A video platform is a delivery method, not a substitute for emergency preparation or an accessible local care system.

If urgent danger emerges, stay in supportive contact where feasible while activating appropriate local assistance and agreed backup. If contact is lost, follow the established contingency arrangement and applicable procedures rather than assume silence means improvement. Remote work also requires honest limits: some assessments or interventions may need in-person qualified care. The practitioner should arrange that transition instead of continuing remotely simply because the conversation remains technically possible.

Adapting Delivery Across African Settings

Consider three fictional service situations. In an urban Nigerian workplace, an employee can reach a clinic but fears that a manager will receive the counselling record. The response must clarify confidentiality, employment authority, and safe referral. In a rural Rwandan setting, a family affected by a landslide needs transport and continuity of care for an older relative. The response must organise reachable assistance and dependent care alongside emotional support. These examples do not describe every Nigerian workplace or Rwandan community. They demonstrate that different barriers change delivery even when respectful contact and safety assessment remain necessary.

In a fictional displacement setting in South Sudan, a person has moved repeatedly and the listed receiving service is no longer

reachable. Follow-up must consider movement, safe contact, and which provider will retain responsibility. The problem cannot be resolved by prescribing better attendance. A similar difficulty could occur in another country after transport disruption or service closure. The operational unit is the person's actual location and circumstances, rather than a continental label or an assumption that services work uniformly within national borders.

Adaptation should therefore preserve necessary safety tasks while revising the means of delivery. Review language, venues, timing, communication, cost, and support arrangements with affected people. Check current local service and professional requirements before action. Avoid treating informal community networks as automatically safe or formal institutions as automatically accessible. The counsellor's contribution is to identify what the person can use, establish professional responsibility, and connect assistance across the conditions that would otherwise interrupt it.

Transference Countertransference and the Urge to Rescue

A client may experience the counsellor as a rescuer, critic, or authority expected to abandon them. These relational possibilities should be explored cautiously alongside the service's actual behaviour. A client who fears abandonment may

have repeatedly encountered failed referrals. Labelling the concern as transference without addressing continuity would miss a real problem. Trust develops through accurate explanation, dependable follow-through, and boundaries that the person can understand.

Countertransference can appear as unusual protectiveness, helplessness, irritation, or a need to demonstrate personal significance. The counsellor may feel pulled to provide money, promise unrestricted availability, disclose personal experiences, or confront someone on the client's behalf. The important question is how the feeling influences action. BACP's ethical framework identifies supervision and appropriate boundaries as professional responsibilities (British Association for Counselling and Psychotherapy, 2018). Reflective support should be available during difficult work, not only after problems occur.

Before acting on an urge, ask what need the action serves, what risks it creates, and whether an appropriate service arrangement would accomplish the purpose more safely. Urgency can require flexibility, but exceptions should be proportionate, explained, documented, and reviewed. The counsellor should not make the client responsible for maintaining professional limits. A strong

wish to help is valuable when translated into competent action; it is not evidence that every contemplated action is justified.

Power Self Disclosure and Ethical Reality

Power asymmetry can make clients reluctant to disagree, particularly when the counsellor also teaches, supervises, employs, or leads worship. Explain overlapping roles and offer appropriate alternatives where possible. Apparent consent may reflect fear of losing assistance or approval. Ask whether the plan is acceptable and make clear which activities are optional. Where an institution controls access to essentials, it must examine how that authority shapes participation in counselling.

Self-disclosure needs a defined client-centred purpose. Sharing a personal story to prove cultural understanding can move attention away from the client or imply that they should cope in the same way. Ask whether disclosure is necessary, whether the timing fits, and whether a simpler response would help. Notice whether the client then begins caring for the counsellor. Warmth and authenticity do not require exchanging equally personal accounts in a relationship with unequal professional responsibilities.

Ethical reality includes fees, records, confidentiality, professional scope, and the availability of services. Boundaries cannot compensate for an organisation that provides no safe

referral or adequate staffing. Conversely, scarcity cannot justify exploitation, coercion, or unsupervised practice outside competence. The response should document constraints and seek accountable solutions. Supervision should examine personal blind spots and institutional pressures together, including expectations that a worker resolve problems that require legal, medical, technical, or policy action.

Organisational Community and Policy Responses

An organisation facing a safeguarding concern or service failure must protect affected people and activate the appropriate procedures. Counselling support should remain distinct from investigation, disciplinary authority, and technical correction. Leadership should identify who makes decisions, who communicates verified information, and how services continue safely. A sympathetic message without corrective action can leave the threat intact. Workers providing support also need boundaries around what they know and can disclose.

Community response requires coordination across essential services and support. The IASC framework, developed in Chapter 9, and the Sphere Handbook help examine complementary responsibilities (Inter-Agency Standing Committee, 2007; Sphere Association, 2018). Identify which

function must act and maintain support while that action is arranged.

Policy makers should fund continuity as well as first contact. Necessary arrangements include accessible communication, qualified consultation, transport where required, supervision, protected records, and monitoring of unmet needs. Evaluate reach, actual service use, safety, and the experiences of people excluded from care. A successful immediate response creates a supported next stage; it does not merely produce a completed form, a referral count, or the appearance that distressed people have become calm.

Teaching Case and Chapter Synthesis

Return to the fictional mother who left an unsafe home with two children. After private enquiry, the counsellor coordinates appropriate health and protection assistance, food, and verified safe accommodation. The mother chooses a trusted sister for limited practical involvement. Information sharing is discussed, and the counsellor avoids contacting the partner during supportive care. Follow-up has an agreed safe channel and responsibility. The receiving service confirms the arrangements rather than leaving the family with an address alone.

The counsellor also recognises an urge to offer personal accommodation and continuous private messaging. Consultation

helps separate the family's needs from the practitioner's wish to rescue. Appropriate assistance remains active while boundaries are maintained. The children's care and schooling enter the continuing plan. If accommodation or referral fails, reassessment follows. The case shows how culture, agency, power, embodied regulation, and professional limits influence actual decisions rather than remain abstract values.

Review whether the immediate plan made the situation safer, whether the person could follow it and whether the receiving service took responsibility. Record unresolved concerns and who will act next.

A Worked Handover Record

This fictional record illustrates a supported transition. At 14:10 a counsellor records that an adult client reports suicidal thoughts and needs urgent qualified evaluation. The record distinguishes the client's account, observations and assessed actions. It identifies support in place, unresolved questions and agreed communication. Detailed trauma narration is not included merely because it occurred in conversation.

At 14:20 the designated receiving clinical service is contacted through a locally verified channel. A clinician confirms capacity and attendance arrangements. The client is told what information will be shared and why. Record consent or, where

protective disclosure is required, the applicable basis and explanation. Share what is necessary for safe transfer and avoid unrelated family or employment details.

At 14:35 feasible transport is confirmed. Name the responsible person or service, expected arrival and who maintains safe support during transition. Identify a fallback if transport fails or danger changes. At 15:20 the receiving service confirms arrival and acceptance of clinical responsibility. Record confirmation and the agreed follow-up role. These times illustrate sequence, not universal deadlines or proof that facilities exist everywhere.

If the first service refuses, the record remains open: refusal reason, alternative contacted, continuing support and escalation decision. Failure to arrive is not automatically non-compliance. Check cost, mobility, fear, language, danger and communication. A supported handover names a receiving function, verified capacity, usable transfer, responsibility during the gap and confirmation or an active fallback.

Supervision examines avoidance as well as rescue. Shame about a failed referral may lead a counsellor to postpone the next call or give defensive instructions. Restore an accountable transition and obtain support. Client records contain care-relevant decisions; detailed exploration of personal reactions belongs in protected supervision.

Reflection and Practice

1. Practise an initial contact that establishes role, consent, privacy, and urgent needs without requiring a detailed trauma narrative.
2. Explain the distinction between psychological first aid, psychological debriefing, and appropriately delivered trauma treatment.
3. Develop a supported referral plan specifying confirmed arrangements, outstanding needs, and what to do if the pathway fails.
4. Review a fictional safety plan for practical usability, including unavailable contacts, privacy, and help outside normal hours.
5. Describe how family involvement might improve care or increase danger in the teaching case.
6. Write a supervision reflection about an urge to rescue. Include bodily state, power, boundaries, and alternative actions.
7. Develop a remote contact contingency plan for a fictional client using a shared device.
8. Distinguish supportive care, safeguarding investigation, and organisational authority after a service failure.
9. Propose indicators of continuity that measure more than the number of referrals or forms completed.

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Chapter 6: Individual Crises, Grief, Trauma and Suicidal Distress

Learning Objectives

By the end of this chapter, readers should be able to distinguish crisis support from diagnosis and specialist treatment; assess grief, traumatic distress and suicidal concerns without imposing a uniform cultural timetable; develop realistic support and referral arrangements; recognise how transference, countertransference and professional power influence individual crisis work; and connect personal recovery with material conditions, relationships and public policy.

Meeting the Person Within the Crisis

A death, threat, illness or other disruption affects someone with particular relationships, commitments and practical needs. Ask which parts of daily life have become harder and which sources of support remain available.

Consider what the person can reach in their own setting, including safe transport, trusted people, a private place to talk and appropriate clinical care.

A useful opening question is, “What has changed, and which part is hardest to carry today?” The answer might concern pain, shame, food, uncertainty, loneliness or immediate danger. Listen before choosing an intervention. Explain the service’s role and

confidentiality limits in language the person understands, and check whether the setting permits an honest conversation. If urgent medical or safety needs are apparent, address them promptly. A respectful relationship matters, but warmth cannot substitute for arranging necessary care. The task is to make the next steps understandable and achievable while retaining the person's participation wherever possible.

Grief as a Varied Human Response

Grief can follow death and other important losses, including the loss of bodily function, livelihood, identity, community or an anticipated future. Bereavement specifically concerns the death of someone significant. Some people cry frequently; others become quiet, irritated, restless or absorbed in responsibilities. A person might feel relief after prolonged suffering and then feel guilty about that relief. Someone may miss a relative deeply while also remembering cruelty within the relationship. The counsellor makes space for these complexities instead of measuring love through visible sorrow or assuming that mixed feelings indicate a defective bond.

The question is not whether the person grieves in a way the counsellor recognises. It is how the loss affects daily life, safety, relationships and meaning. Ask what happens during difficult periods, which activities remain possible, whether the person is

eating and sleeping adequately, and whom they can approach. Investigate practical consequences alongside emotional experience. A bereaved parent may face school fees, transport costs and an estate dispute before having time to speak about longing. Reducing these demands can create room for grief; it does not diminish its emotional importance.

Counsellors should avoid treating familiar stage language as an obligatory sequence. People do not owe practitioners denial, anger, bargaining, depression and acceptance in a prescribed order. A return of sadness around a birthday does not prove that earlier progress was false. Nor does laughter during a family gathering demonstrate that mourning has ended. Invite the person to identify what helps and what becomes overwhelming. The aim is to support a workable relationship with loss and continuing life, rather than certify that a universal timetable has been completed.

Moving Between Loss and Daily Living

Stroebe and Schut's dual process model describes movement between attention to the loss and attention to the demands of changed life. It also recognises respite from both forms of coping. This offers an alternative to assuming that continuous emotional confrontation is necessary for healthy mourning (Stroebe & Schut, 1999). Its concepts can inform conversation,

but the model is not a test that establishes whether an African client is grieving correctly. The practitioner still needs to understand the person's obligations, available choices and preferred ways of remembering.

In an original practice illustration, a woman spends an evening sorting her late husband's photographs, then devotes the next morning to reopening their shop. Both activities may matter. The counsellor can ask whether there is room for remembering, necessary administration and rest, without deciding which activity carries greater emotional authenticity. If the shop must open to provide food, working is not automatically avoidance. If photographs become intolerable, a gradual approach may be more workable than demanding a full account immediately. The person's response and circumstances guide the pace.

An adaptable plan might reserve a brief, chosen period for a memory activity, identify one urgent practical task and protect an opportunity for ordinary companionship. This is a conversational example, not a validated treatment schedule. Review whether it helps or adds pressure. Someone who does not want a deliberate remembrance activity should not be compelled to perform one. Where relatives demand constant public mourning, explore the client's choices and safety. Where work consumes every hour, investigate possible assistance.

Flexibility becomes meaningful only when the person has enough resources to exercise it.

Mourning Practices, Culture and Personal Choice

Mourning may involve religious services, community gatherings, clothing expectations, burial arrangements, memorial meals, prayer, storytelling or private remembrance. Their meanings differ across and within countries, ethnic communities, denominations and households. A counsellor should ask which practices the person values, which are obligatory and which create difficulty. Do not infer a ritual preference from a name, language or place of origin. Someone may wish to honour a family tradition while modifying its cost or timing. Another may feel excluded because their relationship with the deceased was not publicly acknowledged.

Cultural competence includes learning enough to ask informed questions, while cultural humility requires recognising that the client remains the better authority on their own experience. Responsiveness turns that understanding into changes in practice: using an appropriate interpreter, allowing a chosen supporter to attend, adapting appointment times or supporting access to a meaningful ceremony. Cultural safety is assessed partly through the person's experience of the encounter. Ask whether they feel judged, pressured or misrepresented. An

intervention can be fluent in local customs and still be unsafe if it silences a vulnerable participant.

Where a mourning expectation exposes someone to harm, humiliation or severe deprivation, respectful curiosity does not require professional endorsement. Explore the person's concerns privately, clarify what assistance is available and seek relevant safeguarding or legal consultation within the local framework. Avoid promising that the counsellor can settle inheritance or family authority disputes. A useful contribution may be helping the person formulate questions for a qualified adviser, identify safe accompaniment and make a plan for essential needs. Respect for cultural meaning and attention to personal safety must operate together.

When Grief Needs Further Assessment

Supportive counselling should include attention to changes that warrant qualified clinical assessment. Persistent severe impairment, marked deterioration in self-care, suicidal concerns, substance-related harm or experiences the person finds frightening and disabling deserve careful investigation. These concerns can occur alongside grief, and their presence should not be dismissed as culturally expected sorrow. Conversely, culturally meaningful mourning and continuing bonds with the deceased should not be labelled disordered merely because the

counsellor finds them unfamiliar. Ask about distress, functioning, duration, context and the person's own interpretation before drawing conclusions.

Prolonged grief disorder is a clinical diagnosis involving persistent, impairing grief considered in relation to cultural expectations and other explanations. The American Psychiatric Association describes specific diagnostic requirements; duration alone does not establish the condition (American Psychiatric Association, 2025). Counsellors who lack the relevant diagnostic competence should describe observed concerns and arrange assessment rather than pronounce a diagnosis. A screening result can prompt further enquiry, but it cannot decide what a death means to the person or replace a properly contextualised clinical evaluation.

Explain referrals without suggesting that ordinary grief is a failure. For example, "Your distress is making it very difficult to eat, work and remain safe; an additional assessment may help us understand what support is needed." Discuss cost, language, transport, privacy and the possibility that the receiving service is unavailable. Agree on interim support within competence and a follow-up point. Referral is a process involving connection, consent where applicable and review of what actually happened.

Giving an address that the person cannot reach does not complete the professional responsibility to consider continuity.

Traumatic Distress Without Automatic Diagnosis

After a frightening or violating event, people may have intrusive memories, disturbed sleep, heightened alertness, avoidance or changes in trust. Reactions vary, and exposure does not automatically mean that a person has post-traumatic stress disorder. The World Health Organization distinguishes common post-event distress from a condition requiring clinical assessment and recognises effective psychological treatment options for PTSD (World Health Organization, 2026). The counsellor should not diagnose from a dramatic story alone or assume that an outwardly composed survivor is unaffected.

Start by asking what troubles the person now and whether the original danger continues. A survivor may fear travelling because attackers remain nearby, rather than because all travel has become psychologically associated with threat. Someone may avoid a clinic because staff previously breached confidentiality. These possibilities change the response. Practical protection, safer access and accountability may be necessary before or alongside psychological care. Counselling should not teach people to ignore credible danger in order to

appear less anxious. Clarify what is known, what remains uncertain and what protections can realistically be arranged.

Offer choice over the amount of detail disclosed. An initial conversation can establish needs and safety without reconstructing every moment of the event. Ask permission before pursuing sensitive questions and explain why they matter. The person may prefer to describe sleep, bodily discomfort or difficulties caring for children rather than narrate the incident. A competent assessment can work with that starting point while identifying urgent concerns. Record relevant information accurately and sparingly, recognising that unnecessarily detailed records may create additional exposure if access is poorly controlled.

Time, Severity and Continuing Threat

The passage of time influences crisis experience but does not act independently of circumstances. A person whose home is secure may begin restoring routines after a flood. Someone still moving between temporary shelters may confront fresh uncertainty each day. Distinguish the date of the original event from the duration of ongoing exposure and the accumulation of further stressors. The phrase “months since the incident” can conceal repeated intimidation, untreated injuries, debt and interrupted sleep.

Asking what happened afterwards often reveals why distress remains intense.

Severity also requires several perspectives. The event may involve major physical danger, yet the individual's most destabilising concern may be the loss of an essential relationship. A comparatively brief episode of public humiliation may threaten employment and belonging. Assessment should consider immediate intensity, functional disruption, repeated exposure, available support and perceived meaning. Avoid a competition in which only the most visibly catastrophic event deserves care. At the same time, do not overlook urgent medical or protection needs because the client's preferred explanation focuses on emotional pain.

When reviewing persistent distress, ask what has improved, what remains unchanged and what has become worse. Identify whether the plan addressed the actual obstacles. Repeated missed appointments might reflect transport disruption, fear of an abusive relative or the service's unsuitable opening hours. Persistence is therefore information about both the person and the environment. It should prompt reassessment rather than a quick declaration of resistance. A revised plan may require fewer tasks, additional material support, different contact arrangements or a practitioner with more appropriate expertise.

The Body in Individual Crisis Work

People may describe a heavy chest, shaking, exhaustion, stomach discomfort, a sense of numbness or an inability to settle. Listen carefully without assuming that all bodily symptoms are psychological. Medical concerns, injury, medication effects, illness, substance use and emotional distress can coexist. Where symptoms are severe, sudden or concerning, arrange appropriate health assessment rather than relying on relaxation exercises. A counsellor's confidence in a psychosomatic explanation must not delay necessary care. Bodily experience is part of assessment, not a shortcut around it.

Within an appropriate counselling role, offer simple, optional ways to make the conversation more manageable. Ask whether the person wants a quieter seat, water, a pause, feet supported on the floor or attention to familiar objects in the room. Some prefer movement to stillness. Others dislike closing their eyes or focusing on breathing. Explain that they can stop an exercise and report discomfort. A technique should increase usable choice rather than create another demand to perform correctly. Check its effect instead of assuming that a calmer-looking body means the underlying concern is resolved.

The practitioner's own embodiment also matters. Notice a tightening jaw, shallow breathing, numbness, agitation or a

strong urge to rush. These signals may indicate fatigue, personal activation or an emotional response to the encounter; they are not evidence about the client's hidden motives. Briefly regulate posture and attention, retain a steady tone and seek supervision where needed. If the counsellor cannot think clearly enough to practise safely, arrange appropriate support or handover. Self-regulation serves the client by preserving judgement, listening and proportionate action.

Shame, Guilt and Moral Distress

A person may repeatedly ask why they survived, why they did not leave earlier or why they could not protect someone else. Another may feel ashamed of losing a job or requiring assistance. Begin by understanding the claim rather than immediately offering reassurance. Ask what the person believes they should have done, what choices were actually available and whose judgement they fear. The counsellor can help distinguish responsibility, coercion, limited knowledge and circumstances beyond control. Do not make moral or legal findings beyond the professional role.

It can help to examine a specific moment rather than debate the person's whole character. What did they know at that time? What resources, risks and obligations shaped their action? Would they judge someone else in the same circumstances

equally harshly? These are exploratory questions, not a formula that removes guilt. Where the person acknowledges having harmed another, support appropriate accountability and qualified advice without either humiliating them or declaring them absolved. A crisis relationship should not become a private court or a way to avoid consequences.

The counsellor must monitor the urge to rescue the client from every painful feeling. Rapid reassurance can close down an account that needs careful attention. The opposite urge, to punish or lecture, can arise when the story touches the counsellor's values or history. Supervision can help separate ethical concern from personal reactivity. Maintain clear safety responsibilities while allowing complexity. A person can deserve compassionate care and still need to address harmful actions. Compassion is compatible with boundaries, accurate documentation and appropriate referral.

Evidence and Context in Trauma Care

Treatment choices should reflect the presenting condition, the person's preferences, practitioner competence and available evidence. Trauma-focused interventions require relevant training and assessment; they should not be improvised by a helper simply because a survivor has disclosed an event. The WHO humanitarian intervention guide supports trained non-

specialist health providers working with defined clinical problems in humanitarian settings, within an organised system of care (World Health Organization & United Nations High Commissioner for Refugees, 2015). It does not make every community volunteer a diagnostic or treatment specialist.

Research conducted in African settings challenges the assumption that evidence-based psychological care belongs exclusively to wealthy countries. Bass and colleagues evaluated psychotherapy with Congolese survivors of sexual violence and reported benefits for the studied intervention and participants (Bass et al., 2013). This is evidence from a particular population and service arrangement, not proof that the same programme fits every Congolese person or every African crisis. The responsible inference is that locally delivered, carefully supported psychological interventions can be investigated and offered under appropriate conditions.

Before adopting a programme, examine language adaptation, inclusion criteria, supervision, privacy, accessibility and how adverse experiences will be handled. Ask whether the original delivery resources can be reproduced and how outcomes will be evaluated locally. A translated manual alone is insufficient. Conversely, contextual adaptation should not remove essential safeguards while retaining the prestige of an evidence-based

label. Counsellors and policymakers share responsibility for making services both credible and usable. Where specialist treatment is unavailable, provide appropriate interim support and pursue referral pathways without claiming that brief support is equivalent treatment.

Spiritual Meaning and Sources of Support

Spiritual beliefs can offer comfort, community, language for suffering and reasons to continue living. They can also become a source of fear when distress is interpreted as punishment or when disclosure is discouraged. Ask what the person believes, how those beliefs affect the crisis and whether they want spiritual support included. Avoid assuming that religious identity guarantees a helpful community or that secular practice must exclude faith. The relevant question is how a particular relationship or belief functions for this person at this time.

With the person's agreement and appropriate safeguards, a trusted faith leader or traditional support figure may assist with practical companionship, meaningful ritual or social reconnection. Clarify roles and the information to be shared. Do not disclose an entire counselling record merely because a leader is respected. Check whether the person can refuse involvement without retaliation. Where a support figure advocates coercion, humiliation or harmful practices, the counsellor should address

the safety concern and seek appropriate consultation rather than treat status as a substitute for professional judgement.

A counsellor's own spiritual convictions may become especially active in grief or suicidal distress. Notice the impulse to offer a personal theological explanation or seek reassurance that the client shares the counsellor's worldview. Self-disclosure requires a clear client-centred purpose, not a need to resolve the practitioner's discomfort. A simple question about the client's sources of meaning is often more useful than the counsellor's account of belief. Respectful spiritual engagement allows uncertainty and doubt, and leaves room for health care, social assistance and other forms of support.

Talking Directly About Suicidal Distress

Suicidal distress may involve thoughts of death, a wish to escape, active intentions or actions already taken. Use direct, understandable questions and a calm tone. Do not rely on euphemisms that leave the meaning unclear. Ask about current thoughts, intention, planning, access to means, recent actions, earlier attempts, substance use and available support. The NIMH brief safety assessment guidance emphasises assessment and urgent evaluation when current suicidal thoughts require it (National Institute of Mental Health, n.d.-a). Local emergency

procedures and professional scope must guide the actual response.

A person may describe wanting pain to stop while being uncertain about dying. Take this ambivalence seriously without turning it into reassurance that no action will occur. Explore what changes during the most difficult hours, whether they are alone and what has interrupted previous dangerous moments. Ask permission where possible to involve appropriate support, while explaining relevant confidentiality limits. If immediate danger or a medical emergency is present, arrange urgent care, supported supervision and transfer through appropriate local services. Do not leave the person to navigate a referral alone when their safety cannot be maintained.

The counsellor should avoid shock, condemnation and promises of absolute secrecy. A moral lecture may increase concealment. Equally, a mechanically administered questionnaire can leave the person feeling unseen. Combine clear enquiry with acknowledgement of suffering and practical action. Document the information that shaped decisions, the uncertainties and the steps taken. Explain those steps to the person in accessible language. Respectful engagement and decisive safety action belong together; neither should be postponed until the other has been perfected.

Risk Formulation and the Limits of Scores

Risk formulation connects the person's present circumstances, foreseeable changes and available protections to an action plan. It asks what could make the next hours or days more dangerous and what can reduce that danger. A checklist may organise enquiry but cannot guarantee an outcome. NICE recommends against using risk scales or global risk categories to predict future suicide or determine treatment and discharge following self-harm (National Institute for Health and Care Excellence, 2022). This caution is particularly relevant where imported tools lack appropriate local validation or are used without trained assessment.

Protective factors should be examined for their actual availability. Having children, religious commitments or a supportive relative does not cancel current intention or access to means. A relative may be away, a belief may be under strain or a person may believe their family would be better without them. Ask how support works in practice and whether it remains reachable during difficult periods. Apparent success, education or social standing also does not establish safety. The formulation should explain why a specific plan is proportionate to the evidence now available.

Be explicit about uncertainty. Records can state that the person described particular concerns, that certain information could not be confirmed and that specified steps were agreed or required. Avoid writing that someone is definitively safe because they smiled, denied intent once or accepted an appointment. Reassess when circumstances change, particularly after new losses, conflict or service transitions. The purpose is not defensive prediction. It is accountable care that makes the reasoning behind assessment, consultation and follow-up visible to the next responsible practitioner.

Making a Safety Plan Usable

A collaborative safety plan identifies signs of deterioration, practical ways to get through difficult moments, people or places that offer support, professional contacts and steps to reduce access to dangerous means. It differs from asking for a promise never to self-harm, which is not a substitute for assessment or care (National Institute of Mental Health, n.d.-a). Use the person's own language and check whether the plan can be accessed privately. This chapter builds on the fuller planning framework in Chapter Five rather than replacing it with a universal form.

Test the plan against ordinary constraints. Does the named supporter answer at night? Is there phone credit? Can the person

travel safely? Does storing a plan on a shared phone expose private information? Can a proposed means-safety arrangement be made without confrontation or creating danger for another person? Where a component fails, revise it. In a rural setting, a reachable local health facility and trusted accompaniment may be more practical than a distant specialist's telephone number. Verify local contact details; never invent a service to make the form appear complete.

Agree on who will do what and when the situation will be reviewed. If urgent intervention is necessary, a written plan must not delay it. After immediate care, ask whether the support person understands their role and whether the client felt respected. Plans can also become coercive when relatives use them to justify constant surveillance or restriction unrelated to safety. Review such effects. A usable plan supports proportionate protection, participation and continuity, with arrangements adjusted as circumstances and needs change.

After an Attempt or Episode of Self Harm

Following self-harm or a suicide attempt, immediate physical care and appropriate psychosocial assessment are essential. A person may fear condemnation, punishment, exposure or the cost of treatment. Explain what the service can provide and seek accurate local information about legal and institutional

requirements rather than assuming that one rule applies across Africa. The counsellor's task includes helping the person understand the next steps and facilitating continuity within their competence. Do not minimise an episode because injury appears limited or because the person expresses regret.

Explore the sequence leading to the episode without demanding a dramatic confession. What became difficult, what support was attempted, what happened immediately beforehand and what remains unresolved? The purpose is to identify needs and future intervention points, not allocate blame. Check the safety of returning home or to work and the availability of necessary health care. A family's willingness to receive the person does not establish that the environment is supportive. Privacy, conflict, violence, access to means and the person's wishes all require consideration.

The practitioner may feel relief once the immediate emergency passes and become less attentive to follow-up. The client may also feel temporarily better after being heard or receiving care. Neither reaction settles the longer-term situation. Confirm the handover, arrange a realistic review and clarify how new concerns should be raised. Avoid promising uninterrupted personal availability. Organised continuity, including service-level arrangements for absence and emergencies, is more

sustainable than a counsellor assuming sole responsibility for every subsequent hour.

Children Adolescents and Developmental Needs

Children and adolescents may express crisis through behaviour, bodily complaints, withdrawal, school difficulties or direct statements. Developmental understanding influences how they interpret death, threat and responsibility. Use age-appropriate language, invite questions and check understanding instead of assuming that silence means comprehension. The counsellor should work within relevant consent, assent and safeguarding procedures, explaining confidentiality and its limits in terms the young person can understand. Adult approval does not remove the need to hear the child's experience and preferences.

School can be a source of support and also a place of humiliation, bullying or overwhelming demand. Ask about trusted adults, peer relationships, attendance, concentration and whether information sharing would help or expose the student. A carefully agreed adjustment might involve temporary flexibility with assignments or access to a quiet conversation, rather than public identification as a crisis case. Do not assume that teachers have the time or training to provide specialist treatment. Clarify roles and seek the young person's involvement in decisions that affect school life.

Family involvement requires attention to safety. A young person may hesitate because the feared harm comes from a caregiver or because previous disclosures were punished. Arrange appropriate private enquiry and follow local safeguarding pathways. Avoid leading questions or conducting an investigation outside the professional role. When an adult must be informed for safety, explain what will happen as far as possible and minimise unnecessary disclosure. The quality of this explanation can influence whether the young person seeks help again.

Age Disability and Access

An older adult may face bereavement together with reduced income, illness or shrinking social networks. Ask about chosen relationships, daily routines, transport, hearing, vision and the practical conditions for seeking care. Do not assume that adult children are available, benevolent or authorised to decide on the person's behalf. A person's age does not make suicidal statements harmless or remove their right to participate. Similarly, a younger person's distress should not be dismissed as immaturity because they have fewer years of life experience. Disability can affect communication and access without determining emotional capacity. Ask what accommodations are useful rather than automatically directing questions to a

companion. An interpreter, communication aid, accessible entrance or different appointment format may be necessary. Ensure that adjustments protect privacy and understanding. A support person should not answer every question unless the client wants and needs that assistance. Where decision-making support is required, obtain appropriate guidance and distinguish it from taking control solely for administrative convenience.

Counsellors need to notice biases about dependency, productivity and a life worth living. These can appear in the questions asked, the effort made to obtain care and assumptions about prognosis. Reflect on whether the same concern would prompt a more urgent response in a different client. Cultural responsiveness includes attention to disability, age, class, gender and other intersecting circumstances. Accessibility is an intervention issue because a service that cannot be entered, understood or afforded cannot provide the support it promises.

Sexual Violence Identity and Disclosure

A survivor of sexual violence may need medical, protection, psychological and practical support. Disclosure can create further risks through stigma, retaliation or breaches of confidentiality. Ask what the person wants help with and explain options without requiring a complete narrative as the price of assistance. Gender does not determine who can be harmed or

whose account deserves attention. Men, boys and people whose identity is stigmatised may face additional barriers to being believed. Treat these possibilities as reasons for careful enquiry, not assumptions about any individual.

Respect choices while explaining time-sensitive health and protection options through qualified services. The counsellor should not conduct forensic procedures, promise legal outcomes or pressure the survivor into public disclosure. Where reporting duties apply, seek accurate local guidance and explain the limits of choice truthfully. Safe referral requires checking whether a receiving service is accessible and respectful. A referral that exposes the person to known hostility or unnecessary repetition of their account can increase harm and discourage future help seeking.

Monitor the practitioner's own reactions. Anger at an alleged perpetrator, identification with the survivor or discomfort about sexuality may influence questions and decisions. The urge to secure justice immediately can unintentionally displace the survivor's priorities. The urge to avoid difficult material can leave necessary care unaddressed. Use supervision to retain a steady, competent role. The client should experience concern, clear options and appropriate protection, rather than being

recruited into the counsellor's personal campaign or left carrying the counsellor's distress.

Transference and the Meaning of the Helper

A client may experience the counsellor through expectations formed in earlier relationships. They may anticipate rejection, seek parental reassurance, distrust authority or test whether disagreement leads to abandonment. These possibilities are often described through transference. They should be explored cautiously rather than used as confident explanations of every response. Distrust may be entirely understandable when institutions have actually harmed the person. Before interpreting a reaction as a repeated personal pattern, ask whether the present service has behaved in a way that reasonably creates concern.

In crisis, a client may want the counsellor to decide everything or remain constantly available. Acknowledge the need for reassurance while clarifying the working relationship. Explain which decisions require professional action and which can be made collaboratively. Set predictable contact arrangements and discuss what happens outside appointments. Reliability can be demonstrated through keeping agreed commitments, not through offering unlimited access. A person who understands the arrangement has a better chance of using several supports rather than depending on a single practitioner.

Avoid making interpretations that serve the counsellor's authority more than the client's understanding. Saying that a person is "transferring anger" can become a way to dismiss a legitimate complaint. Invite feedback about the encounter and respond to actual mistakes. Where relational patterns appear relevant, use tentative language and seek the person's view. The objective is greater understanding and usable agency. It is not to turn a brief crisis conversation into an intensive analysis that the setting, practitioner or client has not agreed to undertake.

Countertransference Pulls and Professional Boundaries

Counsellors may feel protective, frightened, irritated, helpless or unusually invested. Countertransference refers broadly to clinically relevant responses arising within the therapeutic relationship, including the practitioner's own history and sensitivities. Research associates effective management of countertransference with better psychotherapy processes and outcomes, while not establishing a simple universal causal rule (Hayes et al., 2018). In practical crisis work, the central issue is whether the practitioner can notice a response and keep it from distorting assessment, boundaries or care.

Useful questions include: Am I rushing to rescue? Do I want the client to reassure me? Am I extending availability because I fear blame? Am I avoiding a necessary referral because I want to feel

indispensable? Notice bodily cues and check the evidence behind decisions. Personal generosity can be valuable, but unplanned money, secret contact or exceptional promises may create dependency and unfair access. Follow service arrangements for material assistance and discuss boundary decisions in supervision. A strong urge is information to examine, not an instruction to obey.

Self-disclosure deserves the same scrutiny. Ask what the disclosure would help the client understand, whether a simpler response would achieve that purpose and what burden it might place on them. A brief relevant statement may sometimes help; a detailed account of the counsellor's own bereavement may require the client to offer care. Professional power remains present even in a warm encounter. Clear fees, consent, records, contact rules and complaint routes help make that power accountable. Boundaries should be explained with respect and applied with thoughtful flexibility within ethical and organisational requirements.

Fictional Case: A Bereaved Trader

The following case is fictional and illustrates decisions rather than a research finding. Amaka, a trader in southeastern Nigeria, seeks help after her husband dies. She reports little sleep, intense longing and fear that she will lose access to the shop. Relatives

describe her return to work as insufficient mourning. The counsellor first asks what she needs most urgently and learns that food and school expenses depend on daily sales. Assessment considers grief, functioning, immediate safety and practical insecurity without deciding that work proves emotional avoidance.

Amaka wants prayer with a trusted friend and a private opportunity to remember her husband. She does not want a large family meeting because an inheritance dispute is already heated. The counsellor explores possible support, discusses referral to qualified legal advice and agrees on manageable follow-up. A brief grief conversation is combined with identifying help for essential expenses and childcare. The counsellor avoids negotiating property rights personally or declaring which family custom is authentic. Cultural responsiveness here changes the plan while preserving the client's voice and professional role.

During supervision, the counsellor notices strong identification with Amaka and an urge to lend money privately. That urge is examined before action. Available service assistance is considered through transparent procedures instead. Subsequent review asks whether Amaka obtained advice, whether the shop remains accessible and how she is managing difficult evenings. Progress is not measured by the disappearance of tears. It is

considered through safety, workable routines, chosen support and the changing impact of grief. If distress becomes severely impairing or suicidal concerns emerge, additional assessment and care are arranged.

Fictional Case: A Displaced Young Adult

This fictional example concerns Musa, a young adult displaced from Sudan and living in temporary accommodation. He describes recurring images, uncertainty about missing relatives and thoughts that life is no longer worth continuing. The counsellor avoids assuming a PTSD diagnosis or treating his concerns as a predictable national characteristic. Direct assessment explores current suicidal thoughts, intention, means, recent actions and available support. The immediate response follows the urgency of the findings, with appropriate emergency or health care arranged where necessary and a clear explanation of confidentiality limits.

Alongside clinical concerns, Musa needs privacy, reliable information about tracing relatives and a safe place to sleep. A generic recommendation to telephone family is unusable because he has lost contact and access to money. The plan therefore identifies actual reachable supports and verifies local service arrangements. He chooses how much of his story to tell. The counsellor does not demand a detailed trauma account to

prove deservingness and does not promise that tracing will produce reunion. Honest uncertainty is combined with specific assistance and follow-up.

The counsellor notices helplessness about conditions that cannot be resolved in one appointment. Supervision helps prevent that helplessness from becoming either premature reassurance or withdrawal. Review distinguishes new exposure from continuing distress and asks which parts of the plan functioned. A specialist referral may be appropriate, but its accessibility must be checked. Musa's crisis illustrates why individual intervention can require coordinated practical support while retaining careful personal assessment. Neither nationality nor diagnosis alone determines the necessary response.

Individual Recovery and Public Responsibility

Individual recovery can be supported through modest, chosen goals: obtaining necessary care, restoring a meal routine, contacting a safe person or returning to one valued activity. Agree on goals that fit the person's resources and avoid making compliance the main measure of success. Ask what changed because of the intervention and what remains difficult. Outcomes should include whether the person felt respected and whether the service reduced barriers. A counsellor should also

recognise when further treatment, social assistance or protection is needed beyond their own role.

Policy affects the possibilities available in every individual plan. Affordable care, accessible transport, privacy, responsible information systems and reliable referral arrangements make advice actionable. The WHO LIVE LIFE guide places suicide prevention within coordinated national implementation, including measures beyond the counselling room (World Health Organization, 2021b). Local planning should connect these wider responsibilities with service data and community participation. Do not identify gaps through identifiable client stories when anonymised information can serve the purpose. People seeking care should not become involuntary publicity material.

Individual crisis work combines assessment, a supportive relationship and practical assistance. Notice how personal reactions and professional authority affect decisions. At follow-up, check whether the person obtained the help that was agreed.

Reviewing an Individual Plan

Compare present circumstances with the original formulation. Ask what is safer, which difficulties remain, what daily activities have resumed and what the person wants help with next. Working again while lonely and reporting less fear while unsafe

housing persists are separate findings. Symptoms, functioning and removal of an external threat may change at different speeds. Review may record regular meals, a manageable schedule, chosen companionship and continuing assessment of suicidal distress when indicated. It does not require a bereaved person to stop remembering or display a prescribed stage. Arrange emerging clinical care through Chapters 4 and 5. Distinguish supportive from specialist tasks and identify the provider responsible for each.

Check whether the relationship has become constraining. Can the person disagree? Is repeated self-disclosure shifting attention to the counsellor? Is a request for reliable service being interpreted as dependency? Connect supervision to an observable adjustment: clearer contacts, less disclosure, better enquiry or another qualified opinion. Include the person's account of care.

Practice and Reflection

For students: compare Amaka's and Musa's immediate needs, longer-term concerns and practical barriers. Identify information that remains unknown and explain how it would change the response. Draft a referral explanation that preserves dignity and does not imply a diagnosis already established.

For practitioners: describe an occasion when a pull to rescue, withdraw or reassure influenced your thinking. Identify the bodily signal, the assumption involved and the supervision or service arrangement that would help you respond more proportionately.

For policymakers: examine whether a person can actually reach the care named in a local safety plan. Consider cost, opening hours, language, disability access, transport, privacy and continuity after transfer.

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Chapter 7: Family Crises, Relationships, Livelihoods and Safety

Learning Objectives

By the end of this chapter, readers should be able to assess family crises without treating a household as a single client with one voice; connect stress, resources, meaning and relational patterns to intervention; distinguish conflict from coercion and abuse; support caregiving, livelihoods and children's needs within professional scope; manage confidentiality, alliances and boundaries in work involving several people; and evaluate family recovery through safety, participation and equitable access to support.

A Shared Crisis With Unequal Consequences

A family crisis disrupts the relationships, resources or routines that sustain daily life. Illness, violence, job loss or displacement may affect household members differently.

Ask which relationships matter to the situation. People living elsewhere, foster caregivers, grandparents or other relatives may have responsibilities the household roster does not show.

Clarify who is receiving the service and who has agreed to take part. An individual may want help with family concerns while asking to keep some information private.

Stress Resources and the Meaning of Events

The Double ABCX model draws attention to accumulated demands, available resources, family meanings and processes of adaptation (McCubbin & Patterson, 1983). It helps practitioners look beyond a single precipitating event. A hospital admission may occur after months of debt, interrupted work and unresolved conflict. Family resources include more than money: reliable assistance, information, transport, practical skills and safe relationships also matter. The framework is useful as an organising lens, but it should not become a score that ranks families as competent or deficient.

Apply the model through specific questions. What demands were present before the current event? What new obligations have appeared? Which resources remain available, and which have been lost? How do different members interpret what is happening? A father may experience job loss as humiliation, a partner as a financial emergency and a child as fear that school attendance will end. These meanings can coexist. The counsellor does not need to choose one as the correct family narrative before beginning practical support.

A limitation emerges when a family model is used to distribute responsibility evenly despite unequal power. The concept of a shared meaning must not obscure intimidation or denial. One

person's account of "necessary discipline" may describe another's experience of violence. Use the framework to widen enquiry, then apply appropriate safety assessment and local safeguarding requirements. Theoretical elegance is less important than whether the practitioner recognises danger, identifies actionable needs and preserves the voices of people whose choices are constrained.

Resilience Without Praising Exhaustion

Walsh's family resilience approach highlights belief systems, organisational patterns and communication or problem-solving processes (Walsh, 2016). These domains can help a practitioner identify strengths such as meaningful hope, flexible care arrangements and the ability to exchange useful information. They should be explored in the actual family rather than assumed from cultural reputation. A household may have strong religious meaning and poor communication about expenses, or effective task sharing alongside unresolved grief. Strengths and difficulties can be present together.

Resilience language becomes harmful when it praises people for carrying preventable burdens without assistance. A child who takes over adult caregiving may be resourceful while also losing education and rest. A woman who sustains a household through constant work may need protection from exhaustion rather than

another compliment about sacrifice. Ask what the current arrangement costs each person and whether it can continue safely. The practical goal is to strengthen support and reduce avoidable strain, not make endurance the standard by which deservingness is judged.

Hope should be specific enough to guide action. It may involve obtaining a medical explanation, sharing a night-time care task or keeping a child connected to school. Families should not be promised restoration of every previous role or relationship. Some crises require living arrangements, boundaries or expectations to change substantially. A resilient response can include separation from danger or refusal of an unfair obligation. The counsellor should assess whether the arrangement increases safety and choice, rather than equating family recovery with keeping every relationship physically together.

Mapping Relationships and Care

An initial relationship map can identify important people, residence, caregiving and decision pathways. Ask the family to explain connections in their own terms and invite correction. A genogram may help organise family relationships; an ecomap may show links with services, work, school and community resources. These are aids to enquiry, not predictive tests or proof of a causal explanation. Use them only where they are

understandable and useful. A simple conversation or accessible drawing may be more appropriate than a formal diagram.

Add a care map that records tasks and their actual distribution. Who prepares food, obtains medicines, supervises children, earns income, attends appointments and handles administrative demands? What happens if the main caregiver becomes ill or unavailable? Distinguish a named helper from someone who has agreed and can realistically assist. A relative living abroad may provide money but no daily supervision. Another may be physically nearby but unsafe to involve. A map should reflect functioning and consent rather than assume that kinship automatically produces reliable support.

Use the map to identify one or two pressure points for immediate change. Perhaps one person needs a rest period, a child needs an alternative school escort or the household needs verified information from a health service. Avoid turning assessment into a large catalogue of deficits that nobody can act on. Explain why information is being collected and who will see it. A family map can contain sensitive information about relationships, absence and conflict; store and share it with the same care as other professional records.

Assessment focus	Questions to explore	Implication for the plan
Care and daily tasks	Who does each essential task, and at what cost?	Reduce overload and agree realistic backup arrangements.
Resources and access	Which money, transport, services and safe supports are actually available?	Build around verified options and address access barriers.
Voice and authority	Who can disagree, decide and speak privately?	Adapt participation and investigate coercion or exclusion.
Safety and privacy	What danger exists during and after contact?	Use appropriate protection pathways and safe communication.
Change over time	What was present before, and what has accumulated?	Review continuing exposure and revise priorities.

Listening Beyond the Family Spokesperson

Family encounters often begin with the most confident or socially authorised person speaking. That account may be valuable but incomplete. Invite other perspectives without creating a contest in which each person must defend themselves publicly. Explain that separate conversations may be appropriate

for understanding needs and safety. Consider age, communication needs, language and disability access. An adult's fluent account should not eclipse a child's concern or a quieter person's experience. Participation requires conditions in which speech is possible, not merely an invitation to speak.

Private enquiry needs careful planning. If someone is monitored, a separate appointment or unexpected telephone call could generate suspicion. Ask what contact is safe and avoid assuming that a shared device is confidential. Do not leave messages revealing counselling, violence or safeguarding concerns without agreement and a justified basis. The service should consider how appointments are labelled, where people wait and who can access records. Privacy is partly relational and partly organisational; it cannot be achieved through a counselling promise alone.

A counsellor may feel pressure to support the family's recognised authority in order to gain cooperation. Respectful engagement is useful, but it must not replace independent judgement. Ask whether the proposed plan gives each affected person a meaningful opportunity to participate and whether refusal carries consequences. The practitioner's professional power can amplify the strongest family voice if an agreement is presented as neutral despite unequal conditions. Make the

reasoning transparent, seek consultation where necessary and keep safety concerns visible in the assessment.

Illness and the Reorganisation of Family Life

Serious illness can affect income, household tasks, sleep, intimacy, parenting and plans for the future. The family may have incomplete or conflicting medical information. Encourage questions for qualified health professionals and help organise practical concerns without interpreting a diagnosis beyond competence. Ask what the person who is ill understands and wants others to know. Relatives' anxiety does not automatically justify excluding them from decisions. Where capacity or consent concerns arise, use relevant local clinical and legal guidance rather than informal family assumptions.

Care arrangements can develop rapidly and remain unexamined. A daughter may become the default caregiver because others assume she is available; a spouse may take on tasks they cannot physically sustain. Explore time, transport, physical demands and emotional strain. Ask which tasks require trained assistance and which can be shared safely. Counsellors should not instruct families in medical procedures they are not qualified to teach. Coordinating with health services can identify appropriate education and practical support while preserving confidentiality and avoiding contradictory advice.

Anticipatory fears may need attention even where the outcome is uncertain. A family might worry about death, long-term disability, treatment costs or how to explain illness to children. Help them distinguish decisions needed now from possibilities that do not yet require action. Encourage truthful, age-appropriate communication without forcing disclosure beyond what can safely and ethically be shared. The goal is neither relentless optimism nor preparing for every imaginable catastrophe. It is sufficient understanding, manageable planning and support for the people carrying the present demands.

Caregiver Strain and Sustainable Assistance

A caregiver may feel love, resentment, guilt and exhaustion simultaneously. Allow these feelings without implying that frustration means abandonment. Ask about sleep, pain, employment, social contact and opportunities to step away. Caregiver strain can affect the quality and safety of care, but the enquiry should not begin as an accusation. Identify what assistance would make the role more sustainable and whether the caregiver can ask for it. A person may need practical redistribution more urgently than an exercise in positive thinking.

Negotiate specific offers where the situation is safe for joint planning. “I will collect the prescribed medicines on Tuesday”

is more useful than “everyone will help.” Check the helper’s agreement, resources and backup options. Avoid assigning intimate care or supervision to a child because it is convenient. Involve qualified services when tasks exceed household capacity. If formal respite is unavailable, explore realistic alternatives without presenting unreliable arrangements as equivalent. An honest description of gaps can support advocacy and prevents the family from being blamed when the plan fails. The counsellor should watch for identification with a hardworking caregiver and resentment toward absent relatives. These reactions may reveal an issue worth exploring, but they do not establish motive or responsibility. Ask what each person can actually contribute and what limits exist. Some apparently absent members may face illness, poverty or unsafe travel; others may indeed avoid responsibility. Assess rather than assume. Maintain attention to the dependent person’s needs as well as caregiver wellbeing, and review whether proposed changes improve safety for both.

Loss of Income Debt and Financial Crisis

Income loss can threaten food, housing, treatment, schooling and social standing. Assessment should distinguish an immediate shortage from longer-term debt or uncertain employment. Ask what essential expenses are due, which

resources remain accessible and whether the person controls their own income. A household may appear solvent while one member has no safe access to money. Discuss financial information carefully because disclosure can intensify conflict. Counselling can support planning and emotional understanding, but specialised financial or legal questions require competent advice.

Help the family identify urgent priorities and verified assistance. A simple list of essential needs, deadlines, available funds and possible supports can make uncertainty more manageable. Present it as an organising aid, not an expert financial recommendation. Do not advise risky borrowing, investments or disposal of assets beyond competence. Explore whether social assistance, employer arrangements, trusted community support or qualified debt advice is available. Check eligibility, costs and privacy rather than assuming that a named programme can assist every family.

Shame can make discussion difficult, particularly where income is tied to identity or authority. A person who formerly provided for others may feel powerless. Another may be relieved to gain a stronger voice while fearing conflict. Invite discussion of these meanings without excusing intimidation. Clarify that distress about financial loss does not justify controlling or harming

others. A practical plan should preserve essential needs and reduce uncertainty while ensuring that vulnerable members are not forced to finance the response through unsafe work, interrupted education or coerced dependency.

Gender Authority and Power Asymmetry

Family power can be expressed through money, age, property, residence, social status or control of information. Its pattern should be assessed rather than inferred from gender alone. Ask who can make decisions, travel, seek care, retain documents and disagree without retaliation. These questions reveal the practical conditions for consent. A person may attend counselling willingly while being unable to refuse a particular family proposal. The practitioner should not treat silence or a signature as sufficient evidence of freely given agreement.

Cultural responsiveness requires understanding authority arrangements and their meaning, while cultural safety requires examining how those arrangements affect the person seeking help. A family elder may be a valued mediator or a source of pressure; the same role can function differently across situations. Ask the individual whom they want involved and what consequences involvement might have. Avoid describing an entire community as oppressive or assuming that familiar forms

of hierarchy are harmless. Evaluate actual conduct, available choice and consequences.

The counsellor also occupies an authoritative position. Technical language, professional status and control over records may influence what clients feel able to challenge. Explain options in ordinary terms, invite questions and make disagreement possible. Where several participants are present, do not hide the practitioner's judgement behind a vague statement that "the family has agreed." Record how views were heard and what safety concerns remain. Professional neutrality means fair and accountable attention; it does not require treating threats and requests for safety as equivalent negotiating positions.

Bereavement Within a Family

After a death, different members may grieve at different times and in different ways. One wants conversation, another manages practical tasks and a child returns repeatedly to concrete questions. These differences can generate accusations of indifference or excessive emotion. Help the family understand each person's needs without appointing a correct mourner. Ask about the relationship with the deceased and changes in roles, routines and resources. A loss can alter who earns income, who provides care and who feels entitled to make decisions.

A shared remembrance activity may help where participants want it and can take part safely. It might involve telling a chosen story, keeping a photograph or observing a meaningful practice. Do not prescribe a ritual or require emotional disclosure in front of relatives. Some people need private space, particularly when the relationship was painful or socially unrecognised. Ask whether public mourning expectations create costs or exposure. The counsellor can support conversation about options while avoiding the role of cultural adjudicator or organiser of obligations beyond the agreed service.

Children need truthful, understandable explanations and opportunities to revisit questions. Adults may wish to protect them through silence but inadvertently leave frightening gaps. Work within competence and encourage caregivers to distinguish what is known from uncertainty. Avoid giving children responsibility for an adult's emotional survival. A child can participate in family remembrance without becoming the caregiver for a bereaved parent. Review schooling, sleep, support and changes in daily care, and arrange further assessment where concerns about safety or functioning warrant it.

Ambiguous Loss and Unresolved Absence

Boss's account of ambiguous loss addresses situations in which absence and presence are uncertain or do not align in familiar ways (Boss, 1999). A missing relative, for example, may be physically absent while remaining central to family life. This lens can help explain why a demand for closure is inappropriate. It should not be used to collapse bereavement, migration, disappearance and illness into one identical experience. Ask what is uncertain, what information exists and how the uncertainty affects particular decisions.

Families may differ over whether to continue searching, redistribute responsibilities or plan. The counsellor should not decide that hope is irrational or promise that reunion will occur. Help members identify what can be done with present information and what remains unresolved. A person may continue meaningful remembrance while also protecting daily needs. Practical tracing or documentation requests should be directed through verified, appropriate services. Consider privacy and security before circulating names, photographs or location information, especially where disappearance relates to violence. Living with uncertainty can involve repeated waves of distress whenever new information appears. Plan for these moments where possible: who will verify information, who can provide

support and which decisions should wait until facts are clearer? These are practical arrangements, not a programme that eliminates ambiguity. The counsellor must tolerate uncertainty too. An urge to declare an outcome may arise from professional discomfort rather than reliable knowledge. Supporting the family includes remaining honest about what is unknown while helping them act where meaningful choices remain available.

Displacement Separation and Reunification

Displacement can disrupt care networks, livelihoods, documents, schooling and privacy. Families may be separated across locations and communication channels. Begin by identifying immediate safety, essential needs and reliable contact, rather than assuming the first priority is a group counselling session. Nationality or country of origin does not establish what has happened to a particular household. A displaced family from South Sudan, Ethiopia or the Democratic Republic of the Congo may face different circumstances depending on location, resources, exposure and current service access.

Reunification requires careful verification and appropriate protection procedures. A claimed relative is not automatically a safe caregiver, and a child's return should not be improvised through informal contact. Counsellors should work through

competent child protection or tracing services, avoiding promises that exceed their role. Ask the person's wishes and consider risks associated with disclosing location. Where adults are separated, support communication choices while recognising coercion and conflict may predate displacement. A practical desire to restore family contact does not establish that every relationship should be resumed.

Following reunion, expectations may be mismatched. People may have changed roles, experienced different losses or developed new obligations. Allow discussion of these changes without demanding immediate harmony. Practical arrangements for residence, income, schooling and care may need renewed agreement. Continuing threat can keep the family in crisis even after physical reunion. Review what resources are available now rather than assuming that togetherness completes recovery. The outcome should be assessed through safety, functioning, participation and access to support, not reunion alone.

Conflict Patterns and Repair

Families under stress may repeat patterns of accusation, withdrawal, interruption or avoidance. In situations without coercion or significant safety concerns, a counsellor can help participants describe specific difficulties and practise more workable exchanges. Ask what happens before, during and after

an argument, and what each person is trying to achieve. Avoid labelling one member as the family problem without understanding the interaction and context. At the same time, relational explanations must not erase an individual's responsibility for harmful conduct.

A practical conversation can separate an observation, its effect and a request. For example, a caregiver might say that an agreed collection did not happen, that medication access was delayed and that they need confirmation of who will collect it tomorrow. This is an original communication illustration, not a validated assessment instrument. It works only if the participants can speak without intimidation. The counsellor should check whether the request is realistic and whether apparent agreement will be followed by punishment outside the room.

Repair involves more than polite wording. An apology may need to be accompanied by changed behaviour, reliable task completion or appropriate restitution. Ask what evidence would make an agreement credible and how it will be reviewed. Do not pressure someone to forgive as a condition of receiving care. Where safety concerns emerge, reassess the suitability of joint work. A communication technique should never be used to persuade a harmed person that better phrasing is the solution to another person's coercion.

Coercion and Violence Are Safety Concerns

Coercion may involve threats, monitoring, isolation, financial restriction, sexual pressure or control of movement and documents. Violence can occur alongside these patterns or without an immediately visible injury. Assessment should examine fear, consequences of disagreement and the person's practical freedom. Do not reduce the situation to a mutual communication problem. A person who changes their behaviour to avoid harm may appear agreeable in a family session while remaining unsafe. Private, carefully arranged enquiry can be essential to understanding what is happening.

WHO guidance for health care responding to intimate partner and sexual violence emphasises supportive listening, attention to needs, validation, safety and support, with privacy and appropriate care (World Health Organization, 2013b, 2014). Counsellors must apply relevant local procedures and their professional competence. Joint mediation or couple work may be unsafe where coercion prevents free participation or disclosure creates retaliation. Do not confront an alleged perpetrator with a private disclosure as a routine counselling step. Seek appropriate consultation and specialist pathways rather than improvising reconciliation.

Discuss options without blaming the harmed person for staying or insisting that leaving is immediately feasible. Housing, children, income, transport and threats can constrain choices. Safety planning must be individualised and should not create additional exposure through documents, messages or contact arrangements. Explain any reporting duties accurately and avoid promising complete control over institutional responses. The counsellor's role is to support informed choices within safety responsibilities and connect the person with competent assistance. The absence of an easy option does not justify withdrawing concern or substituting moral judgement.

Children Safeguarding and Family Responsibility

Children's safety requires attention to abuse, neglect, exploitation, unsafe caregiving and exposure to violence. Crisis can increase strain, but it does not excuse harm. Ask about essential care, supervision, schooling, health and trusted adults through developmentally appropriate enquiry. Listen without suggesting answers or requiring a child to resolve inconsistencies between adults. The WHO child maltreatment handbook is intended for health professionals and supports organised, competent responses; it is not permission for an untrained counsellor to conduct a forensic investigation (World Health Organization, 2022a).

When a concern arises, follow applicable local safeguarding procedures and obtain consultation where necessary. Explain next steps to the child and relevant caregivers as far as safety and duties permit. Document carefully, distinguishing what was said from what the practitioner inferred. Avoid promising secrecy that cannot be maintained or making guarantees about what another agency will decide. The objective is appropriate protection and care, with unnecessary repetition of the child's account and avoidable exposure minimised.

Families may need practical support as well as safeguarding action. Poverty and lack of services can affect care arrangements; assessing them carefully helps avoid equating deprivation with deliberate neglect. Yet material difficulty must not hide immediate danger. Coordinate with competent services to address both protection and essential needs. The counsellor should monitor personal triggers, especially where a child's account evokes the practitioner's own history. Strong emotion can support concern, but sound action requires clear thinking, professional boundaries and accurate use of the local pathway.

Adolescents Parenting and Developing Autonomy

Adolescents may experience family crisis through disrupted education, changed care responsibilities, conflict over independence or uncertainty about their future. Ask how the

crisis affects peer contact, privacy, study and daily obligations. Adults may interpret withdrawal as disrespect while the adolescent feels overwhelmed or unheard. Encourage age-appropriate participation in planning. Clarify confidentiality, assent and consent arrangements according to the setting, and explain where safety responsibilities limit privacy. Avoid presenting autonomy as a universal requirement to leave family relationships behind.

In safe circumstances, parenting support can include predictable expectations, nonviolent responses, listening and practical negotiation about responsibilities. Help adults distinguish essential boundaries from demands driven by fear or loss of control. A young person may reasonably contribute to household tasks, but excessive care or work obligations can undermine development and wellbeing. Ask what the adolescent can sustain and whether school staff or other supports can help. Do not rely exclusively on the most compliant child, whose distress may be less visible.

The practitioner can become pulled into the role of approving parent, rebellious ally or disciplinarian. Notice these invitations without assuming that they are manipulative. Keep the service's purpose clear and hear the adolescent's perspective alongside relevant adult responsibilities. Where an adult requests that

counselling make a child obedient, explain that the role includes understanding needs, safety and workable relationships. If abuse or coercion is present, ordinary family negotiation is insufficient. Appropriate safeguarding and specialist assessment take priority over securing a superficially harmonious agreement.

African Evidence for Family Support

The Sugira Muryango trial in Rwanda evaluated a home-visiting programme delivered by trained workers to families with young children receiving government social protection. It reported improvements in observed parent-child relationships and several caregiving outcomes, alongside reductions in harsh discipline. The study had defined eligibility and excluded certain severe active crises, so its findings should not be presented as validation of an emergency family crisis intervention (Betancourt et al., 2020). Its relevance is evidence that structured family support can be studied in an African service context.

The practical lesson is to examine the conditions of delivery before adopting a programme elsewhere. What training, supervision, time and referral arrangements were used? Which participants were included? What resources existed alongside the intervention? These questions belong to programme appraisal, not a claim that one country's families resemble

another's. A promising intervention may require careful adaptation and evaluation in Kenya, Nigeria or Ethiopia. Adaptation should involve local practitioners and families, including people who face barriers to participation, rather than translation alone.

Evidence-informed family work also needs honest outcome reporting. Record where an intervention helped, where it did not and which families could not access it. Avoid relying only on adult satisfaction when children's safety or caregiver burden is central. A service can report fewer arguments while one person has become more afraid to speak. Use appropriate methods within competence and consider unintended effects. Local evaluation strengthens knowledge when it is transparent about context, limitations and resources, rather than treating "African evidence" as one interchangeable category.

Extended Kinship and Community Support

Extended relatives may provide money, childcare, transport, housing and a sense of continuity. They may also introduce obligations, conflict or unwanted disclosure. Ask the family to identify particular people and the assistance they are willing to seek. A large network is not automatically a usable resource, and a small household is not necessarily isolated. Investigate reliability, cost, confidentiality and the person's freedom to

decline. Support becomes meaningful through actual conduct and availability rather than the number of names on a family map.

Where a relative is invited into planning, clarify the role and the information they need. Someone helping with transport may not need details of a private disclosure. Someone providing care may require specific practical guidance from a qualified service. Agree on the duration of arrangements and review whether they create pressure or unequal obligations. Avoid appointing a respected relative as an informal supervisor of the client's entire life. Family involvement should support the agreed goals, not expand control because the practitioner finds delegation convenient.

Community and faith figures may assist where the client wants their involvement and where their role is safe. Check whether they can respect confidentiality and refrain from coercive advice. The counsellor should not assume that community status establishes competence in violence response, child protection or clinical care. Explain professional boundaries and retain responsibility for relevant decisions within the service. If a proposed supporter becomes a source of harm, reassess the arrangement. Cultural responsiveness includes the willingness

to revise a familiar support strategy when it does not serve the person.

Planning a Safe Family Meeting

A joint meeting should have a clear purpose, appropriate participants and a reason to believe that they can take part safely. It may focus on sharing care tasks, clarifying school arrangements or discussing practical information. Assess whether anyone fears consequences for speaking and whether a joint format would expose private material. Do not convene a meeting merely because the presenting problem involves a family. Some circumstances require individual support, safeguarding or specialist work before any joint encounter can be considered.

Where joint work is suitable, explain the agenda, confidentiality arrangements, expected conduct and the counsellor's role. Agree how interruptions and breaks will be handled. Invite each participant's account without forcing equal speaking time mechanically or requiring a child to contradict an adult publicly. Keep the discussion close to achievable decisions. If new safety information emerges, pause and reassess rather than push toward completion. The meeting's apparent success is less important than what participants will face afterwards.

Finish by confirming specific actions, responsible people and a review point. Ask whether the agreement is understood and whether anyone has concerns about carrying it out. Do not obtain signatures merely to create an appearance of commitment. Follow-up should check both implementation and consequences, including whether a participant was blamed for what they said. A meeting is one component of intervention. It cannot repair every relationship, establish the truth of every dispute or guarantee that the family will carry out a plan safely.

Confidentiality When Several People Are Involved

Family work requires an explicit policy about information shared privately and jointly. Explain it before inviting disclosures and ensure it fits the service's ethical obligations and local framework. Different professional approaches may handle private information differently; the important point is that the arrangement must be understandable and agreed where possible. Do not promise each person absolute secrecy while also promising full openness to the family. Where safety duties limit confidentiality, describe those limits accurately without suggesting that every disclosure will automatically be broadcast. Information requests can come from relatives, schools, employers, health services or organisations funding care. Assess each request on its own basis. The payer is not necessarily

entitled to clinical detail. Obtain appropriate consent or identify a legitimate duty, share only what is needed and record the reasoning. A shared surname does not authorise access. Digital messages and appointment reminders also require attention because apparently routine contact can reveal sensitive involvement. Ask the client how information can be communicated safely.

Counsellors may feel trapped when one participant asks them to keep a secret that affects joint work. Use the previously explained policy, assess safety and seek supervision or consultation. Avoid sudden unilateral disclosure or covertly using the information to pressure another participant. If the existing arrangement can no longer support ethical work, discuss appropriate changes, referral or discontinuation with continuity considered. Professional integrity is shown through transparent handling of limits, not through pretending that complex multiparty confidentiality has a simple universal solution.

Alliances Transference and Countertransference

Family members may experience the counsellor as an ally, judge, parent, authority figure or possible rescuer. These relational expectations can affect what they disclose and how they respond to disagreement. Transference is one lens for understanding such patterns, but an apparent alliance may also

reflect the counsellor's actual conduct. Examine whether questions, seating, language or repeated agreement have favoured one participant. Invite feedback and address mistakes before interpreting a response as a projection from an earlier relationship.

Countertransference may involve sympathy for one member, irritation toward another or a strong desire to preserve the family. The practitioner may identify with a child, an exhausted caregiver or someone facing rejection. Notice the pull to form a coalition, deliver a verdict or provide exceptional help. Ask what evidence supports the reaction and what information remains missing. Supervision can help the counsellor retain compassionate attention while avoiding partiality that distorts assessment. Fairness does not mean ignoring unequal power or withholding a necessary safety response.

Self-disclosure requires a clear purpose in family work. An account of the counsellor's own marriage, parenting or bereavement may suggest a preferred family model and shift attention to professional authority. Ask whether a disclosure would improve understanding or mainly meet the practitioner's wish to be accepted. Often a careful question or acknowledgement achieves the aim with less burden. The counsellor should also notice embodied reactions, regulate their

own arousal and avoid turning tension into hurried agreement. Professional composure supports thought; it should not conceal uncertainty that warrants consultation.

Professional Boundaries and Systemic Realities

Families may ask the counsellor to lend money, host a relative, mediate a property dispute, sign a document or become available at all hours. Some requests reflect urgent need; others arise because the counsellor is perceived as influential. Respond with empathy and clarity about role and competence. Identify appropriate services and transparent assistance arrangements where available. Informal rescue can create dependence, conflicts of interest and unequal access. The practitioner's good intention does not remove these consequences or justify undertaking specialised legal, financial or medical tasks.

Service limitations also need honest discussion. A counsellor cannot promise shelter that does not exist or specialist care that cannot be reached. Check options, describe gaps and support realistic interim arrangements within competence. Where systemic barriers repeatedly undermine care, record anonymised patterns for service improvement and advocacy. Do not convert family sessions into political instruction or use clients' identifiable stories without valid permission. Ethical practice includes recognising structural conditions while continuing to

address the immediate needs within the practitioner's actual role.

Boundaries can be applied respectfully rather than as cold refusal. Explain what the service can do, why a requested action lies outside it and what next step may help. A family facing debt may still benefit from organised questions for an adviser; a caregiver may need help contacting a health service. Monitor personal blind spots about poverty, family form, religion and gender. The counsellor's assumptions can shape which requests seem reasonable. Consultation and reflective practice help keep professional power proportionate, accountable and responsive.

Fictional Case: Illness and Income Loss in Ibadan

This case is fictional. A household in Ibadan seeks support after a father's illness interrupts income. His partner cares for him, works longer hours and asks their eldest daughter to miss school. A visiting uncle proposes taking control of finances. The counsellor clarifies the service arrangement and hears separate concerns where appropriate. Assessment includes medical care access, essential expenses, caregiving demands, school attendance and decision-making power. It does not assume that the uncle's proposal is helpful or harmful solely because of his family position.

The father wants to remain involved in decisions but feels ashamed about needing help. His partner reports exhaustion; their daughter says she fears disappointing everyone. In a safe, agreed meeting, the family identifies tasks that adults can share and questions to take to health and financial advisers. The daughter's education is treated as a substantive need rather than a negotiable symbol of loyalty. The plan includes realistic transport and care arrangements, with a review to check whether named helpers actually contribute.

The counsellor notices resentment toward the uncle and an urge to defend the partner immediately. Reflection distinguishes legitimate concern about control from assumptions about motive. Private enquiry checks whether coercion exists. If it does, the joint plan must be reconsidered with appropriate safety consultation. Follow-up asks whether care is sustained, expenses are manageable and participants can disagree safely. An agreement that keeps the household functioning through the daughter's continued absence from school would not count as satisfactory recovery merely because the adults report less conflict.

Fictional Case: Separation and Uncertainty in Kenya

This fictional example concerns a family living in Kenya after displacement, with relatives in different locations and uncertain

information about a missing member. One adult wants to circulate a child's photograph widely to locate kin. Another fears that doing so could reveal their location. The counsellor does not choose a position based on nationality or assume that all reunion is safe. The initial response examines immediate needs, available documents, trusted contact and appropriate tracing or protection services. Any information sharing requires careful attention to consent and risk.

The family also disagrees about whether to plan for the next school term while a relative remains missing. The counsellor allows both continuing hope and practical planning to be discussed. There is no demand for emotional closure. The children receive understandable explanations and are not asked to decide the adults' search strategy. Verified services handle matters beyond counselling competence. A modest plan addresses daily care, safe communication and a review point, acknowledging that uncertainty may remain despite everyone's effort.

During follow-up, the counsellor checks whether new information is reliable, whether accommodation has changed and whether contact arrangements remain safe. The family's distress is not interpreted as treatment failure simply because the missing person has not been found. Outcomes include improved

care, reduced avoidable exposure and participation in decisions. This case illustrates a contextual use of family concepts without claiming that Kenya, displacement or ambiguous loss defines one uniform experience. The response follows the actual people, risks and resources.

Reviewing Family Recovery and Preventing Recurrence

Review should examine both shared functioning and each person's experience. Are essential needs met? Is care distributed more sustainably? Can children attend school? Has violence stopped, and can people speak without fear? Has service access improved? Ask what the intervention changed and whether it created new burdens. Do not rely solely on the family spokesperson or count appointment attendance as recovery. A practical arrangement may need revision when health, income or residence changes, even if it worked well initially.

Prevention includes strengthening supports before demands become overwhelming. Services can provide accessible information, practical parenting support, caregiver assistance, reliable referral and opportunities for confidential help seeking. Policymakers should connect family wellbeing with housing, education, health, income protection and competent violence response. Programmes need evaluation that includes unequal impacts and unintended effects. Family responsibility cannot

compensate indefinitely for unavailable services. A public system should not rely on unpaid care from the least powerful members while presenting the arrangement as cultural strength. Family crisis intervention is therefore relational, practical and ethical. It considers accumulated stress and resources while examining power, safety and individual voice. Cultural humility and competence improve understanding; responsiveness changes the intervention; cultural safety asks how the encounter is experienced by those affected. Attention to transference, countertransference, internal state and boundaries helps the practitioner make sound decisions. The aim is a workable, accountable response in which support does not require silence, harm is not renamed conflict and family recovery is judged through the lives of all those carrying its consequences.

Deciding Whether to Hold a Joint Family Meeting

Begin with purpose, such as coordinating care during illness. Check privately whether prospective participants can speak freely, fear retaliation or have monitored communication. Separate contact must not itself expose someone to danger. The presence of an influential relative does not establish consent by everyone else.

Where coercion, violence or immediate safeguarding concerns are suspected, prioritise assessment and protection through

competent services. Do not use a joint session to obtain disclosure, mediate abuse or negotiate safety with the suspected perpetrator. Explain role and confidentiality limits. Chapters 4 and 5 remain applicable, with attention to unequal family power. If suitable, agree attendance, information-sharing limits and a process for pausing or leaving. Hear less powerful participants. Allocate tasks according to capacity and agreement: a relative may offer transport but be unable to fund treatment. Record the task, responsible person, review time and fallback. Do not assign care automatically to whoever speaks least.

Review privately where necessary. Polite agreement can conceal pressure or produce conflict at home. Ask whether the plan was usable and whether anyone experienced adverse consequences. Reassess suitability if risk changes. Preserving family unity must not override protection or consent. This educational sequence is not a validated family-crisis protocol.

Practice and Reflection

For students: use the care map to assess the fictional Ibadan case. Separate confirmed information from assumptions and identify which concerns require health, financial, legal or safeguarding expertise.

For practitioners: draft an explanation of confidentiality for a family intervention. Then describe how you would respond if a

participant disclosed information privately that made joint work unsafe.

For policymakers: examine a family support programme's eligibility, training, supervision, referral and outcome measures. Consider who is excluded, whose unpaid work makes participation possible and how safety concerns are detected.

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Chapter 8: Organisational Crises, Leadership, Safeguarding and Service Failure

Learning Objectives

Readers should be able to assess threats to people and organisational functioning; assign crisis responsibilities without confusing counselling, investigation and management; respond to safeguarding concerns through competent local procedures; develop realistic continuity arrangements; support employees while addressing working conditions; communicate responsibly under uncertainty; and evaluate recovery through protection, corrective action and accountable leadership.

The Organisation as a Setting of Crisis

An organisational crisis threatens people, essential activities or institutional obligations. A school may face a safeguarding allegation, and a hospital may lose a critical service.

Service failures can affect households and communities. Interrupted wages may leave families without income, while a closed clinic can cut off access to care.

Staffing, governance, infrastructure and referral options vary across organisations. A small training centre and a large hospital need different arrangements for responding to a disruption.

Recognising Escalation Before an Incident Becomes Unmanageable

Early signals can include repeated complaints, unexplained absences, unsafe shortcuts, delayed maintenance, staff turnover or a growing gap between written procedures and everyday practice. None of these proves a crisis by itself. They invite enquiry about patterns, consequences and whether concerns have a safe route to resolution. An isolated equipment fault may be manageable; recurring faults with no backup may threaten essential care. A disagreement may be ordinary workplace conflict; repeated intimidation that prevents reporting may undermine the organisation's protective capacity.

Ask how information travels. Who hears concerns first? Who decides whether they matter? What happens when a supervisor is implicated? An institution can possess a complaint form while discouraging its use through ridicule, delay or retaliation. Informal warnings may also disappear when staff assume that somebody else has acted. Establish routes that convert concerns into reviewable decisions without making every minor difficulty an emergency. A named recipient, an acknowledgement and an escalation arrangement can reduce the uncertainty that otherwise allows unresolved problems to accumulate.

Counsellors may notice recurring service concerns through individual encounters. Protect confidentiality while considering whether anonymised patterns warrant organisational attention or whether a specific safety duty requires action. Do not provide management with private client accounts simply because they would be useful evidence. Clarify the professional basis for any disclosure and obtain appropriate consultation. Listening to distress gives access to sensitive information, not unlimited authority to use it. Prevention requires connecting relevant patterns to responsible action while preserving the trust and rights of those seeking support.

Assessing Harm, Severity and Time

Organisational assessment should consider immediate danger, scale of disruption, continuing exposure and foreseeable consequences. Ask whether anyone needs urgent medical care, whether children or other users remain exposed, which services have stopped and what will happen if the interruption continues. Severity is not captured by financial cost alone. A brief failure in supervision may carry major risk, while a longer delay in a nonessential activity may be tolerable. Record the assumptions behind priorities so that changing information can lead to an appropriate revision.

Time has several meanings. There is the time since the precipitating event, the period during which exposure continues and the deadline beyond which delayed action causes additional harm. A safeguarding allegation may concern earlier conduct while raising a current access concern. A records outage may create little immediate visible distress but soon prevent necessary follow-up. Leaders should distinguish these clocks rather than treat every incident through a generic first-day script. The plan needs actions for the immediate period and arrangements for the days or weeks that follow.

Assess who bears the consequences. A closure may protect users from danger while removing employees' income and families' childcare. Those consequences do not justify unsafe reopening; they require additional planning. Seek the views of affected groups through suitable methods, including private routes where authority inhibits speech. The organisation's preferred account should not become the only evidence. An assessment is stronger when it identifies known facts, uncertainties, conflicting reports and practical constraints, and explains how each influences the response.

A Decision Structure That Can Act

A crisis plan should identify who coordinates the incident, who can make urgent decisions and who substitutes if that person is

unavailable or conflicted. Other responsibilities may include protection, health assistance, safeguarding, service continuity, staff support, communication and records. Small organisations may combine some functions, but they need to recognise conflicts. A manager accused of misconduct should not control the route through which the concern is examined. Where internal independence is impossible, obtain appropriate external assistance or oversight through the relevant framework.

Authority must be practical. A named safeguarding lead without time, access or permission to act is an incomplete safeguard. Confirm how resources are authorised, how decisions are recorded and when additional expertise is sought. Establish manageable review points rather than requiring every decision to await a large committee. At the same time, urgent authority should not become unchecked control. Important restrictions, service changes and disclosures need a documented rationale, a responsible decision-maker and an arrangement for reconsideration when new information emerges.

The counsellor should know where their own responsibility begins and ends. They may assess individual needs, provide support and recommend referral, while another professional manages investigation or employment decisions. Clarify these arrangements before an incident where possible. During a crisis,

remind participants of them in understandable terms. A competent role structure reduces confusion, protects confidentiality and allows different tasks to proceed without requiring one person to become therapist, investigator, legal adviser and public spokesperson simultaneously.

Planning role	Main responsibility	Boundary requiring attention
Incident coordinator	Organise decisions, resources and review	Does not suppress concerns or decide matters outside competence.
Safeguarding lead	Activate protection and relevant reporting procedures	Does not replace authorised investigation with informal interrogation.
Operations lead	Maintain, transfer or safely suspend essential functions	Does not continue unsafe work solely to meet targets.
Counsellor or support provider	Assess and support people within professional scope	Does not supply private session material for routine management use.

Planning role	Main responsibility	Boundary requiring attention
Authorised investigator	Establish facts through a competent process	Does not use therapeutic support to coach or obtain testimony.
Communications lead	Provide accurate and proportionate information	Does not expose identities or present uncertain findings as established.

Safeguarding as an Organisational Responsibility

Safeguarding addresses harm that can arise through an organisation's staff, activities, operations or partners. Keeping Children Safe's international standards organise child safeguarding around policy, people, procedures and accountability (Keeping Children Safe, n.d.). These domains help an institution examine whether its commitments can actually be implemented. They are an international practice reference, not a substitute for national law or sector requirements. The institution must identify the rules and competent authorities relevant to its location, activities and users.

A workable policy explains expected conduct, reporting routes, responsibilities and response arrangements. Recruitment and induction should address appropriate checks, role boundaries and how concerns are raised, within applicable requirements.

Procedures should cover ordinary activities as well as emergencies, travel, online contact and partner delivery where relevant. Accountability requires reviewing whether practice follows policy and whether failures are corrected. A document that staff cannot understand or users cannot access offers limited protection, regardless of its formal approval.

Cultural responsiveness influences how safeguarding information is explained and how people can raise concerns. Use suitable languages, accessible formats and routes that do not depend entirely on literacy or social status. Cultural humility also requires questioning assumptions about whose account will be believed. Respect for an elder, teacher, pastor or successful professional must not place them beyond scrutiny. Cultural safety asks whether a child, employee or service user can approach the organisation without humiliation or retaliation. Protection should be visible in the conditions of participation, not only in policy language.

Responding to a Safeguarding Disclosure

When someone reports possible harm, listen without demanding a complete account immediately. Establish whether there is current danger or an urgent health need, explain the relevant limits of confidentiality and activate the appropriate procedure. Ask only what is necessary for the role and initial response.

Avoid leading questions, informal cross-examination or promises about the eventual outcome. A counsellor's concern should not become an amateur investigation. Qualified safeguarding and investigative advice is especially important where children, violence or complex institutional relationships are involved.

Consider whether the person alleged to have caused harm retains access to affected people, information or resources. Appropriate protective arrangements should follow competent advice and relevant procedures, with decisions documented and reviewed. Protection need not wait for every factual issue to be resolved, but measures should be proportionate and distinguish precaution from a finding of guilt. Do not broadcast an allegation or require public disclosure as proof of seriousness. Equally, do not delay necessary safety action merely because the person concerned has status or the organisation fears reputational loss.

Explain what happens next and identify a safe contact arrangement. Ask whether telephone calls, messages or appointments could expose the person. Minimise unnecessary repetition and share relevant information only through appropriate channels. The organisation should monitor retaliation and provide routes outside the ordinary hierarchy when needed. Receiving a disclosure creates responsibilities that

continue beyond the first conversation. A supportive response includes follow-through, honest information about limits and coordination with competent services, rather than reassurance that somebody will probably deal with it.

Keeping Support and Investigation Distinct

Therapeutic support aims to assist a person's wellbeing, understanding and safety. Investigation aims to establish facts through an authorised process. Both may be necessary, but their purposes and information arrangements differ. A person should know whether they are speaking to a counsellor, an investigator or a manager. Do not disguise evidence gathering as confidential care. Where roles cannot be separated internally, assess the conflict and arrange appropriate alternative provision rather than assume that good intentions remove it.

A counsellor should not coach a person's testimony, decide guilt through emotional presentation or judge credibility solely from consistency. Distressed people may have difficulty recalling or organising information; composed people may also have serious concerns. Investigators need relevant competence and procedural safeguards. Counsellors can help clients understand options and access support without constructing an account for them. Document the distinction between what was reported, what was observed and what is inferred. Avoid placing

speculative relational interpretations in records likely to be treated as findings.

The counsellor may feel pulled to obtain justice quickly or protect a colleague from what appears to be an unfair accusation. These reactions deserve reflection and supervision. They must not determine disclosure, advocacy or assessment beyond the agreed role. Compassion can be offered to different affected people without treating their positions as identical or erasing accountability. If the practitioner has a personal or supervisory relationship with a participant, consider whether continuing the role is appropriate. Clear boundaries protect both competent care and a fair process.

Complaints, Whistleblowing and Retaliation

A complaint route should be understandable, reachable and able to respond. Explain who receives concerns, how acknowledgement occurs and how progress will be communicated. Different types of complaint may require different pathways, including safeguarding, service quality and employment issues. An anonymous route may help some people, but it does not remove the need for careful assessment or guarantee an outcome. Be honest about the limits of anonymity, particularly in a small institution where circumstances may reveal identity.

Retaliation can involve threats, dismissal, exclusion, changed duties, public humiliation or withdrawal of opportunities. Ask what could happen after a concern is raised and how the organisation will detect and address it. A policy promising protection is insufficient if the complainant must rely on the implicated manager for every subsequent decision. Appropriate independence, secure records and follow-up can make the promise more credible. Relevant employment and legal questions should be addressed by competent advisers under the local framework, not through generic assurances about continental rights or procedures.

The Core Humanitarian Standard emphasises rights, dignity, participation and organisational accountability to people affected by crises (CHS Alliance et al., 2024). Its humanitarian context should be respected, while other institutions can consider similar accountability questions. Can users challenge a service safely? Does feedback produce a reasoned response? Does the organisation learn from it? These are practical matters to assess. A complaint should not disappear because a person also received counselling or because leaders regard public criticism as disloyalty.

Service Failure and the People Who Depend on It

Service failure occurs when an organisation cannot provide an activity people rely on, or provides it unsafely. Causes may include infrastructure faults, missing supplies, staff shortages, inaccessible records or poor coordination. Begin by identifying what has stopped and who depends on it. Do not focus only on restoring the organisation's internal routine. A counselling centre's interrupted follow-up, a school's supervision gap and a clinic's supply failure require different actions because their users face different consequences.

Separate services that can be deferred from those requiring urgent continuity, transfer or safe suspension. Ask what essential information and resources are needed to support the decision. A transfer is not complete simply because another organisation has been named; confirm capacity, eligibility, access and appropriate information sharing. Where no alternative exists, explain the gap honestly, consider feasible interim measures within competence and escalate the unresolved risk. Avoid presenting an unsafe workaround as success merely because it allows activity to continue.

Communication should tell affected people what has changed, what they should do and where further information will come from. Consider people with limited connectivity, disability-

related access needs or language barriers. If families must collect children or clients must attend another facility, instructions need enough clarity to prevent avoidable confusion. Review whether the change creates costs or exposure that some users cannot manage. Service continuity is a human outcome: people receive safe, usable assistance, rather than the organisation simply reporting that a function is technically operating.

Assessing Essential Functions and Dependencies

A proportionate business impact analysis examines essential functions, consequences of interruption, dependencies and feasible recovery arrangements. It is an operational assessment method, not a psychological instrument. A small organisation can begin with a short list of services, the people they support and the resources each requires. Identify staffing, premises, electricity, communication, records, transport and suppliers as relevant. The purpose is to understand where a failure would propagate and what a workable backup must contain.

For each function, ask how long interruption could be tolerated before serious consequences arise, and who has the authority to make that judgement. Avoid copying recovery times from an unrelated institution. A function that appears administratively minor may support critical appointments or protection contact. Identify minimum information needed for safe continuity and

ensure that access remains controlled. A backup that depends on one person's private phone or undocumented memory is fragile, even if it has worked during previous minor disruptions.

Test assumptions through realistic discussion. What if the named substitute is absent, the alternative building is inaccessible or the communications network fails? Prioritise a few changes that the organisation can sustain, rather than producing a long plan with no budget or ownership. Seek appropriate technical advice for specialised systems. Counsellors can describe the effects of interruption on clients, but should not certify engineering, cybersecurity or clinical arrangements outside competence. Good continuity planning draws on several forms of expertise and makes responsibility explicit.

Data Exposure Records and Digital Communication

An information incident can expose identities, health information, complaints, financial details or locations. Treat it as a potential human safety issue as well as a technical problem. Activate the organisation's relevant response procedure, obtain qualified advice and consider any applicable notification duties. Do not improvise cybersecurity actions or legal conclusions beyond competence. Ask who could be harmed by the exposure and what immediate protective steps are appropriate. The

absence of a visible public leak does not establish that access was harmless.

Collect and retain only information needed for a legitimate purpose. Clarify access, secure sharing and continuity arrangements before an incident. Crisis pressure can encourage staff to circulate spreadsheets or counselling notes through convenient channels, increasing exposure. A request for rapid coordination still needs proportionate information sharing. Record decisions without including unnecessary intimate detail. Where contact information is used during an emergency, check whether messages could reveal sensitive service involvement to others using the device.

Counsellors must resist pressure to make private records a general management resource. An organisation funding care may legitimately need limited administrative information, but that does not automatically justify clinical disclosure. Explain the arrangement to clients and managers. When a duty requires sharing, identify the basis and disclose appropriately. Digital tools can improve access while changing confidentiality risks; they should be assessed for the actual setting, including shared phones, unreliable connections and user understanding. Convenience alone is not a sufficient reason to adopt a communication method.

Supporting Employees While Changing Conditions

Employees may feel frightened, angry, ashamed, exhausted or uncertain about their livelihood. Offer accessible support and explain confidentiality, fees if any and referral arrangements. WHO guidance on mental health at work includes organisational interventions alongside manager training, worker training, individual assistance and support for participation in employment (World Health Organization, 2022b). This supports attention to working conditions as well as individual needs. A wellbeing session cannot by itself repair intimidation, impossible demands or repeatedly unsafe exposure.

Ask whether schedules, staffing, rest, supervision or practical information need to change. Staff may be unable to use counselling during the hours offered or may fear that attendance will affect advancement. Provide routes that do not make support a test of loyalty. Where group support is offered, clarify its purpose and avoid requiring personal disclosure. Managers should receive appropriate guidance about supportive communication without being positioned as clinicians. Individual assessment and qualified care remain important where concerns exceed ordinary workplace support.

The counsellor should assess the employee's actual concern rather than assume that work is its only source. A crisis may also

involve bereavement, family care or housing insecurity. Explore relevant connections while keeping the service's scope clear. If an organisation requests evidence that a worker is fit, loyal or reliable, distinguish that request from counselling and obtain an appropriate separate professional process where necessary. The therapeutic relationship should not become an undisclosed instrument for evaluating employment performance.

Supporting Leaders Without Removing Accountability

Leaders under pressure may face conflicting demands, incomplete information and anxiety about consequences. Support can help them organise decisions, regulate immediate reactions and seek appropriate advice. Ask what requires action now, what can be delegated and what remains uncertain. Encourage a manageable decision record and scheduled review. A counsellor working personally with a leader should maintain a clear service agreement and avoid becoming an unofficial adviser on every operational issue simply because distress is involved.

Leadership vulnerability does not excuse concealment, retaliation or unsafe decisions. A supportive encounter can acknowledge strain while retaining attention to responsibility. If the leader describes pressure to suppress a concern, explore the consequences and appropriate consultation rather than reassure

them that institutional survival justifies any response. Relevant legal and governance questions belong with qualified advisers. The counsellor should avoid issuing an ethical certificate that the leader can use to defend decisions made outside the counselling relationship.

Countertransference may be especially strong with influential clients. A practitioner may seek approval; fear losing a contract or enjoy proximity to authority. Another may become hostile toward management and fail to hear a legitimate account. Notice these pressures and discuss them in supervision. Professional independence requires clear boundaries around payment, reporting and information. The leader's ability to authorise resources does not give them ownership of the counsellor's judgement or of other clients' confidential material.

Cultural Humility in Institutional Practice

Institutional culture includes informal rules about respect, loyalty, hierarchy and who can question a decision. These rules interact with language, religion, age, class and local relationships. Ask staff and users how the organisation actually works rather than relying entirely on senior descriptions. A formal invitation to contribute may be ineffective where junior staff expect punishment. Separate or anonymous methods may

improve participation, but they need careful design and honest explanations about confidentiality limits.

Cultural competence helps practitioners understand relevant meanings; humility prevents them from assuming that their knowledge represents every employee or user. Responsiveness involves practical adjustments such as accessible meeting times, language support or alternative complaint routes. Safety concerns whether people experience the process as respectful and can participate without avoidable exposure. An organisation can celebrate local culture while excluding those with less status. Evaluate specific conditions rather than using a broad claim of cultural familiarity to justify a single approach.

Counsellors should examine their own relationship to institutional norms. They may accept deference as natural, overvalue an imported policy or regard informal community help as automatically unreliable. These assumptions can distort advice. Seek local expertise and listen to people whose experience differs from the dominant account. Adapt methods without weakening safeguards. The relevant standard is whether the response is competent, understandable and protective in its actual setting, with professional authority used in a way that people can question.

Transference Countertransference and Pulls in Organisational Work

Employees may experience a counsellor as an extension of management, a rescuer or an authority who will decide who is right. Such expectations may reflect earlier relationships, but they may also follow the service's actual reporting arrangement. Before interpreting distrust as transference, check whether the organisation has explained confidentiality clearly and whether previous information sharing created legitimate concern. Tell clients who employs the counsellor, what information is reported and which limits apply. Transparency helps make the encounter usable.

Countertransference can include fear of being blamed, identification with staff, loyalty to a colleague or an urge to expose wrongdoing immediately. A counsellor should notice what these responses prompt them to do. Are they asking leading questions, making promises, avoiding a referral or disclosing more than necessary? Pause where possible, consult and separate evidence from emotional conviction. A strong pull can reveal an issue requiring attention, but it does not settle the correct professional action.

Internal state influences judgement too. Fatigue, shallow breathing, agitation or numbness may signal that the practitioner

needs support, a brief pause or handover. These bodily responses are information about the practitioner, not proof that a client is deceptive or an organisation dangerous. Regulate sufficiently to think and listen, and seek supervision when needed. Crisis work should not depend on heroic availability. Sustainable staffing and consultation make professional boundaries possible and reduce the likelihood that exhaustion will be mistaken for commitment.

Self-Disclosure Dual Roles and Conflicts of Interest

Self-disclosure may seem attractive when staff want evidence that the counsellor understands their workplace. Ask whether a personal account would benefit the client or mainly secure acceptance. Describing the practitioner's own conflict with management may recruit the client into an alliance. Revealing a similar bereavement may burden them with comparison. Often careful listening and an explanation of role are more useful. Where disclosure has a clear purpose, keep it proportionate and review its effect rather than assume familiarity creates trust.

Dual roles can arise when the counsellor is also a supervisor, trainer, colleague, board member or family acquaintance. These relationships are not identical in risk, but they require explicit assessment. Consider power, consent, confidentiality and whether another provider is needed. A junior employee may find

it difficult to decline counselling from someone who evaluates them. Small organisations may have limited alternatives, yet that constraint should prompt transparent arrangements and appropriate consultation rather than concealment of the conflict. Professional boundaries include contact outside sessions, gifts, money, records, advocacy and public communication. Explain relevant arrangements and avoid exceptional promises driven by urgency or fear of losing the relationship. If the counsellor needs to change or end a role, plan continuity rather than abruptly withdraw. Ethical judgement should account for context while retaining a clear purpose: preserving competent care, avoiding exploitation and making professional power accountable. An informal setting does not remove the responsibility to explain what the relationship can and cannot provide.

Communicating Under Uncertainty

An organisational update should state what is known, what action is being taken and when further information will be offered. Different audiences need different details. Families may need collection instructions, staff may need role clarity and regulators may require specified information. Public communication should protect identities and avoid speculation. Verify facts before issuing an update, but do not use uncertainty as a reason to withhold basic protective instructions. Information

can be limited and still useful when its scope is clearly explained.

Coombs's situational crisis communication theory examines how stakeholders respond to crises and communication strategies in relation to organisational reputation (Coombs, 2007). It can help explain why different incidents evoke different expectations. Its reputational purpose also defines a limitation for counselling and safeguarding practice: communication cannot be evaluated solely by whether it protects the institution's image. The practical ethical priority is accurate information supporting safety, participation and accountability. A persuasive message does not compensate for unresolved harm or an inaccessible complaint route.

Use channels that affected people can reach. A website announcement may miss users without connectivity; a public group message may expose identities. Explain who will respond to questions and how corrections will be made. Avoid requiring distressed individuals to represent the organisation publicly. If they choose to speak, ensure that involvement is voluntary and does not condition access to support. The counsellor should not become a spokesperson using private clinical knowledge. Communications expertise, competent governance and confidential care serve related but distinct purposes.

Learning From System Failure

Reason's discussion of human error distinguishes attention to individual mistakes from attention to system conditions and defences (Reason, 2000). This lens helps a review examine how staffing, supervision, information and safeguards influenced an incident. It should not be used to declare that nobody is responsible. Deliberate misconduct, unsafe management and system weaknesses can coexist. The organisation needs a competent process that examines evidence and identifies appropriate action rather than reflexively blaming the most junior person or dissolving every decision into an abstract system.

Ask what information was available at the time, what procedures existed and whether staff could use them. Examine missing resources, contradictory instructions and pressures to bypass safeguards. Identify where a different arrangement could interrupt a similar sequence in future. Do not judge every past decision as though the final outcome had been known in advance. Equally, do not excuse warnings that were knowingly ignored. A useful review distinguishes understandable uncertainty from preventable failure through careful evidence and appropriate expertise.

Translate findings into assigned corrective actions with deadlines and review. A training session may be needed, but it will not solve a reporting route controlled by the implicated manager. New equipment will not help if nobody maintains it. Ask what evidence will demonstrate that the change operates in practice. Invite affected users and staff to comment safely on the revised arrangement. Learning becomes credible when it alters conditions, rather than producing a report that allows leaders to announce completion without checking whether people are better protected.

Operational Review and Emotional Support

An operational review examines events, decisions and service arrangements. Emotional support addresses people's distress and care needs. Make the purpose clear and avoid requiring staff to narrate traumatic experiences in order to participate in a service review. WHO guidance advises against psychological debriefing as a routine intervention to prevent post-traumatic symptoms after a recent traumatic event (World Health Organization, 2012). This does not prohibit ordinary supportive conversation or appropriate treatment; it cautions against assuming that compulsory processing is preventive care.

A review can focus on what happened operationally, what information was available and what should change. People may

still become distressed, so provide breaks and access to support without turning the meeting into therapy. Consider whether participation can occur through different methods where direct attendance is difficult. Clarify record use and avoid placing sensitive personal material in a general review report. A skilled facilitator should keep attention on the agreed purpose while responding respectfully to the human effects of the incident.

Staff support should remain accessible after public attention declines. Some people may seek help later, especially when immediate duties initially absorbed their attention. Others may prefer practical adjustments and ordinary social support. Do not diagnose the entire workforce or assume everyone needs the same intervention. Maintain referral options and review conditions that sustain strain. Organisational recovery includes the ability to offer appropriate care over time while making operational changes that reduce further exposure.

Reopening Restitution and Recovery

Reopening should follow evidence that necessary safeguards and functions are in place. Identify who can authorise it, what remains incomplete and which restrictions or monitoring arrangements are needed. A public deadline should not override unresolved safety concerns. Where services resume gradually, explain what users can expect and which alternatives remain

available. Review whether some groups face new barriers after the change, such as increased costs, inaccessible premises or reduced hours. Restored activity is not automatically restored access.

Affected people may need acknowledgement, practical assistance, correction of records or other forms of remedy through competent procedures. Counselling should not be offered as a substitute for material or organisational responsibility. A person can receive emotional support and still require an institution to address loss or misconduct. Do not ask them to certify forgiveness or withdraw a complaint as evidence of recovery. Relevant compensation, employment and legal issues require appropriate expertise and a fair process, not therapeutic negotiation outside the counsellor's role.

Measure recovery through safer functioning, completed corrective actions, continuity, complaint handling and the experiences of affected users. Ask whether retaliation has occurred and whether the changes persist after leadership attention moves elsewhere. Track gaps honestly. A quiet institution may be recovering, or people may have stopped reporting because nothing changed. Interpretation requires more than public sentiment. Accountability is sustained through reviewable decisions, usable feedback routes and evidence that

the organisation has altered the conditions that prolonged the crisis.

Preparing Through Exercises and Realistic Resources

Preparation can include a discussion exercise in which staff work through a plausible incident and identify decisions, contact routes and missing resources. This need not simulate traumatic exposure. Use scenarios suited to the organisation, such as loss of access to essential records or a safeguarding concern involving a senior person. Clarify that the exercise tests arrangements rather than individuals' emotional toughness. Record gaps and assign feasible improvements. Avoid elaborate plans that depend on equipment, expertise or staffing the institution does not possess.

Review contact details, substitutes and partnerships regularly. A referral list becomes unreliable when services move, eligibility changes or named staff leave. Verify information through appropriate channels before relying on it during an incident. Protect sensitive details in the plan while making necessary instructions available to users and staff. Budget for essential training, maintenance and consultation. A small organisation may begin with a few well-supported safeguards, provided it identifies unresolved risks and pursues appropriate improvements instead of claiming complete preparedness.

Counsellors can contribute by explaining likely support needs, confidentiality arrangements and the practical effects of interruption. Their participation should not imply competence in every crisis domain. Preparation is stronger when clinical, safeguarding, operational, technical and governance expertise are connected through clear roles. In African settings with uneven resources, collaboration can make this possible, but partners must be assessed for capacity and safety. A familiar organisation is not automatically a suitable recipient of confidential information or a reliable source of specialist care.

Fictional Case: A School Safeguarding Concern

This case is fictional. A private school receives an allegation involving a respected employee who has regular unsupervised access to students. Leaders initially focus on rumours and ask the counsellor to speak with the child and report whether the account is true. The counsellor explains that support is distinct from authorised investigation. Immediate enquiry addresses safety and necessary care, while the safeguarding procedure is activated. Appropriate advice informs access restrictions and reporting, with precaution distinguished from a finding and the rationale recorded.

Parents need understandable information about protection and contact arrangements without exposure of the child's private

account. Staff need clarity about duties and routes for concerns. The counsellor does not coach testimony or become the school's public defender. A suitable provider offers confidential support, with limits explained. The school checks whether any participant faces retaliation and arranges an appropriate investigation through competent channels. Cultural respect for the employee's seniority remains compatible with scrutiny and protective action.

During supervision, the counsellor notices fear of losing employment and an urge to minimise the concern. Naming that pressure helps preserve judgement. The subsequent organisational review examines recruitment, supervision, reporting and how earlier concerns were handled. Recovery is evaluated through corrected arrangements and affected people's access to care and feedback. A favourable public statement would not demonstrate success if unsupervised access, intimidation or unresolved reporting gaps remained. The case illustrates why professional boundaries and institutional accountability are central components of crisis intervention.

Fictional Case: A Counselling Service Outage

This fictional example concerns a counselling organisation whose premises become inaccessible after heavy rain. Staff cannot safely retrieve records, several appointments are

interrupted and one client requires urgent follow-up. The operations lead identifies essential functions and obtains appropriate advice about premises and information access. The counsellor assesses the client's current needs through an agreed safe contact route, arranges necessary care and confirms transfer where appropriate. Nobody is expected to enter an unsafe building merely to preserve the appointment schedule.

The organisation communicates changes without disclosing clients' identities. Alternative provision is checked for privacy, accessibility, staffing and capacity. Employees receive information about duties and support rather than a vague instruction to remain available indefinitely. The incident reveals that backup contact arrangements depended on one absent employee. A corrective plan identifies secure, proportionate information access, substitutes and verified referral contacts. Technical changes are reviewed by competent people, while counsellors explain what continuity requires for their clients.

Follow-up checks whether people actually reached alternative services and whether the interruption created new costs or exposure. The counsellor notices a pull to use a personal phone for every contact and considers the boundary and privacy implications through consultation. Recovery includes safe resumption, confirmed client continuity and a tested backup

arrangement. This example does not prescribe one technological solution. It shows how operational and counselling responsibilities can be coordinated without collapsing them into an improvised response centred on one practitioner's availability.

Organisational Crisis Practice as Accountable Care

An effective organisational response makes safety, responsibility and information usable under pressure. It identifies harms, assigns competent roles, protects confidential support and acts on the conditions sustaining the incident. Counsellors contribute most when their remit is clear and their professional judgement remains independent. Cultural humility and responsiveness help the organisation hear people whose experience differs from the official account. Attention to power and cultural safety helps determine whether participation is meaningful or merely ceremonial.

The practitioner's internal dynamics are part of this work because they affect decisions. Transference, countertransference, pulls, bodily state, disclosure intentions and blind spots can influence whether a concern is heard, minimised or overinterpreted. Reflective practice should connect these experiences to concrete professional actions and supervision. Ethical competence is demonstrated through what

the counsellor does with information and authority. It is not established by personal warmth or a general commitment to helping.

For policymakers, the chapter's implications concern practical governance: accessible reporting, competent safeguarding, continuity requirements, worker support and meaningful review. For institutions, recovery is a sustained change in functioning and protection. For affected people, it includes understandable information, usable care and a route to challenge failures. These perspectives need not compete if the response is properly organised. A crisis plan becomes credible when the people it is meant to protect can see how it operates and what happens when it falls short.

African Institutional Planning and Service Continuity

Nigeria's National Disaster Management Framework, published on NEMA's website in 2013, describes coordination and institutional roles across government levels and community structures (National Emergency Management Agency, 2013). It is a governance source, not a counselling manual. NEMA announced a review on 24 June 2026 (National Emergency Management Agency, 2026). Check operative local arrangements before relying on historical role descriptions.

For an organisation, map internal leadership, emergency and protection functions, clinical support, communications, records and service-continuation decisions. A counsellor contributes knowledge of support needs while remaining distinct from an investigator or incident commander. A national framework does not establish that a referral office is staffed, transport available or complaints safe.

A fictional counselling centre loses its booking system. Its continuity record identifies discovery time, affected appointments and risk of missed urgent contact. The manager assigns a continuity lead. A clinical lead reviews care priorities using authorised records. A records officer checks security and recovery. Communications explain how to make contact without identifying clients publicly.

Record temporary contacts, coverage, privacy, receiving-service capacity and next review. Verify urgent contacts individually; a mass message does not prove everyone was reached. After recovery, reconcile changes and confirm delayed care was addressed. Appendix C supplies a worksheet. Safeguarding allegations require a separate authorised process with support distinct from evidence gathering.

The reflective difficulty may be identification with leadership. Admiration for a founder can encourage minimising a complaint

or interpreting an employee as disloyal. Supervision asks what information was excluded and which decision protects the affected person. Correction includes independent reporting, clearer roles and accurate records, applying Chapter 1's concepts without repeating their definitions.

Practice and Reflection

For students: analyse the two fictional cases and identify decisions requiring counselling, safeguarding, technical, operational or legal expertise. Explain what information each role needs and what should remain confidential.

For practitioners: write a service agreement for organisation-funded counselling that explains confidentiality, reporting and emergency arrangements. Identify one dual-role pressure and how you would address it.

For leaders and policymakers: test one essential service against the absence of its usual staff member, premises or communication channel. Assign a feasible corrective action and define evidence that it works.

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Chapter 9: Community Crises, Displacement, Disasters and Collective Recovery

Learning Objectives

Readers should be able to assess community hazards, resources and unequal exposure; coordinate material, social and psychological support; use participatory assessment without treating leaders as the only community voice; adapt crisis theories to actual local conditions; support displaced people and host communities; maintain protection, confidentiality and professional boundaries; and evaluate recovery through access, safety, participation and reduced future risk.

Community Crisis as a Shared Disruption

A community crisis disrupts the systems people use for safety, livelihoods, services and social support. Flooding can damage homes and roads, while a landslide can isolate settlements.

Households facing the same incident may have different transport, savings and support. One may need help moving an older relative, while another may need to replace essential documents.

Use information about the affected area to decide what is feasible. An urban flood and a remote landslide can call for different ways to reach people and restore services.

Hazards Exposure Vulnerability and Capacity

A hazard is a potential source of harm; exposure concerns who or what is in its path. Vulnerability describes conditions that increase susceptibility or constrain a response, while capacity includes resources and abilities that support action. These concepts help explain why similar rainfall or conflict exposure can produce different consequences. A family may live in a hazardous location because safer housing is unaffordable. Another may receive an alert but have no accessible route to leave. Information alone cannot resolve the conditions preventing action.

Avoid treating vulnerability as a permanent identity. A person with a disability may have strong support and effective evacuation arrangements, while an apparently independent neighbour is isolated. Assess communication, mobility, housing, income, discrimination, care needs and access to services as relevant. Also examine capacities: local knowledge, safe networks, practical skills and trusted institutions. Recognising capacity does not mean withholding assistance. People can be resourceful and still face demands beyond what they can manage without organised support.

A practical assessment links each concern to possible action. If a warning is not understood, communication needs adjustment.

If people understand but cannot move, transport and assistance are necessary. If a shelter is physically accessible but unsafe for a particular group, protection and accommodation arrangements require review. Counsellors can help explain how fear, trust and relationships influence these decisions, but technical hazard assessment belongs with competent specialists. Collaboration prevents psychological explanations from replacing engineering, health or protection knowledge that the situation requires.

Layered Mental Health and Psychosocial Support

The IASC framework distinguishes basic services and security, community and family support, focused non-specialised assistance and specialised services. These layers address different needs and should operate together (Inter-Agency Standing Committee, 2007). They are not a ladder that everyone must climb. A person may need several forms of support at once, including specialist care while also needing shelter and safe family contact. The framework is a planning guide, not a diagnosis or an assumption about the proportion of people requiring treatment.

Support layer	Examples	Delivery requirement
Basic services and security	Essential material assistance and protection	Dignity, accessibility and safety.
Community and family support	Safe contact, routines and chosen social activities	Voluntary and inclusive participation.
Focused non specialised support	Structured assistance delivered by trained workers	Competence, supervision and referral.
Specialised services	Qualified care for severe or complex needs	Appropriate assessment and continuity.

The model helps avoid offering identical counselling to everyone or expecting informal solidarity to meet every need. Its use requires coordination and attention to actual access. Local implementation must examine available staff, languages, services and referral routes rather than reproducing a diagram without a functioning system. A written list of layers does not show that a person can obtain care. Ask who provides each component, how a referral works and what happens when the receiving service is unavailable.

In an original planning illustration, a man with an established mental health condition loses access to his usual care during evacuation. He may need qualified clinical follow-up and safe accommodation at the same time. Another resident may primarily need information, companionship and help restoring a routine. Assessment should establish their different needs without assuming that one is more deserving. The response becomes coherent when material and psychological assistance are connected through clear roles, rather than delivered as separate programmes that each refer the person elsewhere.

Rapid Assessment Without Unnecessary Burden

Early assessment should identify immediate hazards, essential needs and available resources. Combine reliable official information with local accounts, direct observation where safe and service data. Ask where people are staying, which facilities function, who cannot reach assistance and what urgent concerns remain. Do not begin with a large survey of traumatic experiences when those details will not change immediate support. The need for evidence does not justify collecting information that people cannot understand, do not wish to provide or cannot safely disclose.

Explain the purpose of each enquiry and what assistance it can reasonably influence. Consent should not be confused with a

person's wish to receive aid. Make clear where possible that declining unnecessary questions does not remove eligibility. Use accessible language and appropriate interpretation. Avoid requiring people to repeat their account to several organisations merely because agencies have separate forms. Coordination can reduce duplication while retaining appropriate information controls. A shorter assessment linked to action may be more useful than a detailed report that arrives after urgent decisions have passed.

Record uncertainties and missing groups. A rapid picture will be incomplete, especially where roads, communication or registration systems fail. Treat the assessment as a basis for revision rather than a final description of the population. Ask what information would change priorities and obtain it proportionately. Counsellors can contribute observations about distress and access without claiming that a convenience sample establishes community prevalence. Qualified research methods are needed for population estimates. Acute assistance and research have related but distinct purposes, which should be explained clearly.

Participatory Mapping and Local Knowledge

The IFRC enhanced vulnerability and capacity assessment approach supports participatory examination of risks, capacities

and possible action (International Federation of Red Cross and Red Crescent Societies, n.d.). Community mapping can reveal hazards, routes, water points, services and people who need assistance. Its value lies in combining local knowledge with action. It should not require residents to enter dangerous areas or disclose sensitive locations publicly. Adapt the method to literacy, language, disability access and the security conditions of the setting.

An original practical exercise might ask several groups to identify places that become inaccessible during heavy rain and explain which daily activities are affected. Compare the accounts rather than assume one map is complete. A trader may know market routes, a caregiver may identify inaccessible health access and young people may notice unsafe school travel. Bring relevant technical specialists into the discussion. Residents' knowledge can improve assessment while still requiring professional evaluation of structural safety or hazard conditions. Use the results to choose feasible actions and identify unresolved needs. Explain which organisation or authority can act on each issue and how progress will be reviewed. Avoid inviting participation only to approve decisions already made elsewhere. If a proposal cannot be implemented, give a reasoned explanation and consider alternatives. Participation creates

expectations, so it must be linked to honest information about authority, resources and limits. Community involvement is meaningful when people can influence priorities and challenge assumptions, not merely contribute data for an external plan.

Representation Power and the Community Voice

Local leaders may provide essential access, history and coordination. Their account is valuable without being exhaustive. Women, young people, older adults, people with disabilities, minority groups, informal residents and displaced people may experience needs differently. Ask who is absent from meetings and why. Work schedules, transport, childcare, language and fear can constrain participation. A public meeting that anyone may attend does not necessarily provide equal opportunity to speak or influence decisions.

Arrange additional methods where needed, including smaller discussions, accessible interviews and private routes for sensitive concerns. Avoid placing individuals at risk by asking them to challenge powerful figures publicly. Consultation should not require a person to become the spokesperson for everyone sharing an identity. Recognise differences within groups and invite correction. The counsellor must also examine who controls their access to residents and whether dependence

on a gatekeeper is shaping what they hear. A cooperative leader can still leave important experiences outside the account.

Professional power joins community power. External responders may control resources, forms and definitions of need. Explain decisions and eligibility in understandable language, allow feedback and avoid making assistance conditional on public gratitude. Cultural humility means recognising limits in the responder's understanding; responsiveness means adapting how participation occurs. Cultural safety asks whether residents can engage without being stereotyped, silenced or exposed. These principles require practical attention to the encounter, not simply a claim that the team respects local traditions.

Psychological First Aid Within Its Scope

Psychological first aid offers humane, practical support after serious crisis events, with attention to immediate needs, dignity and connection to assistance. The WHO guide is intended for field workers and does not make PFA a clinical treatment or a compulsory account of trauma (World Health Organization et al., 2011). Helpers need preparation, clear limits and referral arrangements. The appropriate starting point is the person's present concern, not the helper's wish to hear a complete story.

In an original example, a resident at a temporary shelter is distressed because they cannot locate their medication or contact

a relative. A helper listens, checks urgent needs, offers understandable information and connects them with the relevant service. The conversation may also provide reassurance through reliable practical action. It should not include unqualified medication advice or a promise that the relative will be found. The helper asks what support is wanted and avoids pushing for details unrelated to the immediate task.

Check whether assistance was effective. Did the person reach the service? Was the information understood? Did a contact arrangement create exposure? Distress that remains severe or involves immediate safety concerns requires competent assessment and appropriate care. PFA can be useful while other needs remain unresolved, but it should not be used to claim that all psychological consequences have been addressed. A trained helper's role is strengthened by knowing when to consult or refer and by being able to explain those steps respectfully.

Safety, Calming Efficacy, Connection and Hope

Hobfoll and colleagues proposed five guiding elements for immediate and mid-term mass-trauma intervention: safety, calming, individual and collective efficacy, connectedness and hope (Hobfoll et al., 2007). These principles provide directions for planning, not a uniform treatment protocol or a guarantee of recovery. Their application requires evidence about the

situation. A message that everyone is safe is inappropriate when a hazard continues; a calming exercise cannot replace protection. The response should translate principles into credible conditions and actions.

An original application might involve providing verified shelter information, reducing unnecessary noise in a support space, offering a manageable role in planning and helping a person reconnect with a chosen supporter. Hope could involve a specific next step rather than a promise that everything will soon return to normal. Ask whether the intervention helps the person feel more able to act. Efficacy should not mean shifting institutional responsibility onto residents whose options remain constrained.

Counsellors should examine whose definition of calm and connection guides the response. A resident may need to express anger about an unsafe arrangement; silencing that anger is not necessarily stabilisation. Another may want private support rather than a group activity. A community gathering may restore belonging for some and create exposure for others. These differences require choice and review. Principles become culturally responsive when their purpose is retained while methods are shaped collaboratively around actual risks, meanings and preferences.

Community Resilience and Its Limits

Norris and colleagues describe community resilience through networks of adaptive capacities, including economic resources, social capital, information and communication, and community competence (Norris et al., 2008). This approach links recovery to the conditions that allow collective action. It helps move beyond explanations centred only on individual toughness. The framework remains an analytic lens to contextualise, not proof that a community with strong social ties can manage every disaster without external support.

Ask which networks actually help whom. Mutual assistance may be reliable within one group while excluding newcomers or people with stigmatised identities. A local association may organise transport but lack funds to repair infrastructure. A community can possess considerable knowledge while having little authority over land or service decisions. Identify these capacities and limits together. Praising resilience without recognising resource gaps can make deprivation appear culturally admirable and transfer responsibility away from institutions able to reduce it.

Assess recovery through distribution as well as totals. A restored market may improve income for some households while others remain unable to reach it. A new warning system may serve

registered residents and miss informal settlements. These are planning concerns, not reasons to dismiss collective strengths. The goal is to connect capacities with equitable support and accountable decisions. A community should not need to demonstrate extraordinary endurance before its claim to protection, services and dignified assistance is taken seriously.

Displacement as Repeated and Accumulated Loss

Displacement may separate families, interrupt livelihoods, alter identity and remove access to familiar services. Some people move once and settle; others move repeatedly while resources diminish. Ask what happened before arrival, what remains available and what dangers continue. Do not assume that reaching a settlement or crossing a border completes the crisis. Shelter may be insecure, information uncertain and treatment interrupted. The response needs attention to present conditions as well as earlier experiences.

Counsellors should distinguish displacement status from psychological diagnosis. A person may want help with documents, school access or contact before discussing emotional distress. Another may require urgent clinical care. Both possibilities deserve assessment. Language, discrimination, transport and unfamiliar procedures can affect access. Explain the role of the service and verify referral options. Do not promise

legal status, resettlement or reunion beyond the counsellor's authority. Qualified services should address specialised protection and legal questions under the relevant framework.

Repeated movement makes continuity difficult. Agree on safe ways to carry or transfer necessary information without exposing sensitive details. Ask whether the person can keep documents private and whether a receiving service can be contacted. Plan follow-up realistically, recognising that connectivity and location may change. A missed appointment may reflect movement or danger rather than lack of motivation. Record what remains unresolved and coordinate appropriately so that the person does not have to rebuild access from the beginning at every transition.

Host Communities and Shared Resources

Host communities may provide accommodation, food, work and social support while also facing pressure on services and livelihoods. Recognise these contributions and strains without framing displaced people as the cause of every local difficulty. Assess water, school, health, housing and income conditions for both groups. Assistance criteria should be explained clearly and examined for unintended exclusion. Unequal access can generate resentment, especially when people do not understand why neighbours receive different support.

Where safe and appropriate, involve hosts and displaced residents in practical discussions about shared concerns. These might address access routes, waste, school use or information. Do not require a joint meeting where intimidation or significant conflict prevents free participation. Separate enquiry may be needed first. Counsellors can support communication and identify relational pressures, but allocation and protection decisions require responsible authorities and competent agencies. A conversation cannot resolve a resource shortage that needs material action.

Respond to rumours with verified information and accessible feedback routes. Avoid moral lectures that dismiss genuine service pressures or endorse prejudice. Explain what is known about assistance, what decisions are pending and where concerns can be raised. Review whether programmes favour those with stronger connections or clearer documentation. Shared recovery depends on fairness that people can understand, as well as actual resources. Social cohesion should not become an instruction for disadvantaged residents to remain quiet about exclusion.

Children, Education and Safe Routines

Community crises can interrupt schooling, supervision, play and health access. Children may become separated, take on

excessive work or care responsibilities, or face violence and exploitation. Assessment should identify essential care and appropriate protection pathways. Use developmentally suitable communication and avoid asking children to settle adult disputes or publicly narrate traumatic experiences. Family and school involvement need attention to safety and confidentiality. A child's apparent adaptability does not remove the need to understand their circumstances.

Education can restore routine and connection when provision is safe and accessible. UNICEF's account of Kenya's 2024 floods documents damaged school infrastructure, lost learning materials and displaced students, illustrating how educational disruption extends beyond an initial emergency (Muraya & Odhiambo, 2024). The implication for planning is to examine practical access as well as psychological support. This historical example is not a description of every Kenyan school or a claim about current nationwide conditions.

Temporary learning and child activities require competent supervision, accessibility and safeguarding. Do not create an attractive programme without arrangements for safe arrival, collection and reporting concerns. Ask caregivers and children about barriers, including fees, transport, clothing, disability access and care obligations. Counsellors can coordinate

appropriate support and referral while teachers retain educational roles. If participation depends on a child suppressing distress or acting grateful for assistance, the activity has lost part of its protective purpose. Review both attendance and children's experience of safety.

Disability, Age and Access to Assistance

Accessibility should be considered in warnings, evacuation, registration, shelter, sanitation, distribution and referral. Ask people what assistance they need and what they can manage independently. Do not assume that a companion should answer every question or control information. Communication aids, interpretation, accessible routes or different appointment arrangements may be necessary. A technically available service can remain unusable if a person cannot enter it, understand the process or wait safely for assistance.

Older adults may face interrupted care, separation from supporters or difficulty replacing lost documents. Others may provide important local knowledge and care for children. Assess both needs and contributions without romanticising responsibility. A person with chronic illness may require qualified health coordination, not merely inclusion in a general support group. Counsellors should avoid interpreting confusion, pain or exhaustion as emotional reactions without considering

medical assessment. Multiple causes can coexist, and competent care requires relevant expertise.

Design feedback so people with access barriers can report problems. Counting distribution does not reveal who could not collect items or use them. Home visits or other outreach may be appropriate where safe and competently organised, but should not expose recipients or bypass consent. Consult people with disabilities and their representative organisations without assuming that one representative knows every need. Cultural responsiveness includes these differences within communities. Equitable support is demonstrated through usable access and participation, not through a statement that everyone is welcome.

Violence, Exploitation and Aid Related Power

Crisis settings can create opportunities for exploitation when people depend on others for shelter, transport, work or assistance. Assess safety in places of residence, distribution and service contact. A person may fear losing aid if they disclose harassment or abuse. Explain complaint and protection routes in accessible language and avoid making support conditional on silence. Sensitive enquiry should be private and competently handled. Do not ask for public accounts of violence during community meetings or collect details beyond the professional role.

Aid workers, volunteers and counsellors hold power through access to resources and information. Boundaries should prevent using that position for personal relationships, favours or coercive exchange. Consent is compromised when a person reasonably believes refusal will affect essential support. Organisations need clear conduct expectations, safe reporting and appropriate response procedures. The principles of dignity and accountability in the Core Humanitarian Standard are relevant to these relationships (CHS Alliance et al., 2024). A code alone is insufficient if complaints lead to retaliation or disappear.

Counsellors should connect survivors with competent health, protection and other relevant services while explaining confidentiality limits accurately. Avoid promising that every institutional response will be within the survivor's control. Consider risks linked to information sharing and contact. The practitioner may feel a strong urge to expose an alleged offender immediately; supervision and safeguarding consultation help determine proportionate action. Concern must produce a competent response, not public disclosure that increases danger or an informal settlement that leaves the person without protection.

Severe Distress and Continuity of Clinical Care

Some residents will need qualified assessment and treatment for severe or complex concerns, including conditions present before the crisis. Identify urgent medical or safety issues and follow appropriate local procedures. Counsellors should not diagnose the whole community or assume that trauma explains every symptom. Confusion, agitation or physical distress may involve health problems requiring prompt evaluation. Work within competence and coordinate with health services rather than attempting to manage all concerns through conversation.

People already receiving care may lose medicines, records or contact with providers. Facilitate appropriate health assessment and continuity; do not advise starting, stopping or replacing medication outside professional authority. Ask what service was used, what information can be shared and what barriers now exist. Where records are missing, qualified providers determine the appropriate clinical response. The counsellor can help organise questions, accompaniment and communication without assuming responsibility for medical decisions.

Urgent suicidal concerns require direct assessment by appropriately competent personnel and a supported care pathway, as discussed in Chapters Four to Six. Community programmes need an actual referral arrangement for such

situations, not a vague instruction to seek help. Check transport, opening hours, cost and receiving capacity. When specialist access is limited, obtain appropriate consultation and arrange feasible interim support within competence. The absence of an easy referral does not justify declaring the person safe or presenting a group activity as equivalent clinical care.

Mourning, Memory and Cultural Meaning

Collective loss may lead to funerals, memorials, prayer, public ceremonies or informal remembrance. These activities can support meaning and connection when people wish to participate. Ask which practices matter, who is included and whether participation is safe and affordable. Community identity does not establish a single ritual preference. Some residents may want private mourning, belong to a different faith or have painful relationships with those remembered. Assistance should not depend on joining an approved ceremony.

Counsellors can support discussion of options while avoiding authority over cultural authenticity. Where health or safety conditions constrain a practice, coordinate with competent services and explain the reasons honestly. Do not dismiss spiritual concerns as irrational or endorse harmful practices because they are described as traditional. Cultural humility involves understanding meaning; professional responsibility

involves assessing consequences. A chosen faith or community supporter can be involved with appropriate consent and role clarity, without receiving unnecessary private information.

Memorial activities may also involve political or social tensions. Consider whether names, photographs or accounts could expose people or reinforce exclusion. Ask whose losses are publicly acknowledged and whose remain unrecognised. The counsellor should not promise that a ceremony will resolve grief or require forgiveness as evidence of recovery. Meaning can change over time, and some people will need individual support. Collective remembrance and personal care can coexist without being treated as competing or universally necessary forms of intervention.

Information, Rumours and Public Trust

Information influences whether people seek care, move to safety or use assistance. Provide verified, understandable messages about available services, eligibility, hazards and next updates. Distinguish known facts from uncertainty and correct errors openly. Different channels may be needed for different residents, including people with limited literacy or connectivity. A technically accurate announcement can fail if it arrives too late, uses unfamiliar language or depends on a device that people no longer possess.

Rumours may arise where information is absent or institutions are distrusted. Ask what people have heard and why an explanation appears credible. Do not assume that disagreement reflects ignorance. Past breaches, inconsistent distribution or changing instructions can create understandable doubt. Respond with evidence and practical transparency, not ridicule. Community figures may help communicate, but they should not become the sole gatekeepers of information. Residents need routes to ask questions and challenge a message without losing access to support.

Counsellors should avoid using individual encounters to obtain information for public messaging without a clear basis and valid consent where required. Personal stories can reveal identity even when a name is omitted. Photography and publicity deserve particular care where assistance creates pressure to cooperate. Explain that support is not conditional on appearing in media. Trust develops through reliable conduct, appropriate confidentiality and correction of mistakes. A reassuring slogan is unlikely to compensate for a process people experience as unfair or unsafe.

Data Consent and Responsible Assessment

Community assessment can produce sensitive information about identity, location, health, violence and family separation.

Determine what is needed, who will access it and how it will be protected. Avoid collecting details merely because a form permits them. In insecure settings, information that appears administratively routine can create danger. Use proportionate sharing and qualified advice about applicable data requirements. A counsellor should not promise that an entire interagency system is confidential if they cannot explain its actual arrangements.

Consent requires understanding the purpose and foreseeable use of information, within the limits of the setting. Distinguish service registration, individual care and research. People should not be led to believe that a research interview is necessary for aid when it is not. Explain what choices they have and what cannot be guaranteed. Children's information and sensitive protection accounts require additional safeguards through appropriate procedures. Do not circulate identifying maps or lists in public coordination groups because they seem convenient.

Review information as conditions change. A contact route safe last week may become risky after relocation or conflict. A shared phone may be accessed by someone who controls the person's movement. Ask about these possibilities without assuming danger in every contact. Record only what is needed to support

the relevant decision. Responsible assessment connects information to action and protects the person who provides it; it does not treat residents as a source of unlimited data for programme reporting.

Counsellor Relationships Transference and Countertransference

Residents may experience a counsellor as a powerful outsider, a representative of authorities, a parent-like protector or a person who controls assistance. These expectations may reflect earlier relationships and current service arrangements. Before interpreting distrust as transference, examine whether the programme has explained roles or created legitimate concerns. Clarify what the counsellor can provide, what they cannot decide and how information is used. The relationship becomes safer when its power and limits are visible.

Countertransference may include rescue fantasies, anger at institutions, helplessness about resource gaps or a wish to be seen as indispensable. Notice how these responses influence decisions. A practitioner may offer money privately, promise uninterrupted contact or take on responsibilities outside competence. Another may withdraw because the scale of suffering feels unbearable. Supervision and team consultation help translate concern into proportionate action. Emotional

intensity is not a reliable measure of which intervention is appropriate.

Internal state and embodiment deserve deliberate attention. Fatigue, numbness, agitation or difficulty concentrating can affect assessment and boundaries. Use rest, manageable workloads, consultation and handover arrangements rather than relying on willpower. Brief personal regulation can support a clearer encounter, but service conditions must also change where demands are unsafe. Counsellors should not expect residents to reassure them or hear extensive personal distress. Professional care depends on a supported practitioner who can remain present, think carefully and recognise when another person needs to take over.

Boundaries Self Disclosure and Volunteer Support

In close community settings, a practitioner may encounter clients socially or have relationships with their relatives. Explain how confidentiality and contact will be handled and assess any conflicts. Do not assume that familiarity removes power asymmetry. A resident dependent on the programme may find it difficult to decline a personal invitation or extra role. Clear boundaries protect participation and prevent assistance from becoming an obligation to the helper. Where a dual relationship

cannot be managed safely, consider alternative provision and continuity.

Self-disclosure should have a specific purpose serving the client. Telling residents about the counsellor's own loss may appear to offer connection while actually shifting attention or inviting comparison. Ask whether an acknowledgement, question or explanation would be more useful. Do not use personal hardship to establish authority over how others should cope. Cultural responsiveness can involve appropriate warmth and ordinary social courtesy without disclosing private material or blurring the service relationship.

Volunteers need defined duties, preparation, supervision and referral routes. They may provide information, practical assistance and supportive contact without becoming clinicians. Explain conduct expectations, confidentiality and how concerns are escalated. Do not rely on an enthusiastic volunteer to manage severe distress alone or assume that local knowledge guarantees safeguarding competence. Support for helpers should include practical working conditions and access to consultation. A programme built around unbounded generosity is vulnerable to exhaustion, inconsistent care and exploitation even when participants begin with sincere intentions.

Coordination Referral and the Gaps Between Services

Coordination should clarify which organisations provide which functions, who receives referrals and how unresolved concerns are escalated. A person should not be moved repeatedly between agencies that each define the need as somebody else's responsibility. Verify receiving capacity and explain the pathway. Share necessary information appropriately and obtain consent or identify relevant duties. Where no service can meet the need, record the gap and seek a responsible decision rather than allow it to vanish within a coordination meeting.

Counsellors can identify where material and psychological needs interact. A client may repeatedly miss care because transport is unavailable or decline group support because childcare is absent. These observations can inform programme improvement without exposing private accounts. Coordination should connect the barriers to action: adjusting hours, arranging appropriate transport or identifying safe childcare. Avoid presenting referrals as outcomes when nobody checks whether access occurred. A warm handover, where appropriate and feasible, can reduce the burden of negotiating unfamiliar systems alone.

Local organisations and residents should have meaningful roles in coordination, with resources matching responsibilities.

Inviting local staff to deliver decisions made elsewhere is not equal participation. Ask who controls budgets, information and programme priorities, and whether smaller partners can raise concerns safely. Respect expertise without assuming that every organisation has adequate safeguards or capacity. Partnerships require assessment and review. Effective coordination is demonstrated through accessible, continuous care and accountable action, rather than the number of meetings or agencies represented.

Why Community Crises Persist

A crisis can persist because exposure continues, essential resources remain absent or successive losses arrive before recovery is possible. A rebuilt shelter may still stand in a hazardous location. Restored employment may be insecure. A community may receive supplies while children remain without safe schooling or people lose access to health care. Assessment should distinguish the original incident from the conditions now sustaining distress. Repeated counselling is unlikely to resolve a practical danger that has not been addressed.

Relational and institutional factors also matter. Unfair distribution, confusing eligibility and retaliation can reduce trust. Families may become overloaded, and community networks may be weakened by movement or conflict. Ask what

has changed since the first response and which assumptions failed. Do not explain every continuing difficulty as resistance or a lack of resilience. Residents may be responding reasonably to unreliable services and constrained choices. A useful review identifies both psychological needs and the responsibilities of institutions able to alter the conditions.

Persistence may require a different scale of action. An individual counsellor can support a person and communicate anonymised access barriers, while authorities and organisations address infrastructure, protection and service gaps. Keep these responsibilities connected without claiming that counselling can control them all. Explain limits honestly and continue feasible care. Avoid abandoning people because the wider problem remains unsolved. Sustained support, revised plans and accountable escalation can still reduce harm while longer-term decisions are pursued.

Recovery Preparedness and Reducing Future Risk

The Sendai Framework links disaster risk reduction with understanding risk, strengthening governance, investing in resilience and improving preparedness and recovery (United Nations Office for Disaster Risk Reduction, 2015). These priorities place prevention beyond the counselling room. Their local application requires actual decisions about infrastructure,

services, information and participation. They do not prescribe one psychological intervention or replace national arrangements. Communities need a clear connection between the risks they identify and the institutions responsible for acting on them.

An original preparedness exercise might examine what residents would need to receive a warning, travel safely and maintain essential care. Include people whose movement or communication requires assistance, and check whether the plan depends on unpaid work by already overloaded caregivers. Test contact routes and clarify who has authority to act. Technical safety advice should come from competent sources. A counsellor can contribute understanding of trust, distress and family obligations while avoiding certification of evacuation routes or structures outside competence.

Recovery should reduce future exposure where possible rather than reproduce every previous arrangement. Ask whether repaired services are accessible, whether people can sustain livelihoods and whether assistance has introduced new inequalities. Relocation or rebuilding decisions can affect belonging, work and care networks; residents need understandable information and meaningful participation. Do not treat objections as irrational attachment without examining

consequences. Psychological recovery and risk reduction are connected through the practical conditions in which people can live, work and maintain relationships safely.

Fictional Case: A Landslide Affected Settlement in Rwanda

This case is fictional. Heavy rain damages homes and blocks a road serving a settlement in Rwanda. Some residents move to temporary accommodation while others remain near damaged property. The response begins with competent hazard assessment, immediate protection and essential needs. A counsellor joins the team with a defined support role. Separate conversations reveal that an older adult cannot reach distribution, caregivers lack privacy and some children are missing school. These concerns supplement the initial account from local representatives rather than discrediting their contribution.

The team checks accessible assistance, safe transport and appropriate health referrals. Residents help identify routes and practical barriers without being asked to inspect dangerous structures. Counselling contact focuses on current needs and chosen support, with further assessment where severe concerns emerge. A proposed public remembrance activity remains optional, and private support is available. The counsellor does not promise rapid rebuilding or require people to narrate loss in

front of neighbours. Technical and administrative decisions remain with competent services.

During supervision, the counsellor notices a strong urge to solve every practical problem personally. The team clarifies responsibility and establishes a review of unresolved gaps. Follow-up asks whether people reached assistance, whether contact arrangements remained safe and whether the hazard changed. Recovery is not declared because temporary accommodation has been opened. The relevant evidence includes usable services, sustained care, participation and reduced exposure. The case illustrates contextual practice without presenting the fictional sequence as an account of a particular Rwandan disaster.

Fictional Case: Displacement and Host Community Pressure

This fictional example concerns displaced families from South Sudan living alongside a host community in another location. Both groups report pressure on water access and schooling. Assistance registration has excluded some households with unclear documents, and rumours suggest that counselling attendance influences aid. The team explains eligibility through responsible channels and separates psychological support from allocation decisions. Assessment examines urgent needs, protection, existing care and access barriers. National origin

does not determine who needs specialist support or whose account receives priority.

Residents and hosts are consulted through suitable methods, including private routes for people who fear speaking publicly. A practical meeting addresses shared service pressures only after assessing whether participation is safe. Counsellors support communication while responsible agencies consider material arrangements. Individual care remains available, with confidentiality and limits explained. Tracing and protection concerns are directed to verified competent services. Volunteers receive clear duties and supervision instead of being asked to absorb every unresolved problem informally.

Review checks whether excluded households gained a fair assessment, whether referral worked and whether any participant faced retaliation. The counsellor monitors an urge to side automatically with one group and considers the evidence in supervision. Success involves safer, more equitable access and reduced avoidable strain, not a photograph of residents appearing united. The case shows how community response must connect relationships with resources and authority. Dialogue can assist collective recovery when it accompanies competent practical action rather than replacing it.

Evaluating Collective Recovery

Evaluation should ask what changed for people, who benefited and who remains excluded. Useful domains include safety, essential service access, school participation, care continuity, livelihood recovery and the ability to obtain information or raise concerns. Choose measures suited to the programme and context, with appropriate expertise for clinical or population assessment. Do not infer community recovery from attendance at a support group or a favourable leader's account. Participation data need interpretation alongside the experiences of those who could not attend.

Include unintended effects. Did registration expose sensitive information? Did a programme increase unpaid caregiving or favour those with stronger connections? Did a group activity make some residents feel pressured to disclose? Use feedback safely and explain how it influences decisions. A person should not risk assistance by reporting that a service did not help. Evaluation can be proportionate without being superficial: a few carefully chosen questions linked to corrective action may be more useful than extensive data collection without follow-through.

Community crisis practice combines material realism, competent care and accountable relationships. It recognises

collective capacities while examining inequality, continuing threat and service gaps. Cultural humility, competence, responsiveness and safety shape assessment and participation. Counsellor self-awareness and boundaries shape what happens with professional power. Recovery is supported when people can access care, act on reliable information and participate in decisions affecting their lives. The response should remain open to revision because communities and their circumstances continue to change after the first emergency has passed.

Response Early Recovery and Sustained Risk Reduction

These phases are planning categories, not fixed psychological stages or deadlines. Immediate response addresses active hazards, urgent health and protection needs, accessible warnings and basic services. Authorised coordination identifies operational leads. Health teams assess clinical needs; protection functions address safeguarding; trained support workers offer practical help and psychological first aid within their roles. Counsellors identify distress needing further care and communicate access obstacles through agreed channels.

Check who is absent from the account. Hear people with disabilities, older residents, adolescents, caregivers, displaced people and hosts through safe accessible methods. A queue or leader’s report may omit those unable to travel. Collect

information for an identified action; do not require trauma disclosure to establish material-assistance eligibility.

Early recovery overlaps with response. Tasks include health and school continuity, safe support, livelihoods and continuing displacement. Check who has not returned to school, why medication was interrupted and which referrals actually reached accepting services. Use Chapter 5's handover standard. Residents help set priorities, with confidential routes for disagreement. Review hazard conditions and pace of change, not only elapsed time.

Sustained risk reduction asks what made the disruption damaging and which institutions can change those conditions. Examine warnings, drainage or land use with competent technical advice, care access and exclusion. Assign funding and maintenance. Counselling supports participation and recovery but cannot repair a road or authorise relocation. Keep psychosocial and operational responsibilities connected and distinct.

A practical review record has four fields: unresolved need, responsible function, next action and review trigger. Triggers include a new warning, unavailable receiving service, missed contact or intimidation. Explain how people can reach the responsible function and receive its decision. Publish aggregated

information where individual accounts would expose people to stigma or retaliation.

In the fictional landslide case, consider a disability-access dilemma. The counsellor assumes residents missing the group are unwilling to participate. A resident explains that the route cannot be used with a mobility aid. Change the venue and arrange accessible contact, then check its effect. Supervision examines the assumption and defensiveness. The lesson is a specific service correction.

Practice and Reflection

For students: compare the two fictional cases and identify immediate hazards, access barriers, capacities and needs requiring specialist expertise. Explain why national identity alone cannot determine intervention.

For practitioners: plan a participatory assessment that includes people unable to attend a public meeting. Specify what information is necessary, how consent and confidentiality will be handled and what action will follow.

For policymakers: examine one recovery programme's distribution of benefits, unpaid work and decision-making power. Identify an unintended effect to monitor and a route through which affected residents can obtain a response.

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Chapter 10: Prevention, Policy, Preparedness and Evaluation

Learning Objectives

Readers should be able to distinguish prevention, preparedness, early intervention and recurrence prevention; connect individual and relational care with institutional and public responsibilities; develop a contextual plan with realistic authority and resources; design appropriate evaluation without confusing activity with benefit; recognise cultural and professional power in programme decisions; and use evidence and local learning to improve crisis services across diverse African settings.

Prevention as a Shared Responsibility

Prevention reduces avoidable threats and helps services notice and respond to deterioration early. Preparedness sets out what people and institutions will do when disruption occurs.

The four levels discussed in this book are connected. Unsafe working conditions can affect an employee's health. Flooding can interrupt access to medication and strain the services a community relies on.

Plans should reflect local hazards, authority, services and resources. A city, a rural district and a conflict-affected area may need different arrangements to carry out the same protective duties.

Distinguishing Levels and Targets of Prevention

Primary prevention reduces exposure or vulnerability before a crisis develops. Secondary prevention identifies emerging concerns and connects people with timely assistance. Tertiary prevention limits continuing impairment and recurrence after a serious episode. These distinctions help organise planning, but activities can overlap. Accessible health care may prevent deterioration, support an early response and sustain recovery. A service should explain what an activity is intended to change rather than assume its prevention level establishes effectiveness. Another distinction concerns whom an intervention reaches. Universal provision is offered across a defined population, such as understandable information for all students. Selective provision addresses groups facing identified elevated exposure or barriers. Indicated provision responds to particular signs or concerns in individuals. These are planning categories, not labels of worth or permanent vulnerability. A targeted programme needs a clear rationale, fair access and arrangements for people outside its eligibility who nevertheless require care. Universal provision can also exclude people if its delivery is inaccessible.

Ask what risk or protective condition each activity addresses. A lecture may improve knowledge without changing a dangerous

workplace. A referral arrangement may help only if transport and receiving capacity exist. Avoid accumulating programmes because they sound preventive. Specify the intended pathway between an action and an outcome, identify assumptions and review possible harms. The same activity can be helpful in one setting and burdensome in another. Prevention becomes accountable when its purpose, audience, resources and limits are explicit.

Matching Responsibilities to the Level of Action

Individuals can identify chosen supports, seek appropriate care and participate in plans. Families can share tasks safely, communicate essential information and reconsider unfair care burdens. Organisations can maintain safeguards and continuity. Public authorities can address infrastructure, services and equitable protection. These responsibilities interact but are not interchangeable. A household cannot repair a failed drainage system through improved communication, and a government strategy cannot replace an individual assessment when urgent distress requires care.

Assign responsibility according to authority and capacity. A community volunteer can provide prepared practical support without becoming responsible for clinical treatment. A counsellor can identify recurring barriers without controlling a

public budget. Leaders who can change unsafe service conditions should not transfer that responsibility to clients by offering coping advice alone. At the same time, structural analysis should not prevent feasible personal assistance. People may benefit from immediate support while wider decisions are being pursued. The plan needs both a practical next step and an appropriate route for unresolved concerns.

This educational matrix summarises connected responsibilities. It is a planning aid rather than a universal legal arrangement. Adapt it to the locality, sector and available expertise. For every proposed action, identify a responsible person or institution, necessary resources and a review point. Where no actor has accepted responsibility, record the gap honestly instead of hiding it behind collective language. Shared responsibility works when participants know what they are expected and authorised to do.

Level	Preventive focus	Evidence to examine
Individual	Chosen supports, accessible care and realistic plans	Whether assistance is reachable and useful.
Family	Sustainable care, safe relationships and essential routines	Burden, participation and safety across members.

Level	Preventive focus	Evidence to examine
Organisation	Safeguarding, working conditions and continuity	Functioning safeguards and completed corrective action.
Community	Inclusive risk assessment and service access	Who remains exposed or excluded.
Public system	Governance, funding and competent services	Implemented responsibilities and equitable outcomes.

Building a Contextual Situation Analysis

A situation analysis describes the problem a plan is meant to address. Begin with known hazards, current services, previous incidents and the experiences of affected people. Distinguish verified facts from assumptions and gaps. A district may have several counselling providers while lacking an urgent referral route. A workplace may offer support but discourage attendance. A community may receive warnings without accessible evacuation assistance. These details matter more for implementation than a broad statement that crisis awareness is low.

Use several sources where feasible: service records, operational reports, community consultation, staff accounts and appropriate research. Consider people who do not use services as well as

those who attend. Their absence may reflect cost, language, fear, transport or mistrust. Do not infer population need entirely from the clients already reached. Avoid collecting extensive personal histories where a smaller set of questions can identify actionable barriers. Information gathering should have an understandable purpose and appropriate safeguards, particularly in insecure or politically sensitive settings.

Review the analysis over time. Migration, staffing, roads, eligibility and service hours may change. A plan based on last year's referral list can become unreliable. Specify who updates information and what changes trigger review. Counsellors contribute knowledge about human experience and access while technical specialists assess relevant hazards and infrastructure. Local residents contribute practical understanding without being required to certify safety outside their competence. A sound analysis joins these perspectives and makes uncertainty visible enough to guide further enquiry.

Shared Standards and Contextual Adaptation

The answer to the book's central question is that crisis prevention and intervention are not one size fits all. Shared principles such as competent assessment, protection, informed participation and appropriate confidentiality can guide practice across settings. Their implementation depends on exposure,

meaning, resources and professional authority. A method developed in America, Australia, Canada or Asia is not automatically unsuitable for Africa. Nor does international recognition establish that it can be transferred without examining language, evidence, feasibility and consequences.

Theories should be judged by the questions they illuminate and the assumptions they carry. A systems lens may reveal interactions while needing additional attention to unequal power. A cognitive approach may help examine interpretations while requiring recognition of credible continuing danger. Resource-based explanations can connect distress with loss while not fully explaining a person's spiritual meaning. Crisis models reviewed earlier offer tools for thinking; none should remove the need to hear the particular person or community. Useful application is conditional and transparent.

Adaptation should state what changed and why. Changes might concern language, examples, contact methods, family involvement or delivery arrangements. Preserve essential safeguards and identify whether the original evidence still supports the revised approach. Do not claim a locally adapted programme is validated simply because participants found it familiar. Equally, local knowledge should not be dismissed because it differs from an imported manual. Combine careful

appraisal, participation and evaluation, with willingness to revise methods when actual experience challenges the plan.

Cultural Humility Competence Responsiveness and Safety

Translate Chapter 2's cultural responsibilities into service requirements. Assign responsibility for interpretation, accessible communication, privacy and a route for questioning decisions. Fund these functions. A designated review should ask affected people whether the arrangements let them understand, disagree and obtain assistance without humiliation or pressure.

For example, if residents cannot use the written referral form, the service tests supported oral explanation and an accessible format. It checks understanding and completion with residents, protects confidentiality and records unresolved barriers. A language count alone cannot demonstrate responsiveness. Nor does the presence of a community representative show that less powerful residents were heard.

Audit decisions and their effects: what barrier was reported, who changed the arrangement, what did it cost and what happened afterwards? Review concerns independently when they involve a gatekeeper or staff member controlling access. These records connect humility, competence, responsiveness and cultural safety to funding and accountability.

Developing a Theory of Change

A theory of change explains how planned activities are expected to produce desired outcomes, under specified conditions. It is a planning account to test, not a guarantee of causation. For example, training staff to recognise concerns may improve referral only if they understand their role, can consult a supervisor and have a receiving service. If those conditions are missing, additional training may increase identification without improving access. State the assumptions so evaluation can distinguish a delivery problem from an implausible pathway.

Separate resources, activities, outputs and outcomes. Resources include staff, time and funding. Activities include training, consultation or service provision. Outputs are immediate products such as completed sessions or established contact routes. Outcomes concern changes in access, functioning, safety or other agreed goals. Longer-term effects require appropriate evidence and cautious interpretation. A programme should not describe attendance certificates as improved competence or a list of referrals as successful treatment. The connection between each stage needs investigation.

Use the account to prioritise. Ask which assumption is most uncertain and which failure would make the programme unsafe or ineffective. Pilot manageable components where appropriate,

obtain feedback and revise. Involve people who will use and deliver the service so that hidden constraints are identified early. An elegant diagram adds little if the programme cannot fund transport or supervision. The theory of change becomes useful when it informs decisions about what to implement, what to measure and what would justify stopping or changing an activity.

Governance and the Responsibilities of Public Policy

Policy should explain who leads, who contributes and how responsibilities connect. Crisis care may involve health, education, social protection, emergency management, local government, professional bodies and civil society. Their functions need coordination without treating every task as identical. Identify routes for referral, consultation, protection and escalation. Where responsibilities overlap, clarify how disagreements are resolved. A statement that all agencies should collaborate is insufficient when a person's urgent need remains between services that each decline ownership.

Obtain accurate local guidance on consent, professional scope, reporting, data protection and sector obligations. These vary across jurisdictions and can change. This book offers principles and questions, not a continent-wide legal protocol. Policymakers should ensure that service arrangements reflect applicable

requirements and that staff receive understandable guidance. Counsellors should not infer clinical authority from a job title or assume that a foreign ethical document settles a local statutory question. Qualified advice is necessary when legal or regulatory interpretation shapes decisions.

Governance also concerns accountability for failure. People need a route to challenge inaccessible care, misconduct or unsafe decisions. Explain how concerns are received, reviewed and communicated back. Protect against retaliation through workable arrangements, not only policy promises. The public system should use relevant findings to improve services while safeguarding private information. Leadership is demonstrated through funded responsibilities and reviewable action. An approved strategy has limited value if nobody can explain what changes for the person trying to obtain help.

Financing What Makes a Service Usable

A budget should reflect the complete delivery pathway. Training costs are only one component. Staff time, supervision, interpretation, accessible premises, communication, transport, records, referral and follow-up may determine whether a programme works. Ask what a person must spend to use the service and whether those costs exclude the intended population. An apparently free counselling programme may still be

unaffordable when attendance requires travel, childcare and lost income. Costs shift between institutions and households; evaluation should make that visible.

Set priorities through actual needs and responsibilities. A sophisticated platform may be less urgent than a reliable receiving service or a safe consultation space. Avoid interpreting inexpensive delivery as efficient if it transfers unsupported clinical work to volunteers or exposes users. Equally, a high budget does not prove quality. Explain how spending relates to intended outcomes and what essential protections would be lost under proposed cuts. Seek appropriate financial expertise without promising that the counsellor can resolve every resource decision.

Plan beyond initial funding. Identify recurrent costs, ownership, maintenance and what will happen if a grant ends. Do not recruit clients into ongoing care with no arrangement for continuity or honest explanation of limits. Short programmes can still be valuable if their scope is clear and transitions are competent. Sustainability includes usable services and retained capacity, not simply the survival of an organisation. A funded activity should be judged partly by whether its benefits can continue without imposing new burdens on those it was meant to assist.

Workforce Competence and Task Sharing

Workforce planning should distinguish supportive contact, structured intervention, clinical assessment, specialist treatment, safeguarding and emergency response. Task sharing can improve access when responsibilities, preparation, supervision and escalation are defined. It should not become informal transfer of complex care to whoever is available. A community worker may know local relationships well while needing training and referral support. A clinician may have specialist knowledge while needing language assistance and contextual understanding. Different competencies should complement rather than erase one another.

Assess competence through relevant performance, not attendance alone. Use observed practice, case discussion and appropriate supervision to identify what a worker can safely undertake. Training should include limits, confidentiality, consent and how to respond when an intervention is unsuitable. Do not use distressed clients as unconsenting practice material. Role-play and prepared scenarios can support learning without requiring traumatic disclosure. The educational arrangement needs clear evaluation criteria and opportunities to address gaps before independent responsibilities expand.

Workforce plans also need retention, manageable workloads and support. High turnover can undermine referral knowledge and continuity. A service relying on one practitioner's constant availability is vulnerable even when that practitioner is skilled. Arrange cover and consultation, and ensure that remuneration and expectations are transparent. Policymakers should recognise that supervision requires funded time and expertise. Competence is maintained through an organised system, not a single training event or the hope that personal dedication will compensate for inadequate support.

Counsellor Self Awareness as a Quality Requirement

The practitioner's internal dynamics influence assessment and action. Client transference may involve expectations of rescue, rejection or authority; those expectations may also reflect how the service actually operates. Counsellor countertransference may include identification, irritation, fear or helplessness. Pulls and urges can lead to rushed reassurance, excessive availability or avoidance of necessary referral. Quality assurance should help practitioners notice these responses and examine their effect, rather than assume that personal goodwill guarantees proportionate judgement.

Supervision can ask concrete questions. What evidence shaped the decision? What bodily or emotional response occurred? Did

the counsellor want approval, fear blame or feel indispensable? Was a legitimate complaint interpreted as a client's relational pattern? Separate professional responsibilities from personal reactions while recognising that both are present. Somatic and emotional regulation can help the practitioner think clearly, but it must not be used to tolerate indefinitely unsafe workloads. The service needs conditions in which reflection and handover are possible.

Self-disclosure intentions, blind spots and triggers deserve similar scrutiny. Ask whether a disclosure serves the client's understanding or the practitioner's need to be trusted. Examine assumptions about gender, poverty, religion, disability and authority. Professional power persists in a warm relationship and should be made accountable through consent, boundaries, records and feedback. This attention is preventive because distorted judgement can itself create or prolong harm. Reflective competence is therefore part of service quality, with consequences for training, staffing, supervision and evaluation.

Person Centred Care and Professional Boundaries

Person-centred care begins with the person's needs, preferences and participation while retaining appropriate assessment and safety duties. WHO guidance on community mental health services promotes person-centred and rights-based approaches

and their integration into health and social care systems (World Health Organization, 2021a). Its relevance is broader than a friendly encounter. Service design should allow informed choices, meaningful access and appropriate support, rather than defining people only through symptoms or administrative categories.

Boundaries make participation understandable. Explain who provides the service, how fees and records work, what contact is available and where confidentiality has limits. An organisation-funded service should clarify what information the organisation receives. Family or community involvement needs appropriate consent and safety assessment. A respected person's wish to participate does not automatically entitle them to private details. Where dual roles or conflicts of interest exist, assess whether they can be managed and whether alternative provision is necessary.

Flexibility should have a clear professional rationale. Changing an appointment to accommodate transport may improve access; secret personal contact may create dependency and exposure. Do not assume every exception is harmful or every generous act helpful. Consult, document significant decisions and review their effects. Boundaries should be explained respectfully and applied within the relevant ethical, organisational and regulatory

framework. Their preventive purpose is to support competent, fair care and protect people from exploitation, confusion and promises a practitioner cannot sustain.

Suicide Prevention Beyond the Counselling Room

WHO's LIVE LIFE implementation guide identifies four key interventions: limiting access to means, responsible media reporting, adolescent socio-emotional skills, and early identification, assessment, management and follow-up (World Health Organization, 2021b). These place suicide prevention within coordinated public action. Counselling contributes, but it is not the whole strategy. Country and local programmes need to examine relevant patterns, available services and barriers, rather than assume that a telephone line or awareness campaign completes prevention.

A helpline or other contact service requires trained staff, supervision, accessible communication and a functioning response pathway. Ask what happens when a caller needs urgent care, lives outside the service area or cannot afford onward travel. Consider language, disability access, shared devices and out-of-hours needs. Verify local contacts and explain coverage honestly. Do not publicise an untested route as dependable merely because a programme has launched. Access to initial

conversation and access to appropriate subsequent care are distinct outcomes.

Evaluation should interpret recorded trends cautiously. Changes in reporting, classification, stigma and access can affect what appears in data. An increase in disclosure may accompany improved help seeking; fewer recorded episodes may reflect reduced detection. Use appropriate expertise and several sources rather than claim causation from one total. The chapter does not replace the individual assessment and safety guidance in earlier chapters. A public prevention strategy needs to support those clinical and practical pathways while retaining proportionate attention to privacy, dignity and the people affected.

Disaster Risk Reduction and Preparedness

The Sendai Framework identifies priorities concerning risk understanding, governance, investment and preparedness with recovery that reduces future risk (United Nations Office for Disaster Risk Reduction, 2015). These priorities connect prevention to public responsibilities before a disaster occurs. Their application requires local hazard knowledge, competent technical advice and actual resources. A counselling programme can support understanding of human responses, but it cannot substitute for safe infrastructure or certify a hazardous site.

An original planning exercise might examine whether residents can receive an alert, understand it and act. A message can reach a phone while the person has no transport, cannot read the language or needs assistance to move. Identify these gaps before treating warning coverage as success. Include people who do not attend public meetings and consider essential care during evacuation. Assign responsibility for unresolved barriers and review what action was taken. Information must be connected to feasible protection.

Preparedness also includes service continuity after impact. Ask how health care, safeguarding, schooling and confidential support can continue if premises or roads become inaccessible. Test alternatives realistically and verify receiving capacity. Recovery decisions should consider whether rebuilding reproduces exposure or excludes some users. Residents may have legitimate concerns about relocation, livelihood and belonging. Their participation needs to influence planning rather than serve as ceremonial approval. Reduced future risk is a practical outcome to demonstrate through appropriate evidence over time.

Planning Triggers Scenarios and Review

A preparedness plan should identify activation conditions, responsible roles, substitutes, resources and communication.

Triggers might include loss of an essential function, a safeguarding concern suggesting current exposure or a hazard alert requiring action. Define them through competent local guidance, avoiding vague instructions to act when things become serious. Some decisions need urgent authority; others benefit from scheduled review. Record what is known and why action was chosen so the response can change when new information emerges.

Use plausible scenarios to test the plan. A tabletop exercise might ask what happens if the usual referral facility closes or the responsible manager is implicated in a complaint. Participants discuss decisions and identify missing information without being exposed to a surprise simulation of violence. Explain the purpose, accommodate access needs and avoid evaluating emotional toughness. Exercises should reveal system gaps and improve confidence through workable arrangements. They are not evidence that a team will perform perfectly under every real incident.

Assign corrective actions after the exercise. Who verifies a contact, arranges cover or updates a record procedure? What resources are needed, and when will the change be checked? A plan becomes stale unless ownership and review are sustained. Do not produce an elaborate manual that nobody can find or

implement. A concise operational arrangement can be useful if it is accurate, accessible and tested. Preparedness is demonstrated by the ability to make and carry out appropriate decisions, with honest recognition of remaining limits.

Referral Continuity and the Space Between Services

Prevention of deterioration often depends on successful connection to care. A referral should identify an appropriate receiving service, relevant access conditions and how the person will reach it. Ask about cost, transport, eligibility, language, privacy and capacity. Where consent or a legitimate duty permits, a supported handover may reduce the burden of navigating unfamiliar systems. Giving a name is not equivalent to obtaining care. The originating service should consider appropriate follow-up and what happens if the route fails.

Clarify responsibility during transitions. A person can become lost between providers when each assumes that the other has taken over. Confirm acceptance where necessary and record unresolved concerns. Share information proportionately; continuity does not require unrestricted circulation of counselling notes. The person should understand what is being shared and why, within applicable limits. When care needs exceed available services, seek appropriate consultation and

feasible interim support within competence rather than declare the referral complete because no alternative is easy.

Use repeated failures as system information. Missed connections may reveal unsuitable hours, unaffordable fees or a receiving service with no capacity. They may also reflect preferences or safety concerns that need individual discussion. Do not label non-completion as refusal without enquiry. An anonymised review can identify barriers and assign action while preserving private accounts. A functioning pathway is a preventive resource because it reduces delays and abandonment. It needs maintenance, funding and feedback as much as a physical facility does.

Evaluation Questions Before Data Collection

Evaluation should begin with decisions it needs to inform. Is the programme reaching people who need it? Is delivery competent and safe? What changed, and for whom? Should an activity continue, expand or be revised? These questions determine suitable methods and information. Avoid collecting large quantities of data simply because a reporting form exists. A programme can be heavily documented while nobody knows whether clients found assistance useful or whether an excluded group remains unable to attend.

The OECD evaluation criteria include relevance, coherence, effectiveness, efficiency, impact and sustainability, with principles for thoughtful use (Organisation for Economic Co-operation and Development, 2019). They can help organise enquiry without becoming a rigid scoring exercise. Ask whether the criteria fit the evaluation's purpose and context. Relevance concerns fit with needs; coherence concerns relationships with other efforts. Evidence about these dimensions should be interpreted carefully rather than reduced to a universal numerical grade for a complex crisis service.

Plan evaluation at the outset, with proportionate resources and appropriate expertise. Identify baseline information where useful, review points and arrangements for feedback. Include potential harm and equity rather than measuring only desired benefits. Explain the purpose to participants and protect confidentiality. Evaluators need enough independence to report inconvenient findings, especially where leaders fund the programme. The value of evaluation lies in better decisions and accountable learning, not in producing a favourable document that secures approval without examining consequences.

Choosing Indicators That Reflect Actual Care

Indicators are signs used to examine a particular question. They should have clear definitions, a source and an interpretation.

Session totals describe activity; they do not establish benefit. Referral completion can indicate access but needs a defined endpoint, such as confirmed contact with an appropriate receiving service. Time to action can indicate responsiveness, yet speed alone is insufficient if the action is unsuitable. Select indicators that reflect the programme's goals and can be collected safely and consistently.

The IASC common monitoring and evaluation framework with means of verification supports organised assessment of mental health and psychosocial support in emergency settings (Inter-Agency Standing Committee, 2021). Its framework can inform planning without requiring every service to use identical instruments. Choose methods suited to the population, purpose and delivery context. An imported symptom measure requires appropriate consideration of language, validity, administration and interpretation. A result should not be treated as a diagnosis or as proof that an entire programme caused change.

Combine suitable quantitative information with carefully obtained accounts of experience. Ask what improved, what remained difficult and what the service made harder. Client-defined goals may reveal changes missed by a symptom total, such as safe school attendance or restored care access. Record why information is missing rather than automatically excluding

incomplete cases. A few meaningful indicators can support stronger decisions than a large dashboard of measures unrelated to the actual pathway. Each indicator should lead to a question the service is prepared to answer and act upon.

Evaluation domain	Possible indicator	Question before interpretation
Access	Confirmed appropriate referral contact	Who could not reach care, and why?
Safety	Protection actions and reported adverse experiences	Could people report harm safely?
Functioning	Change in agreed daily activities	What else changed in the person’s circumstances?
Experience	Confidential feedback and complaint response	Did dependence on the service inhibit criticism?

Evaluation domain	Possible indicator	Question before interpretation
Quality	Observed competence and supervision	Was relevant practice assessed rather than attendance counted?
Equity	Access across relevant groups and locations	Is necessary information collected safely?

Interpreting Change and Avoiding Causal Overstatement

A person may improve after receiving counselling while also obtaining housing, health care or family support. Those changes matter to interpretation. Before-and-after measures can describe observed change without establishing that one intervention caused it. Appropriate research designs and analysis are needed for stronger causal claims. Services should state what the evidence supports and where uncertainty remains. Honest qualification makes findings more useful; it does not negate the value of careful practice or observed benefit.

Consider who remains in the evaluation. People who stop attending may face barriers, be dissatisfied or no longer need the service. Their outcomes cannot be assumed. Missing information can bias a favourable account if only continuing

participants are included. Review the reasons where safe and feasible, and explain limitations. A small programme may lack resources for extensive research but can still avoid misleading percentages and unsupported generalisation. Describe the sample, timeframe and measures sufficiently for readers to understand the claim.

Look for alternative explanations and unintended patterns. A reduction in complaints might reflect improved care or greater fear of speaking. Higher attendance might reflect better access or pressure to participate. A community's calmer public appearance might conceal continuing danger. Interpretation requires knowledge of the setting and the voices of affected people. Use consultation and appropriate analytic expertise. Evaluation should not turn uncertainty into confident success because a funder expects a simple answer, nor dismiss useful findings merely because they do not establish every possible cause.

Equity Unintended Effects and Programme Adaptation

Equity asks how needs, resources and benefits are distributed. A programme may produce an overall improvement while leaving remote residents, minority-language speakers or people with disabilities behind. Examine relevant differences without collecting sensitive identity information unnecessarily. Ask who

enters the service, who completes it and who never has a realistic opportunity to participate. Access may require different resources for different people. Equal appointment rules do not automatically create fair opportunity when barriers are unequal. Monitor unintended effects. A family programme may increase unpaid work for women or children. A publicity campaign may reveal service users' identities. A digital platform may improve access for some while excluding people with shared devices or unreliable connectivity. A support group may pressure disclosure. These possibilities should inform assessment and feedback rather than become assumptions that every programme is harmful. When evidence identifies a problem, assign corrective action and review whether the change helps.

Adaptation requires recording what changed, the reason and how outcomes will be examined. Avoid silently altering a programme while continuing to claim the original evidence applies unchanged. Local staff and users should contribute to decisions, including people who have been excluded. Some changes can be assessed through routine service learning; others require more formal evaluation. The standard is proportionate evidence supporting the claim made. Contextual responsiveness is strengthened when it includes the willingness to stop, revise or replace an activity that fails to serve its intended purpose.

Ethical Research and Local Knowledge

Research requires appropriate ethical review, competent design and understandable consent. Distinguish participation from assistance so people do not believe that care or aid depends on joining a study when it does not. Community agreement is not a substitute for individual consent where that is required. Explain foreseeable use of information, confidentiality limits and available choices. Sensitive accounts need appropriate protection and referral arrangements. Do not invite disclosure of severe distress without a plan for responding competently.

Local knowledge belongs in the evidence base, including professional experience, service-user accounts and community capacities. Its inclusion should avoid romanticising every familiar practice or treating an individual account as representative of a country. African scholarship and practice can contribute theory, adaptation and evaluation rather than only supply cases for external interpretation. Researchers should explain whose perspectives shaped questions and who benefits from the findings. Collaboration is more credible when authority, resources and recognition are addressed openly.

The researcher's and practitioner's reflexivity matters. Personal commitments may shape what is noticed, which explanation seems persuasive and how disagreement is treated. Reflect on

power, expectations and professional relationships without turning the report into a confession unrelated to the study. Separate findings from interpretation and acknowledge limitations. New interventions need evidence proportionate to claims of effectiveness. Careful local learning can begin modestly while retaining a clear distinction between promising practice, tested delivery and demonstrated benefit under specified conditions.

Participation Complaints and Accountable Learning

People affected by crises need a usable way to comment on support and challenge failure. The Core Humanitarian Standard emphasises dignity, participation and accountability in relations between communities and supporting organisations (CHS Alliance et al., 2024). These commitments require an enabling environment. A complaint route that nobody trusts or understands cannot demonstrate accountability simply because its contact details appear in a brochure.

Offer methods suited to the setting and explain how concerns are handled. Some people prefer private conversation; others need accessible written or spoken channels. Consider fear of retaliation and whether the usual recipient is implicated. Protect sensitive information and do not promise anonymity beyond what can realistically be maintained. Receiving criticism should

not affect access to appropriate care. Where the organisation cannot provide the requested remedy, explain its decision and any relevant further route through a competent process.

Close the learning loop. Tell people what changed because of feedback, where feasible without exposing private accounts. Assign responsibility and a review point for corrective actions. Repeated concerns can reveal a structural issue rather than individual dissatisfaction. Counsellors should not interpret every complaint as transference or resistance, particularly when the service itself has failed. Accountable learning combines openness to experience with careful assessment. Its purpose is to improve conditions and restore credible participation, not persuade dissatisfied people to endorse the organisation's preferred story.

Fictional Case: A District Crisis Support Plan

This case is fictional. A district partnership in Rwanda wants to improve crisis support after several local service interruptions. Its initial proposal focuses on training volunteers and launching a contact number. A situation analysis finds that receiving services have limited hours, some residents cannot travel and staff are unclear about urgent escalation. The revised plan defines volunteer roles, identifies competent consultation and verifies referral capacity. It also addresses transport and

accessible information rather than expecting training to solve every barrier.

A theory of change explains how prepared initial support connects to appropriate care and what resources are required. Evaluation distinguishes activity from outcomes: workers trained, competence demonstrated, referrals initiated and referrals actually received are recorded separately. Residents can give confidential feedback, including those who did not complete a referral. The programme examines whether language, disability access or cost influences participation. It avoids claiming district-wide improvement from a small group of satisfied attendees.

During review, counsellors identify a pull to remain constantly available because the system still has gaps. Supervision and leadership clarify cover and escalation instead of normalising unbounded personal responsibility. Some arrangements work; others require revision. The plan is judged through accessible care, proportionate safety action and corrected barriers. This example does not prescribe Rwanda's policy or describe an actual district. It shows how prevention becomes practical when training, authority, resources and evidence are connected.

Fictional Case: A Nigerian Workplace and Family Programme

This fictional example concerns an organisation in Nigeria that offers stress sessions after repeated staff absences and service complaints. Private feedback reveals excessive workloads, unclear reporting and fear that counselling records will affect employment. The programme clarifies confidentiality and separates support from performance assessment. Leaders review working conditions through appropriate expertise rather than treating every difficulty as an employee coping deficit. Counsellors retain individual assessment and referral responsibilities while communicating anonymised service barriers appropriately.

Family concerns emerge for some employees, including childcare, illness and income pressure. Participation is adjusted where feasible without assuming that every worker wants relatives involved. A proposed public success story is replaced by voluntary, confidential evaluation. Measures include usable support, agreed functional goals, working-condition changes and complaint response. The organisation does not interpret attendance as proof that staff are recovered or loyalty has improved. Relevant employment matters remain within competent procedures.

The counsellor notices both identification with staff and anxiety about losing the contract. Supervision helps distinguish evidence from pressure and retain independent judgement. Review asks whether workload changes occurred, whether access improved and whether anyone faced retaliation. A programme that produces enthusiastic workshop ratings while unsafe demands continue is not declared effective prevention. The case connects individual support, professional boundaries and institutional responsibility, illustrating why a contextual response must address the conditions that generate and sustain distress.

A Continuing Commitment to Contextual Crisis Care

The book has examined crisis as an interaction between events, meanings, resources, relationships and time. Individual, family, organisational and community responses differ because exposure, support and choices differ. Prevention and intervention therefore require careful assessment and ongoing revision. Neither a country label nor a single theory determines the appropriate response. Shared professional commitments remain useful when their implementation is shaped by actual conditions, competent judgement and the participation of affected people.

For counsellors, the continuing task is to hear the person, recognise urgent needs, work within competence and maintain

accountable relationships. Culture and professional self-awareness belong together. Transference, countertransference, pulls, embodiment, regulation, disclosure intentions, boundaries and blind spots influence what happens with authority and information. For policymakers and leaders, the task is to make competent care possible through funding, governance and usable systems. Good intentions need structures that support action and reveal failure.

For people dealing with crises, a credible response offers understandable options, appropriate protection and support that does not demand silence or conformity. It acknowledges uncertainty without withdrawing practical help. Evaluation should ask whether those commitments are experienced in everyday care and whether barriers are reduced. Crisis work cannot promise control over every loss, but it can reduce avoidable harm and strengthen the conditions for recovery. Its quality is demonstrated through repeated, responsible decisions that connect compassion with evidence, context and accountability.

A Worked District Policy and Theory of Change

This fictional plan assumes existing health and protection services have authorised focal persons, the district can fund coordination and residents can participate safely. Verify these

assumptions. The problem is interrupted care after flooding: residents cannot reach care, receiving capacity is unclear and transfer responsibility is poorly recorded. The goal is usable accountable continuity.

Inputs include staff time, receiving agreements, accessible communications, transport, supervision, secure records and participation costs. Activities include mapping, contact tests, training, supported handovers and review with affected people. Outputs include current maps, tested contacts and recorded transitions. The intended outcome is fewer avoidable interruptions and timely access to assessed care. Safer equitable continuity is a longer-term aim, not a promise to eliminate distress.

The causal explanation is explicit: if people obtain contact, reach accepting services and receive transfer support, avoidable interruptions should decrease. This depends on functioning services, safe transport, trust and staffing. Flooding or staff loss may disrupt it. Monitoring checks assumptions alongside activities. Observed improvement alone does not prove causation; changing hazards and other assistance may contribute.

In month one, a coordination lead confirms participating functions and capacity while a records lead sets minimum

information and access controls. In months two and three, services test routes with simulations that do not expose clients. Accessibility representatives review barriers. From month four, implement only confirmed pathways. Clinical and protection leads retain their professional responsibilities.

Budget staff hours and employment costs; supervision; interpretation and accessible materials; communications; transport; records security; participation; and contingency. Record quantity multiplied by verified local unit cost, funding source, holder and release date. Include recurrent costs. Unfunded transport remains a gap. These are illustrative categories, not a district cost estimate.

Calculate receiving confirmations as confirmed transitions divided by attempted transitions in the review period, recording missing data separately. Time to contact needs stated start and end points, interpreted by urgency and route. Record interruptions and corrective actions. High completion is insufficient if residents with disability or distant housing never enter the pathway. Check who sought help, who was excluded and whether information was gathered safely.

Quarterly review combines confidential feedback, complaints, workload, supervision and budget execution, assigns corrections and a review date. Public summaries protect identities and state

unresolved gaps. Nigeria's framework and NEMA's 2026 review illustrate why governance sources need version control (National Emergency Management Agency, 2013, 2026); they do not validate this fictional plan. Name the approving authority, verify local requirements and assign responsibility for updates.

Practice and Reflection

For students: design a theory of change for one preventive activity. Identify resources, outputs, outcomes, assumptions and a possible unintended effect. Explain which claim your proposed evidence could support.

For practitioners: identify a recurring referral barrier and a boundary pressure in your service. Describe the supervision, organisational action and follow-up needed to address each without exposing private client information.

For policymakers: select one crisis pathway and examine who has authority, who pays, who may be excluded and what happens when the route fails. Define a reviewable action and evidence that people can use the revised arrangement.

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Appendix A Contextual Crisis Assessment Worksheet

This original educational worksheet supports Chapter 4. It is not a validated scale, diagnostic instrument or suicide prediction tool. Use within actual competence and local procedures. Urgent assistance must not wait for completion. Use a confidential identifier and store the record securely.

Encounter and Participation

Record identifier and date: _____

Practitioner and role: _____

Setting and mode of contact: _____

Preferred language and accessible format: _____

Interpreter role and confidentiality: _____

Purpose consent and confidentiality limits explained: _____

Chosen supporters and people who must not be contacted: _____

Present Situation and Immediate Action

What happened when and what remains ongoing: _____

What the person regards as the main difficulty: _____

Immediate health suicide violence safeguarding or hazard concerns: _____

Actions taken responsible function and outstanding urgent needs: _____

Where the person can safely remain while help is arranged: _____

Distress Functioning and Context

Reported distress and change over time: _____

Sleep food medication mobility caregiving work or study disruption: _____

Meaning of difficulty and valued practices: _____

Resources the person can actually use: _____

Cost transport disability language or communication barriers: _____

Trusted and unsafe relationships and pressures affecting consent: _____

Evidence and Formulation

What the person reported: _____

What was observed or confirmed and by whom: _____

Working explanation and alternatives: _____

Unknown information and how it will be checked: _____

Measure purpose version language recall period result and limits: _____

Action following concerning answers or results: _____

Agreed Actions and Review

Person’s priority and agreed next action: _____

Responsible function and completion time: _____

Receiving service capacity confirmation and transfer support: _____

Fallback if the plan fails or danger changes: _____

Follow-up date contact arrangement and review responsibility: _____

Relevant consultation and supervision decision: _____

Use Chapter 5's referral procedure. Keep detailed practitioner self-reflection in supervision records, separate from the client record unless a care-relevant decision requires documentation.

Appendix B Collaborative Safety and Support Plan

This educational worksheet is informed by the collaborative planning approach and Stanley et al. (2018) study discussed in Chapter 5. Wording and practical prompts are the book's synthesis. It is not a validated local instrument, prediction score or promise that danger has ended. A plan complements qualified assessment and urgent care. A promise never to attempt suicide is not a substitute.

Complete with the person in language and a format they can use. A written plan, contact or named supporter may be unsafe if communications are monitored. Verify local services and contact details. Do not insert assumed national or continental emergency numbers.

My Warning Signs

Thoughts feelings bodily changes situations or behaviours telling me I need help:

_____

What has preceded a worsening situation before:

_____

What I Can Try Myself

Safe coping actions I can realistically use:

_____

Where and when I can use them: _____

If they do not help or I feel less safe my next action: _____

People and Places That Help Me Through the Moment

People or safe places offering connection or distraction: _____

How I can reach them and an alternative if unavailable: _____

People or places I should avoid because they increase danger: _____

People I Can Ask Directly for Help

Chosen supporter agreed role and verified contact: _____

What I can say when I need help: _____

What the supporter has agreed and can actually do: _____

Alternative supporter and contact restrictions: _____

Professional and Urgent Assistance

Supporting service verified hours and contact: _____

Locally verified urgent service and access route: _____

Transport and communication: _____

Who maintains safe support while help is arranged: _____

Fallback if the first service is unavailable: _____

Making the Environment Safer

Discuss access to potentially lethal means with a qualified practitioner. Agree feasible safer arrangements, involving a trusted person when consent and safety permit. Do not attempt dangerous confrontation, physical disarmament or untrained rescue.

Agreed change responsible person and time: _____

What remains unsafe and needs further assistance: _____

Review and Access

Date and person responsible for review: _____

How I will keep or access the plan privately: _____

What prompts earlier contact or urgent help: _____

What matters to me and helps me accept support: _____

Check feasibility aloud. Confirm the next action, supporters' agreement and correct contact details. Review after changes in danger, living arrangements, support or receiving-service availability.

Appendix C Organisational and Community Planning Worksheet

This original educational worksheet accompanies Chapters 8–10. It is not an incident-command standard or replacement for an authorised emergency, safeguarding or continuity plan. Complete with responsible functions and affected people. Check requirements locally, protect personal data and separate coordination information from confidential records.

Scope and Authority

Organisation or locality and plan version: _____

Scenario or incident and verification date: _____

Approving authority and coordination lead: _____

Functions involved and responsibilities: _____

Who can authorise expenditure protection and communication: _____

Needs Access and Participation

Immediate hazards health and protection concerns: _____

Critical services and dependencies: _____

Groups missing from assessment and safe ways to hear them: _____

Language disability transport cost and privacy barriers: _____

Feedback and independent complaint route: _____

Operational Action Record

Unresolved need	Responsible function	Action and resources	Review trigger
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Continuity and Coordination

Temporary arrangements for critical services: _____

Receiving services capacity and date checked: _____

Transfer support and confirmation procedure: _____

Alternative if a service or route fails: _____

Accessible communication and correction procedure: _____

Access controls retention and security responsibilities: _____

Resources Monitoring and Recovery

Budget quantity unit cost funding source release date and holder: _____

Supervision staffing and rest arrangements: _____

Indicator numerator denominator source and limits: _____

Affected people’s accounts of access consent and experience: _____

Recovery and longer-term risk-reduction responsibilities: _____

Review findings corrective actions and next version date: _____

Test contact and continuity before relying on the plan. Verify usable assistance rather than counting approvals, attendance or referrals alone.

Glossary

Definitions reflect the book's working use. Professional traditions and legal systems may use terms differently. Chapters 1–3 explain distinctions; Chapters 4–10 show application.

Assessment: Gathering and interpreting relevant information to guide decisions about safety, needs, functioning, resources and care.

Boundary: A limit defining professional role, contact, responsibilities, confidentiality and authority.

Coercive control: A pattern of domination restricting autonomy or safety; not merely mutual disagreement.

Competence: Knowledge, skills and judgement sufficient for an actual task, supported by training, supervision and recognition of limits.

Countertransference: Practitioner reactions in relation to a client. Narrow psychodynamic accounts emphasise unconscious responses linked to personal history; broader usage includes emotional, cognitive and bodily reactions requiring reflection.

Crisis: A disruption in which demands exceed or seriously challenge available coping, support or organisational capacity and require a changed response.

Cultural competence: Relevant cultural knowledge and skills used responsibly without claiming mastery of another person's experience.

Cultural humility: Continuing self-examination, learning and attention to power, including willingness to receive correction.

Cultural responsiveness: Changing communication and delivery in response to meanings, circumstances and preferences.

Cultural safety: Attention to the experience of care and use of professional or institutional power, informed by the person receiving care; distinct from immediate physical safety.

Disaster risk: Potential loss through the interaction of hazards, exposure, vulnerability and capacities.

Embodiment: The bodily dimension of experience; sensations are information for enquiry, not proof of another person's intentions.

Emergency: A situation requiring urgent action to protect life, health or safety; not every crisis is an emergency.

Formulation: A revisable explanation connecting the precipitant, meaning, danger, maintaining pressures, functioning and usable resources.

Handover: An accountable transition of information and responsibility with support during the gap and confirmation or a fallback.

Intensity: Strength of an experience or reaction at a particular time, distinct from severity and continuing danger.

Power asymmetry: Unequal ability to influence decisions, access resources, refuse demands or impose consequences.

Psychological first aid: Humane supportive practical assistance after distressing events, respecting dignity, culture and abilities; not compulsory trauma narration or psychotherapy.

Pull and urge: Reflective descriptive terms for felt pressure or impulse to act; not validated diagnostic constructs.

Regulation: Managing emotional and bodily activation to support attentive proportionate action alongside safe working conditions.

Resilience: Capacities and processes supporting adaptation, influenced by relationships, resources and institutions.

Safety plan: A collaborative usable arrangement for warning signs, coping, safe support, professional assistance and a safer environment.

Screening: Preliminary identification of a concern for further assessment; not diagnosis or prediction of individual suicide.

Self-disclosure: Sharing personal information by the practitioner, requiring a client-centred purpose and consideration of effects and boundaries.

Severity: Seriousness of harm, disruption or danger, assessed through consequences and context as well as distress.

Stressor: An event, condition or demand challenging adaptation.

Supervision: Structured professional reflection and oversight supporting competence, ethics and accountability.

Theory of change: An explicit account of expected outcomes from activities, including assumptions, resources, uncertainty and review.

Transference: Feelings and expectations shaped by earlier relationships that may be directed towards the counsellor; a hypothesis requiring attention to present reality.

Vulnerability: Conditions increasing susceptibility to harm, examined alongside exposure, resources and capacity.

About the Book

Is crisis prevention and intervention one size fits all? Understanding, Preventing and Responding to Crises in Africa examines this question across individual, family, organisational, and community settings. It explores grief, suicidal distress, illness, violence, loss of income, safeguarding concerns, service failures, disasters, and displacement.

Written for counselling students, practitioners, policymakers, organisational leaders, and people experiencing crises, the book connects major theories with African contexts. It examines assessment tools, intervention approaches, and the conditions that shape recovery. Cultural humility, competence, responsiveness, and safety are considered alongside transference, countertransference, power, boundaries, and the counsellor's internal responses. Through practical examples, reflection activities, and planning worksheets, the book encourages informed, compassionate responses suited to the people and circumstances involved.

About the Author



Dr Christian Matthew Adetunji is a Nigerian author, educator, marriage and family therapist, certified mediator, and pastoral counsellor. He holds a PhD in Marriage and Family Therapy from Pan Africa Christian University, Kenya. His work spans counselling education, family relationships, conflict resolution, and professional training. Drawing on his experience in Nigeria, Kenya, and Rwanda, he brings a contextual and systemic perspective to understanding human distress. He advocates compassionate care informed by evidence, cultural humility, ethical responsibility, and professional self-awareness.

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