EVALUATING A MULTI-COMPONENT GROUP INTERVENTION FOR IMPROVING PSYCHOLOGICAL WELL-BEING OF TRAINEE CIVIL SERVANTS IN PAKISTAN:

A RANDOMISED CONTROLLED STUDY

Thesis submitted in accordance with the requirements of the University of Liverpool for the degree of Doctor in Philosophy

By

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Declaration

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis. Furthermore, the material contained in this thesis has not been presented, nor is currently being presented, either wholly or in part for any other degree or qualification.

Preface

I am a medical doctor-turned-civil servant. As a medical student at the Rawalpindi Medical College (now Rawalpindi Medical University), Rawalpindi, Pakistan, the study of human behaviour seemed to be the most intriguing subject to me. Later, I decided to join the Civil Services of Pakistan and became a career diplomat. Much of the medical knowledge that I had acquired during my stay at the Rawalpindi Medical College, became rusty. However, I continued to maintain an interest in the study of human behaviour, emotions, and psychological aberrations on my own. During the course of my career as a diplomat, I had the chance of living in two countries of Asia (Philippines and China) and two countries of Europe (UK and Hungary) besides traveling widely. The nature of my job afforded me the opportunity to interact with a wide cross section of the societies of these countries and develop some insight into their culture and peculiar behaviours. In the course of my career, I became more and more aware of the importance of sound mental health in one's life and career particularly in my line of work- the civil service. From time to time, I was involved in training of junior civil servants which furthered my interest.

While serving as the Consul General of Pakistan in Manchester, 2013 to 2016, I talked about the prevalence of mental health issues and workplace stress among the civil service of Pakistan with Dr Atif Rahman during a chance meeting at the Liverpool University. He encouraged me to further study the subject saying that there were few studies of the impact of stress and behavioural issues on the performance of civil service in developing countries, especially in Pakistan.

On returning to Pakistan, I attended a four-month-long training course at the National Management College, Lahore, a compulsory training for all civil servants or promotion to the senior most positions in the bureaucracy, where I had the opportunity to discuss these issues with a diverse group of senior civil servants. These discussions further encouraged me to explore the idea of developing an intervention for improving the psychological well-being of civil servants of Pakistan. One colleague who agreed with me was Zulfiqar Younas, who later became Director at the Civil Service Academy Lahore (CSA), which is responsible for initial training of newly inducted civil servants of the federal bureaucracy in Pakistan. We decided to introduce psychosocial development issues in the training at CSA through an evidence-based intervention. This led to the study which will be described in this thesis.

Conducting workshops on psychological well-being at the Civil Service Academy turned out to be a unique experience of peeping into the minds of a younger group of civil servants, the challenges they face and their views on the future of development and governance in Pakistan. It also gave me an insight into the loopholes within the civil service training programmes which catered for development of a variety of professional skills but did not pay much attention to the psychosocial skills development of the participants.

As this was an off-site doctorate, I was physically based in Pakistan for the duration of the planning, intervention, development, and execution of the trial. I carried out the designing and planning as well as execution of all the research activities, supported by my supervisors and advisors from the Human Development Research Foundation, a non-profit research organisation in Islamabad. I held extensive stakeholders' consultations, training of trainers' sessions and pre and post workshops discussions necessary for the adaptation and development of the intervention. I liaised closely with the CSA and trainers/facilitators of the workshops for the smooth execution of the trial and collection of the data in accordance with the ethical standards agreed upon. I supervised the conduct of the workshops, cleaned the data, interpreted the findings, and put them in a written form as this thesis.

I am delighted to note that after the trial which was conducted from October 2018 to March 2019, the next batch of new entrants to the Civil Service of Pakistan also underwent a similar training, this time mostly conducted by the regular staff at the CSA and a peer group of working civil servants. This not only introduced some basic practices for stress management, problem management and other tools to the young civil servants, it also acquainted them with methods of training which were different from the mostly lecture based studies that they undertake at CSA. These workshops were able to create awareness among the civil servants of the importance of dealing with their own behavioural and psychological issues as well as those of their colleagues and subordinates. The CSA continues to host these workshops. Following my doctorate, I plan to upscale the workshops to other groups of civil servants of Pakistan, aiming to create a greater awareness of these issues and hopefully providing some tools to understand and address them. This would be a modest but satisfying contribution to enhancing the performance of the civil service and hence, the development of my country.

Acknowledgments

This research project owes much to many people who have helped me during the course of this doctoral research. I can name but a few here.

I am particularly grateful to my supervisors Atif Rahman, Chris Dowrick and Ross White who were always there to guide me throughout the way and provide support. To Atif, I am particularly grateful for sharing his expertise in mental health and research as well as his generosity and patience in guiding me throughout the process. He provided me the vital help I needed to undertake a research project of this magnitude as well as convert my existing skills to those needed for carrying it out. To Chris, I am grateful for his guidance on research methodology and its ethical aspects. Upon Chris's retirement in 2020, Ross White kindly agreed to guide in the shaping up of the thesis.

I am also thankful to the Human Resource Development Foundation Islamabad (HRDF) particularly Dr. Usman Hamdani, who provided the logistic support needed to conduct the research as well as vital inputs throughout the course of the study. Ms. Zill-e-Huma kindly went through the earlier drafts of the thesis. The Clinical Trials Unit (CTU) at the Liverpool School of Tropical Medicine (LSTM) especially Ms. Huan Yuan under supervision of Prof. Duolao Wang was instrumental in the statistical analysis of the trial.

I am also grateful to Mr. Sohail Ahmed, the then Director General of the Civil Service Academy for allowing us to conduct this study at the academy's premises. The study would not have been possible without the valuable administrative, logistic, and substantive input of Zulfiqar Younas, Director (programme) at CSA at the time and his team. In particular, I would like to acknowledge the staff at CSA and working civil servants who took the time out from their busy lives for this project, out of their sheer commitment to the improvement of the conditions and the performance of the Civil Services of Pakistan.

I must also thank my friends who were generally not very encouraging and warned me of the daunting tasks ahead but still went along as true friends of a friend committing a folly feel obliged to. In particular, Dr. Hamid Ateeq Sarwar provided insight into the behaviour of junior civil servants of Pakistan based upon his time as a member of the CSA faculty and Prof. Asad Tameez-ud-din Nizami, the Head of Department of Psychiatry at RMU provided support and

critiqued my work. Raja Aamir Naseem Khan, kindly reviewed the final product and gave his unique and refreshing views as a diplomat-turned-academic. Maj Gen Khurram, Shakeel Malik, Dr Tariq and Sardar Hamid Yar Hiraj, each in their own way humoured me; some with their belief in me, some with their disbelief thus further challenging and unknowingly encouraging me to continue.

I also must acknowledge my wife Nasira and my children Maryam, Ali, Rubab and Maha for bearing with me throughout this long and tortuous journey. Not only did they allow me to spare the time needed for this study but also gave me the emotional and psychological support I needed to complete the work, though at times they found it hard to understand the motivation for getting into this venture at this stage of my career. As a friend commented that I was saying the Fajr (morning) prayers at Asar time (in the evening). Still, they amused and supported me especially my daughter Rubab Ahmed, who began her own doctorate from Lancaster University at less than half my age. I did not shy away from seeking her valuable mathematical insight from time to time. Her siblings Ali and Maha reminded me of the importance of maintaining readability of any written work. If there is one thing I learnt through this venture or adventure, it is that there is always something new to learn, wherever you are in life and anyone can be your teacher.

Dedication

To Ammi and Abbu, my parents, for providing psychological support whenever I needed it, without getting into the reasons for needing it and without judging – much like this intervention.

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List of Abbreviations

AJK	Azad Jammu and Kashmir
CBT	Cognitive Behavioural Therapy
CI	Confidence Interval
CSS	Central Superior Services
CSA	Civil Services Academy (Lahore)
CSP	Civil Services of Pakistan (before 1973)
CTP	Common Training Programme (induction sessions)
DCS	Disease Classification System
DMG	District Management Group (now called Pakistan Administrative Services)
FATA	Federally Administered Tribal Areas (merged into KPK in 2019)
GAD-7	Generalised Anxiety Disorder -7 items
GB	Gilgit Baltistan
HDRF	Human Development Research Foundation (Islamabad)
ITT	Intention to Treat
KPK	Khyber Pakhtunkhwa province
MBCT	Mindfulness-based Cognitive Therapy
NICE	National Institute for Health and care excellence
NSPs	Non-specialist providers
PCQ	Psychological Capital Questionnaire
PI	Principal Investigator

PHQ-9	Patient Health Questionnaire-9 items
PM+	Problem Management Plus
PP	Pre protocol Analysis
PTSD	Post-traumatic stress disorder
SAP	Statistical Analysis Plan
SD	Standard deviations (SD
ToT	Training of trainers
WHO	World Health Organisation
WHO-5	WHO-5 wellbeing index

Definitions

Depression: “A common mental disorder, characterised by sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, feelings of tiredness, and poor concentration” which affects functioning of a person (NCCMH, 2011)

Stress: Originally defined by Selye as “the non-specific responses of the body to any demand for change” (Selye, 1965). In layman language, it is the “fight or flight” response to a stressful event which actually is initiated by the Autonomic Nervous System (ANS) and affects the regulation of the heart rate, respiratory rate, blood vessels, galvanic skin response etc. among others.

Positive stress: or "eustress" is “The low to moderate levels of stress which can help in mobilising personal resources and increasing efficiency of information processing and task completion leading to enhanced performance” (Selye, 1974). It is termed as the “healthy, positive, constructive results of stressful events and stress response” (Kupriyanov & Zhdanov, 2014).

Distress: “An intense, frequent, or prolonged stress leading to ‘strain’ or burnout and negative impact on health, well-being, job performance, and job satisfaction” (Bakker et al., 2004). It distracts energies away from work and towards coping with stress.

Anxiety: “Excessive and difficult-to-control worry accompanied by restlessness, fatigue, inability to concentrate, irritability, muscle tension, and/or sleep disturbance.” Generalised anxiety disorder (GAD) is the display of excessive anxiety or worry for most part of at least half a year, and could be directed towards anything like personal health, work, social interaction or routine life events (Newman et al., 2017).

DALYs: “Disability-adjusted life year” (DALY), is a time-based measure of the burden of disease that combines years of life lost due to premature mortality (YLLs) and years of healthy life lost due to less than full health, or disability (YLDs) (Grosse et al., 2009).

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Evaluating a multi-component group intervention for improving psychological well-being of trainee civil servants in Pakistan: a randomised controlled study

Zahoor Ahmed

Abstract

Introduction: Mental health by its very definition is related to productivity and economic output as well. It has been termed a priority under the UN 2015 Sustainable Development Goals (SDGs). Covid-19 has further brought it into limelight with almost one billion people estimated to have a mental-health or substance-use disorder (Greenwood & Krol, 2020; WHO, 2020). Work-related stress has been associated with psychological problems (Quick et al., 1997). In Pakistan, the civil service carries a disproportionally high burden of responsibility and national development depends on their performance and productivity which in turn cannot be divorced from their state of mental health. However, to the best of my knowledge, no study has so far been conducted on addressing workplace related psychological issues among the civil servants in Pakistan. The present study was conducted to fill this gap. It adapted WHO's low intensity, group psychological intervention, Problem Management Plus (PM+) to design 5 workshops to improve psychological well-being of newly inducted civil servant trainees and evaluate its effectiveness.

Methods: The study was conducted at Civil Service Academy (CSA), Lahore, Pakistan in two phases. In the *first phase*, a scoping review of the literature and consultations with stakeholders were conducted to inform adaptation of the PM+ to ensure effective implementation with trainee civil servants in Pakistan. In the *second phase*, a two-arm single blinded Randomized Controlled Trial (RCT) was conducted to evaluate the effectiveness of the adapted curriculum to reduce symptoms of psychological distress in trainee civil servants in Pakistan. 240 newly inducted civil servants, undergoing a 6 months' induction training were randomized on a 1:1 allocation ratio into intervention and usual training curriculum arm. The intervention arm received the adapted group psychosocial intervention, consisted of 5 training workshops, integrated into their orientation sessions of trainee civil servants along with the usual training. The control arm received the usual training only. The primary outcomes were changes in the scores of psychological distress as measured by Patient Health Questionnaire-9 (PHQ-9) and coping skills strategies as measured by

Brief Cope Questionnaire at 3-months post intervention. Secondary outcomes included symptoms of anxiety, well-being, and psychological capital. Intention-to-treat analyses were done using mixed models adjusted for covariates. Ethical approval of the study was obtained from the Human Development Research Foundation, Pakistan and the University of Liverpool. The trial was registered prospectively on clinicaltrials.gov (NCT03762421).

Results: *Phase 1* showed that PM+ was transferable into Civil Service Academy (CSA) settings following a careful adaptation process. The adaptation retained the concepts and strategies of the intervention while making significant changes in its structure and delivery.

In the RCT conducted in Phase 2, of the 240 participants enrolled, 213 completed the post assessment at 7 weeks and 3 months' post intervention. The mixed-model analysis showed that intervention arm participants reported significantly higher scores on Brief-COPE, compared to control arm participants (m[SD], 23.42[8.86] vs. 21.92[8.55]; mean difference, 95%CI, 2.11 [0.19 to 4.04]; $p<0.05$) at 3-months post-intervention. Similarly, lower scores on PHQ-9 at one-week post intervention were reported by intervention arm participants compared to control arm participants (m[SD], 2.61[2.98] vs. 3.64[4.72]; mean difference, 95%CI, -1.01[-1.80 to -0.22]; $p<0.05$). Statistically significant difference on secondary outcomes at one-week and 3-months post-intervention was also observed.

Conclusions: The adapted PM+ intervention has resulted in improving coping skills and reducing psychological distress in trainee civil servants in Pakistan. The intervention has the potential to be integrated into the curriculum of Civil Service Academy (CSA) and could be useful to equip civil servant trainees with necessary skills to cope with their forthcoming workplace challenges.

Chapter 1: Introduction and overview

ہمارے گھر کی دیواروں پہ ناصر
اداسی بال کھولے سو رہی ہے

Translation

There lies sadness, spreading her, dark long hair, all over the walls of my home

Nasir Kazmi, Urdu poet

Chapter 1: Introduction and overview

This research study done for the purpose of my PhD, consists of two parts as is reflected in the layout of the thesis. The thesis begins with this brief overview followed by a summary of the existing literature (Chapter 2) and description of the objectives of the research (Chapter 3). Following this, the first part of the research which relates to the development of a psychological intervention for civil servants in Pakistan, is described in Chapter 4. The second part concerns the evaluation of the adapted intervention through a randomised controlled trial and is covered in Chapters 5 and 6. Finally, Chapter 7 discusses the findings of the study and its likely implications.

For developing countries like Pakistan, the civil service carries a disproportionally high burden of responsibility. The development of the country depends to a large extent on their performance and productivity which in turn cannot be divorced from their state of mental health. However, to the best of my knowledge, no study has so far been conducted on addressing workplace related psychological issues among the civil servants in Pakistan. The purpose of this study is to address the gap and develop a feasible and culturally appropriate intervention targeting trainee civil servants and evaluate its effectiveness in this population.

Mental Health

Mental health by its very definition is not just a health issue but is also related to productivity and economic output. WHO defines mental health as "a state of wellbeing in which every individual realises his or her potential, can cope with the normal stresses of life, work productively and fruitfully and make a contribution to her or his community" (WHO, 2018). The definition highlights the ability to cope with everyday stresses and to contribute to work and society in a productive manner as central to good mental health. This makes it a subject of interest to the disciplines of management, economics and development besides just health and psychology.

The terminology of 'Global Mental Health' (GMH) was first used by the former US Surgeon General, David Satcher (WHO, 2001). It has evolved multi-disciplinary equity and field of study with a focus on globalization (Patel, 2014). It has led to epidemiological research into disease burden and universal difficulties related to mental-health issues (Bemme & D'Souza, 2014;

Baxter et al., 2013). However, the lack of epidemiological data for low- and middle-income countries limits policy planning and decision making (Baxter et al., 2013).

WHO (2014) called for addressing social determinants of mental health. The Lancet Series on Global Mental Health (2007; 2011) and the mhGAP Action Programme (WHO, 2008) drew attention to the need to fill the 'treatment gap' (i.e., the gap between the numbers of people suffering from mental illness and those receiving treatment) which has been estimated to be around a shocking 85% in low-income countries (Demyttenaere et al., 2004). Inclusion of mental health in the Sustainable Development Goals (UN, 2015), and initiatives such as the 'Out of the Shadows: Making Mental Health a Global Priority' launched by The World Bank in April 2016, were landmarks for addressing structural limitations to mental health and wellbeing.

This coming out of an age-old policy blind spot is a result of the growing understanding of the contribution of mental health issues to the world burden of disease, quantification of their economic burden and their relationship to poverty (Mills & Change, 2018). Covid-19 has further brought mental health into limelight as since the pandemic started, about 42 percent of employees in the world considered their mental health to have deteriorated. As the world hopefully moves towards the tailgate of the COVID-19 pandemic, mental health needs have become even more attention worthy with almost one billion people are estimated to have a mental-health or substance-use disorder (Greenwood & Krol, 2020; WHO, 2020).

The literature on mental-health has debated the universal approach as well as the bottom-up development models. The development of manuals for diagnosing mental disorders assume universal application of the disorders criteria– which has been contested by the relativist approach which focuses on sensitivity towards the beliefs and practices of particular groups (Summerfield, 2008; Mills, 2014). Three inter related concepts are important to note in this context. Firstly, the cultural syndromes which are defined as 'clusters of symptoms and attributions co-occurring among individuals in specific cultural groups, communities, or contexts and recognized locally as "coherent patterns of experience". Secondly, the cultural idioms of distress which are 'ways of expressing distress not necessarily involving specific symptoms or syndromes, but "collective, shared ways of experiencing and talking about personal or social concerns". Finally, the cultural explanations of distress or perceived causes could include 'an explanatory model for culturally recognized meaning or etiology for psychological symptoms' (WHO, 1992).

Common Mental Disorders (CDMs) at workplace

Common Mental Disorders (CDMs) are indeed common including in work settings. Actually, CMD is a blanket term which includes "depression, generalised anxiety disorder (GAD), panic disorder, phobias, social anxiety disorder, obsessive-compulsive disorder (OCD) and PTSD" (NCCMH, 2011). A global study on the burden of diseases, injuries and risk factors held mental and substance use disorders result in 7.4% of all disability-adjusted life years (DALYs) in the world. The same study estimated that this burden increased by 37.6% between 1990 and 2010 (Murray et al., 2015; Whiteford et al., 2013)

The economic impact of mental issues cannot be ignored. Mental health problems among working-age adults result in huge economic losses through their effect on individual's work performance and by causing short-term disability, absenteeism, and rate of turnover (Goetzel et al., 2002). A study based upon the US national co-morbidity survey estimated that $2 billion are lost in human capital every month because of only depression related loss of worker productivity (Birnbaum et al., 2010). Others estimated a loss of 40 million workdays every year to emotional and mental issues in the US alone (Van der Klink et al., 2001). One study calculated the annual cost of common mental disorders to the global economy to be $1.15 trillion (Cuijpers et al., 2016). Another research study by World Economic Forum and Harvard University estimated the cumulative impact of mental disorders on global economic output in 2011-30 would be around $16.3 trillion (Bloom et al., 2012).

A study by OECD estimated that mental health problems engulf more than 4% of the GDP across the EU through its costs to health systems, social security programs, unemployment and loss of productivity. This comes to about Euro 600 billion per year (OECD, 2018). This phenomenon by no way seems confined to the developed world. A study in India, for example, estimated the cost of mental illness to be around $1.03 trillion or 22% of GDP between 2012 and 2030 (Riba et al., 2019).

A 2015 OECD study acknowledges the significance of mental health for labour market and social policies and predicts that one half of the working population will suffer a period of poor mental health during their lifetime and one fifths of the working age population is affected by mental ill health at any given point in time (Arends, 2015). Other studies in western countries show

that about 8 percent of the working population was diagnosed with a mental disorder of some sort (Dewa et al., 2004) and nearly 14 percent of them have mental health problems in the workplace (Lelliott et al., 2008). In the UK, around 30-40% of absenteeism is linked to mental illness (Rajgopal, 2010) and in the Netherlands, about 58% of the work-related disabilities are correlated with mental health (Gründemann et al., 1991). But again, this is not just a so-called white people problem rather a worldwide issue. A study by International Labour Organisation found similar figures in every country studied. (ILO, 2016). 32.4 percent of Japanese workers were focused suffering from work related anxiety and stress while about 28 percent of workers and 13.8 per cent of employers in Chile had reported stress and depression at workplace (ILO, 2016).

Workplace stress as risk factor for CMDs

Work-related stress has been associated with psychological problems like depression and anxiety as well as physiological health issues like hypertension and heart attacks and organisational problems like workplace violence and accidents (Quick et al., 1997). Studies have shown adverse psychosocial work conditions as significant predictors for subclinical anxiety and depression among the working population (Andrea et al., 2009).

International Labour Organisation (ILO) defines workplace stress as a "harmful physical and emotional response caused by an imbalance between the perceived demands and resources and abilities of individuals to cope with those demands" (Cox et al., 2000). Its origins can be traced to organisational design as well as interpersonal relations. Workplace factors that could result in stress are also known as psychosocial hazards and could include a wide variety of issues like the nature of interactions between work environment, job content and organisational conditions on one hand, and the capacities, needs, culture and personal considerations of workers which can influence their health, performance and general satisfaction with their work (Cox et al., 2000).

Stress in workplace is not unusual. One survey showed that more than one third of the workers reported typically feeling tense or stressed out during their workday (Clark, 2012). The impact of psychosocial risks and work-place stress on the health, economy and society is again not confined just to high income developed countries (Kortum & Leka, 2014). As a matter of fact, researchers have noted that despite differences in their environments, workers across the world

face practically the same types of workplace challenges in terms of chemical, biological, physical and psychosocial hazards (Leka & Jain, 2010).

Among the various models used to explain workplace stress, the demand-control model of work-related stress introduced by Karasek (1979) is mostly employed in studies of white-collar workers like civil servants. This model views job strain resulting from the high demands of a particular job combined with the low decision-making latitude it offers. Studies have classified stressors in work related scenarios into "(i) financial; (ii) interpersonal; (iii) internal/self-induced; (iv) the job itself; (v) unpredictability or risk; and (vi) work-life balance" (Grant & Ferris, 2012).

The psychological resources of individuals can be depleted by high stress levels. Stress can also influence the organisational roles of leaders and their relationship with their subordinates. It can affect their effective functioning in their role and make them engage in poor leadership practice. (Harms et al., 2017). This could result in transferring of negative emotions to employees also, a phenomenon which has been called "a crossover effect" or "affective crossover" (Ten Brummelhuis et al., 2014). Studies have also shown that individuals can manifest the negative response to stressors by lashing out at co-workers or showing disrespect to them (Roberts et al., 2011). It's no wonder that studies have found an association between job stressors and an increased incidence of counterproductive workplace behaviour (Fox et al., 2001).

The adverse effects of workplace stress are not just confined to work. It could also negatively impact the quality of life, social functioning, and participation of employees (Cuijpers et al., 2016; Whiteford et al., 2015). Work-place stress could result in personal costs to the employees like low self-esteem, physical health issues, and a damaged family life (Goodspeed & DeLucia, 1990). It may also cause behavioural issues like an increase in drinking smoking (Dollard & Winefield, 2002). The negative effects of stress in one sphere of life have a tendency to affect other areas as well (Repetti, 1987). For example, work stress can impact marriages too (Robinson et al., 2001). In fact, it has been said that through its wide-ranging impact on family, mental health and employment, work-place stress can indirectly affect the community at large (Kelly, 1995).

Addressing workplace mental health issues

World Health Organisation (WHO) has been calling upon employers to consider mental health issues a general legitimate concern at workplace since 2000 (Harnois & Gabriel, 2000);

(Masiero et al, , 2020). In 2017, the annual World Mental Health Day adopted the theme of "Mental health in the workplace" and in the same year, the World Federation for Mental Health published a major report on the issue (WFMH, 2017).

Researchers have termed workplace as “one of the most important settings for mental health promotion” (Miedziun & Czabała, 2015). Workers who receive treatment for CMDs are more likely to be highly productive (Dewa, 2011). Evidence exists to demonstrate the cost-effectiveness of the promotion of the mental health of employees from an organisational point of view through its benefits in terms of enhancing job satisfaction, work productivity and its contribution towards lowering of absenteeism (Preece et al , 2012).

In fact, an analysis of case studies of investments by companies in mental health shows that such investments significantly reduce absences and result in a remarkable return of £9.98 to a pound invested (Hampson, 2020). One study estimated the net economic benefits generated by workplace mental health promotion in the EU range from Euro 3 to 135 billion (Clark, 2012). Another observed benefit to cost ratio of 2.3 to 3.2 to 1 on economic benefits of effective treatment of depression and anxiety disorders which would further rise to 3.5 to 5.7 to 1 if the value of extra years of healthy life was factored in (Thilina & Yadurshini, 2020; Cuijpers et al., 2016). A 2018 study found that nearly 86 percent of employees treated for depression reported a better performance at work and a lower rate of absenteeism subsequently (Goetzel et al., 2018).

Despite growing awareness over the years, mental health is still associated with stigma and discrimination. A survey in UK found that 44% of employees interviewed believed that employees suffering from stress could still perform their jobs effectively. A shocking 42% of them viewed workplace policies in place for addressing mental health and stress as merely necessary to sidestep litigation (Henderson, 2013). A systematic review of papers on employers' ratings of employability found that employers rank potential employees with mental health issues lower than other employees (Brohan et al., 2012). Another survey found that 70% of workers with mental illness attempt to hide their condition from others out of fear of discrimination (Lasalvia et al., 2013). Studies suggest that despite a reported increase in awareness on the effectiveness of treatments for mental health issues, the rate of social acceptance of co-workers with mental health issues has not improved in the past 20 years (Schomerus et al., 2012).

Mental health in the civil service

Mental health in the public sector has garnered considerable research interest in the developed countries. Numerous studies have expressed alarm on the exposure of civil servants to job strain resulting in poor general health (Palazzo et al., 2012). The continuing Whitehall cohort studies are examining various aspects of the health of civil servants in the United Kingdom including its social determinants and the prevalence of various diseases since the 1990s. Studies on direct entrant executive officers in the British Civil Service have found a high prevalence rates of stress with half of the episodes taking a chronic course (Jenkins et al., 1996).

In particular, the Whitehall II study focused on the relationship among work, stress, and health and found that the organisation of work and workplace climate were contributors to social gradient of health (Marmot et al., 1991; Marmot et al., 1978). On the other hand, the studies demonstrated that greater workplace satisfaction and well-being is associated with a higher degree of perceived social support control, variety and use of skills at the workplace (North et al., 1996).

A survey of 1051 senior British civil servants found them showing significantly worse health, wellbeing and dissatisfaction attitude as compared to their private sector counterparts. This is despite the fact that the private sector executives reported a higher number of sources of stress related to their role as managers, work relationships, work life balance and career impediments. The study concluded that stress perceptions of senior civil servants arise from job-specific factors like comparatively less flexibility, excessive work hours and lack of diversity in work. It attributed job dissatisfaction among senior civil servants to an organisational climate with little autonomy and influence, poorer communications and a more autocratic or bureaucratic management style (Bogg & Cooper, 1995). Similarly, a cross-sectional correlational design using an online survey of Irish civil servants showed managerial support and time pressure to be the strongest predictors of well-being (Bulak, 2018). Another study reported that retiring civil servants show positive changes in mental health particularly when they retire from poor working conditions in terms of psychosocial demands, authority to make decision or social support (Fleischmann et al., 2020).

Among the relatively few studies in developing economies, a survey in the Xinjiang Region of China revealed that 33.8% of the civil servants surveyed to be under high and moderate levels of job strain (Guan et al., 2017). A higher job strain was seen in female civil servants or those who

were in the lower income bracket, ethnic Uyghurs, married, or had been working for less than ten years. A higher workplace stress resulted in more chances of burnout and mental fatigue as well as chronic health issues like cardiovascular diseases (Guan et al., 2017). Another survey of 600 civil servants in Beijing showed that work stress had a significant impact on burnout and could directly and indirectly impair their resilience and exacerbate burnout symptoms (Hao et al., 2015). Similarly, a cross-sectional survey in the Indian police service found the presence of moderate stress in 68% and a high-level stress in 16.5% of the respondents (Ragesh et al., 2017).

There have been some studies on the underlying factors of workplace stress in civil servants too. One study identified "the nature of the work, heavy workload and responsibilities, infrastructural problems, conflicts, intense competition, and complicated interpersonal relationships" among the risk factors or psychosocial stressors for Chinese civil servants (Chen, 2005). An analysis of a survey of 404 employees of various public organisations who were studying for an MPA at a leading Chinese university suggested a negative correlation between hindrance stressors and physical as well as mental health issues. However, the correlation was not as strong in the presence of a higher perceived support from the organisation (Bao & Zhong, 2019). Other studies in China show the moderating effect of public service motivation (Liu et al., 2015) and resilience on work related stress (Hao et al., 2015).

Mental health in Pakistan

Pakistan is a middle-income developing country. It is the sixth most populous country in the world with an estimated population of 233.5 million in July 2020 (National Institute of Population Studies (NIPS) [Pakistan] & ICF, 2019). Its per capita Gross domestic product (GDP) is around US$1,375. Pakistan was included by Goldman Sachs in the group of next 11 countries, N11, with a potential of being the largest economies of the world in the next 20 years (Wilson et al., 2007). Malnutrition and poor health have been acknowledged as barriers to socio-economic development of the country (Finance Division, 2021).

Studies have reported a significant prevalence of symptoms of common mental health issues in the population of Pakistan. One study calculated the average prevalence of anxiety and depressive disorders in the country as 34% (with a range of 29-66% for women and 10-33% for men) -among the highest rates in the world (Mirza & Jenkins, 2004). A survey in two rural villages

estimated 60% of the female population and 25% of the male population as being affected by depression (Mumford et al., 1997). Another two-phase survey of a Pakistani village found the prevalence of depressive disorders to be 44.4% with the corresponding rates in males being 25.5% and females 57.75% (Husain et al., 2000). A similar survey in an urban population showed that 25% females and 10% males were affected by anxiety and depressive disorders. Both populations showed higher stress associated with age, living in joint households, and lower level of education (Husain et al., 2000; Mumford et al., 2000).

A study on the prevalence of depression in three Pakistani urban centres showed that 45.98% of the 820 people interviewed, self-reported depressive symptoms (Muhammad Gadit & Mugford, 2007) with Lahore having the highest number of cases of depression (53.4%) followed by Quetta (43.9%). Yet another study showed that 47% of patients attending a clinic in Karachi to be suffering from depression (Gadit et al., 1998).

Similarly, alarming figures emerge from the few studies on workplace stress. A study on university teachers in the private as well as public sectors found themselves to be suffering workplace stress and it was impacting their work in terms of research and teaching. The study identified overload of work and conflict in roles as the major factors responsible for the stress. (Faisal et al., 2019). Another study comparing the perceptions of a group of working adults in Pakistan about workplace related stress issues with that of a similar group of Americans found higher stress levels among the Pakistanis (Afza et al., 2011).

Like other LMICs where about 80% of needy people do not get effective treatment (Dua et al., 2011), Pakistan too has extremely limited mental health human resources with only 342 psychiatrists in the whole country coming around to 0.20 per 100 000 population (WHO, 2009). There have been studies have highlighted the need for capacity building of primary care physicians to address mental disorders (Naqvi et al., 2012). WHO's Mental Health Atlas of 2017 reported that there were only four major psychiatric hospitals in the country at the time with only 344 facilities for residential care (WHO,2018). In addition, there were 654 psychiatric wards in other non-specialised hospitals. This turned out to be a total of 3,729 outpatient facilities for mental health in the whole country catering to about 343.34 users for 100,000 members of the population. Among the outpatient facilities, only 46% were able to provide follow-up services in the community, while only 1% had mobile teams servicing mental health needs. The same study counted the total number

of community-based inpatient facilities for mental health as being only 624 resulting in a ratio of 1.926 beds per 100,000 people (Jooma et al., 2009). Similarly, only about 87 mental health professionals were available for each 100,000 persons. Among them, there are: 342 psychiatrists, 25782 non-specialised doctors, 13643 nurses, 478 psychologists, 3145 social workers, 22 occupational therapists and 102597 other health or mental health workers (Jooma et al., 2009).

On the positive side, there have been some successful projects for integrating mental health into primary care in LMICs including in Pakistan (Budosan, 2011; Humayun, 2017) based upon the WHO Mental Health Gap Action Programme (mhGAP) guidelines for training of non-specialists in primary healthcare to detect mental health issues and make appropriate referrals (Dua et al. 2011). Training of primary care staff to recognize and treat mental disorders could be a cost effective and practical manner to address the massive treatment gap and absence of mental health professionals (Patel, 2008).

Conclusion

In this introductory chapter, I have attempted to highlight the importance of the research area covered by this study. Mental health issues arising from workplace are increasingly being acknowledged as an important issue for the well-being of the employees as well as their productivity and the growth of enterprises and organisations. This is true of the public as well as private sector.

In the following Chapter, I will review existing literature on interventions to address workplace mental health issues in the public sector with an aim to identify an appropriate intervention for civil servants in Pakistan.

Chapter 2: Literature review

Aspiring writers should read the entire canon of literature that precedes them, back to the Greeks and up to the current issue of The Paris Review

William Kennedy

The chief virtue that language can have is clarity.

Hippocrates

Chapter 2: Literature review

The introductory chapter carried out an overview of the significance of mental health for the society and economy, the impact of common mental disorders in workplace, and the cost of workplace stress in terms of its impact on the health of employees as well as their productivity. I also reviewed some of the studies carried out on the prevalence of workplace stress and the status of mental health among civil services in various countries. Finally, I discussed the significance of addressing these issues in Pakistan and found that while the demand for such mental health interventions is high, the resources are stretched. It is therefore important to identify appropriate evidence-based and culturally adapted interventions which are cost-effective as well, to address the psychological well-being of the civil servants of Pakistan - the target population. In this chapter, I will undertake a literature review in order to identify interventions which could be carried out to improve the mental health of civil servants.

Possible interventions for mental health

NICE guidelines recommend "a stepped-care model" for selection of effective interventions and provision of services to people affected by common mental health disorders. The model begins with an intervention of lessor intensity with the possibility of stepping up or down the pathway depending upon the changing needs and the response to the treatment being carried out (Clark, 2011).

Interventions dealing with workplace mental health issues can be classified into those that (1) aim to increase psychological resources and responses of individuals with stress management training as a common denominator usually along with a range of interventions like relaxation methods, cognitive behavioural interventions and client-centred therapy and (2) those that aim to alter the workplace context and involve organisational development and job redesign (Van der Klink et al., 2001). Another study classifies interventions carried out for the purpose of prevention and management of psychosocial risks and work-related stress on the basis of organisational, task/job level, individual and policy/legislative orientations (Hesselink & Jain, 2016).

Literature also makes distinction among interventions based upon the level at which they are carried out (Sauter & Murphy, 2004). According to this classification, primary interventions are those which are by nature proactive and preventive and deal with the harmful effects before

they emerge. Secondary interventions, on the other hand, are aimed towards reversing, reducing or slowing the progression of illnesses. In this case, they can be helpful in enhancing the resources of the individuals and helping them in responding to stressors through relaxation etc. The third type, the tertiary interventions, basically address the negative impacts and provide for treatment of the stress symptoms after they emerge. (Kendall et al., 2000; Quick et al., 1998).

As the study population was non-clinical in nature, I chose to confine my search to psychosocial interventions. Psychosocial interventions can be important to manage work-related mental health issues due to their broad focus on supporting employee well-being as compared to other approaches (Czabała et al., 2011). Such interventions are primary as well as tertiary as they can prevent as well as treat mental health issues like depression (Beck et al., 2005).

A psychosocial intervention has been defined as "any intervention that emphasises psychological or social factors rather than biological factors" (Ruddy & House, 2005). Another definition described psychosocial interventions as: "ones which include education through brochures, videos, classes, self-help groups and/or individual counselling sessions and are accompanied by strategies to increase confidence, reduce social isolation and encourage patients to play an active role in their own health care" (Sobel, 1995). Under this definition, psychosocial interventions include a variety of techniques like social skills training, befriending and other packages of interventions with a psychosocial element. These interventions can lead to improved functionality, symptom reduction, enhanced quality of life, and well-being of the employees by addressing the underlying social, psychological, and behavioural factors (Czabała et al., 2011). The next question before us is to choose the type of literature review suitable for the current study.

Methodology of the review

While doing the literature review, the question was which type of literature review to conduct.

Scoping reviews are becoming increasingly popular in the literature with their number doubling from 2014 to 2017 (Tricco et al., 2018) and have been used in studies in a variety of disciplines (Anderson et al., 2008). A scoping review is defined as ''an exploratory project that systematically maps the literature available on a topic, identifying key concepts, theories, sources of evidence and gaps in the research'' (Grimshaw, 2010). It aims to map the existing literature in

a field of interest in terms of the volume, nature, and characteristics of the primary research (Arksey & O'Malley, 2005; Anderson et al., 2008).

In many aspects the methodology parallels that of a systematic review as both emphasise on methodological rigour and transparency, in order to carry out a comprehensive analysis of literature concerning stated research questions. The difference lies in their objectives.

Broadly speaking, systematic review is a more suitable methodology if the purpose is to contribute towards making of an informed clinical decision by "determining the feasibility, appropriateness, meaningfulness, or effectiveness of a particular intervention" (Munn et al., 2018). On the other hand, scoping reviews can be useful to assess the existing knowledge or map the concepts in an emerging discipline by incorporating variety of literature types besides research studies. Scoping reviews can focus on literature based upon its time period, geographical location, source or origin (Anderson et al., 2008).

In other words, a systematic review aims to gather the finest research available pertaining to a specific question while the scoping review proposes to delineate the body of literature relevant to a topic of interest (Arksey & O'Malley, 2005). Scoping reviews are helpful in highlighting emerging evidence without addressing questions related to the effectiveness or experience of a particular intervention (Pham et al., 2014).

Scoping reviews are generally used for 'reconnaissance' i.e., "to clarify working definitions and conceptual boundaries of a topic or field" (Peters et al., 2020) and can proceed to determining a future systematic review's possible value and scope. It can also be an exercise in itself in order to provide a summary of research findings, identify gaps in the research and make recommendations for carrying out research in the future (Arksey & O'Malley, 2005).

In short, systematic reviews "provide syntheses of the state of knowledge in a field, to identify future research priorities and are used to address questions that otherwise could not be answered by individual studies, identify problems for future rectification and generate or evaluate theories" (Page et al., 2021). Scoping reviews, on the other hand, are convenient when it comes to plotting emerging evidence (Pham et al., 2014). As the name implies, they are aimed at determining the scope of existing literature related to a phenomenon under consideration.

Summary of the indications for conducting a scoping review as follows (Arksey & O'Malley, 2005):

- To identify the patterns of existing evidence in a related discipline
- To clarify the fundamental concepts or definitions used in the existing literature
- To explore the methods used for conducting research on a certain question or in a certain discipline
- To highlight important characteristics of studies on a particular concept
- To lay the ground for a future systematic review
- To underline and analyse existing gaps in research

The objectives of literature review in this research studies and its broad focus makes the scoping review methodology a useful approach for conducting review of the literature on psychosocial interventions to address workplace mental health.

How to conduct a scoping review?

Despite the growing popularity of scoping reviews with their number doubling from 2014 to 2017 (Tricco et al., 2018) and its use in a range of disciplines (Anderson et al., 2008), a study on 24 scoping reviews in literature related to nursing displayed a great degree of variety in terms of their purposes, the procedures followed and the methodology of the reviews (Davis et al., 2009). Another study expressed alarm on the increasingly limited value of such reviews on account of their “lack of definition and clarity of purpose” (Anderson et al., 2008).

The first methodological framework for scoping review appeared only in 2005 when (Arksey & O'Malley, 2005) stimulated discussion about their value. Since then, a number of researchers have further refined the framework (Levac et al., 2010; Daudt et al., 2013).

The JBI International Scientific Committee's Scoping Review Methodology Group provided guidance for conducting scoping reviews in a rigorous, transparent, and trustworthy manner (Peters et al., 2015; Peters et al., 2017). In 2018, the Preferred Reporting Items for Systematic Reviews extension for Scoping Reviews (PRISMAScR) was developed (Tricco et al., 2018). These reporting guidelines and checklists provide guidance on when to conduct a scoping review, how to extract and analyse its findings and how to present its results.

Inter- coder reliability

Inter coder Reliability (ICR) i.e., 'numerical measure of the agreement between different coders' is an important aspect of verifying the validity of the results. It is defined as . The coding frame is the analytic instrument to reduce, classify and sanitize into a conceptual framework (Gaskell, 2000). Subsequently, by applying the coding frame systematically, the data are segmented into data units which are labelled with codes These codes are clustered into themes or narratives to be interpreted according to relevant theory. ICR assesses the robustness of the coding frame and its application (Armstrong et al., 1997).

Strengths and limitations of a scoping review

Both scoping and systematic reviews provide a comprehensive overview of the literature on a given research topic and follow well-defined methodologies, to enable replication of the process. However, scoping reviews are much broader in nature usually following a research question like: "What does the literature say about x population or intervention in y context?", while systematic reviews attempt to provide an answer to a fairly specific, targeted research question.

A major advantage of the scoping reviews is the shorter time required to conduct it. A scoping review allows to follow a more restricted timeframe within the available resources while a timeline of about 12 months would be needed to conduct a comprehensive systematic review to collate "all evidence that fits pre-specified eligibility criteria" to answer a research question could be required. (Armstrong,2011).

Scoping reviews are measured by their flexibility, inclusiveness covering published as well as grey literature and diverse study designs and methodologies, and the potential to combine qualitative and quantitative synthesis approaches. They follow a replicable, transparent, rigorous process exploring and synthesizing evidence on an emerging subject while not being 'as rigid as systematic reviews.' They also focus on the state of research activity rather than evaluate the quality of the literature, allow policy makers to make evidence-informed decisions, and engage stakeholders with expertise in a given content area throughout all stages of the process (Armstrong,2011).

On the other hand, a major disadvantage of the scoping review methodology is its broad formulation of the question and the findings, because of which additional steps might be required to synthesize and draw useful conclusions. The same strengths such as flexibility, broad scope and inclusion of grey literature can pose challenges to establish boundaries to the study scope. Moreover, despite its broad nature, the rigorous methodology as compared to for example, a narrative literature review, means a considerable amount of spade work and challenging for a single researcher. Scoping reviews are also limited by their lack of assessment of the quality of studies and being more inclusive of various types of studies. (O'Brien et al, 2016)

A scoping review of psychosocial interventions in workplace

The literature on the implementation of psychosocial interventions in workplace to improve mental health outcomes of the workers was explored through a scoping review. The purpose of the scoping review was to map the existing research on the topic of the study and to identify gaps in existing literature. The goal was to summarise existing research as well as to identify the need for a subsequent systematic review.

Stages of the review

The scoping review of literature on the implementation of psychosocial interventions to improve mental health of employees was conducted using Arksey and O'Malley's methodological framework. The framework comprises of six stages involving (1) identification of the research question, (2) identification of relevant studies, (3) selection of the studies to be included in the review, (4) outlining the data identified, (5) providing a summary of the results, and (6) carrying out further consultations, if necessary (Arksey & O'Malley, 2005).

Stage 1: Identifying the research question

In this stage, broad research questions for the literature search were developed, about psychosocial interventions to improve mental health problems among employees as below:

1) What are the main psychosocial interventions implemented in the workplace to improve mental health outcomes?

2) What are the components of such interventions?

3) What are the primary theoretical underpinning of the interventions,

4) What is the dosage, duration, and format of the interventions.

Stage 2: Identifying the relevant studies

The review exclusively focused on peer-reviewed and empirical research to understand psychosocial interventions in improving mental health outcomes of employees. Empirical papers published prior to 2019 in peer-reviewed journals were identified for inclusion in the scoping review of the literature.

As the focus of the study is on the implementation of psychosocial interventions to improve mental health related outcomes, articles in which the population was clinically diagnosed having psychological disorders or medical health related conditions as per DSM V/ICD-10 criteria were excluded. Systematic reviews, scoping reviews or reviews of reviews were also excluded, while all other research designs were considered eligible (RCTs, quasi-experimental, pre-post-test, Qualitative studies etc.). Papers in languages other than English language were also excluded. The inclusion and exclusion criteria are summarised below.

<u>Inclusion criteria</u>

- Studies in which the participants of interest are civil servants/public sector employees.
- Studies of Psychosocial/psychological interventions
- Both qualitative and quantitative studies
- Studies reporting mental health outcomes.
- Studies of intervention held in all sorts of workplace settings

<u>Exclusion criteria</u>

- Studies of participants with clinically diagnosed psychological or medical health related conditions as per DSM V/ICD-10 criteria.
- Systematic reviews, scoping reviews or reviews of reviews.

Stage 3: Literature selection

The literature identified in the previous stage was electronically imported into the reference manager and screened for eligibility using Rayyan software using the exclusion and inclusion criteria developed. Using combinations of keywords, the databases PubMed, SCOPUS, CINAHL, and Psych info were searched by using "Psychosocial intervention" as the keyword combined with other components of PICO criteria including Civil servants, workplace setting and mental health where appropriate. The bibliography of the extracted articles was also examined as secondary data source for relevant articles.

Search Terms used

workers OR "civil servants"[tiab] OR "civil servant" OR "civil employees" OR "public sector employees" OR "office workers") AND (psychosocial*[tiab] OR "psychological based"[tiab] OR "psychosocial interventions"[tiab] OR "psychological interventions"[tiab] OR "workplace interventions" OR "employee exercise" OR "occupational workout") AND ("psychological outcomes "[tiab] OR "psychological issues" OR "psychological problems"[tiab] OR " mental health problems"[tiab] OR "mental health" OR "subjective distress" OR anxiety OR depression OR stress[tiab] OR aggression OR "negative emotions" OR "work stress" OR worry OR tension OR burnout OR anger) AND (workplace*[tiab] OR work-place OR "working"* OR offices [tiab] OR "office work" OR "office context" [tiab] OR "work environment" OR "work location" OR "job site" OR "public sector") ("civil servants") OR ("public sector employees") AND ("psychosocial interventions") OR ("psychological interventions") AND (workplace) ("civil servants") OR ("public employees") AND ("psychosocial interventions") OR ("psychological interventions") AND (workplace)

Databases searched

PubMed, SCOPUS, CINAHL, and Psych info

Box 1 Search terms used and databases searched

Stage 4: Charting the data

A literature extraction tool was created in the software Microsoft Excel in order to record the details of study (author, date of publication, location), intervention (nature of the intervention,

components, delivery agent, mode of delivery, format, number of sessions, duration of session and duration of program), outcome measures (details of mental health outcome, type of tools used, primary/secondary outcome measures and organisational outcome measures used), and population (age range, gender, race/ethnicity, sample size, occupation and settings). The data was coded in a predefined extraction sheet.

Stage 5: Collating, summarising, and reporting the results

Data was summarised with the help of descriptive statistics. Nominal data was described with frequencies and percentages. Data was summarised with respect to population characteristics, intervention characteristics, and outcome measures. Population characteristics included age, gender, occupation and country wise analysis. Furthermore, percentage of at-risk population was also computed. Intervention details such as theoretical focus, intervention components, delivery format, session duration, intervention settings, and delivery agents of the intervention were also summarised.

Results

The initial search conducted in different databases yielded 2778 potentially relevant studies. Electronic searches of databases identified 2667 studies while 111 further studies were located by reviewing reference lists of previously published relevant reviews and included articles.

Screening of extracted articles was done on two levels; Title and abstract screening and full text screening. Titles and abstracts were screened through the software “RAYYAN” for relevance. In this process, 2690 studies were excluded as being duplicate or not meeting the inclusion criteria. Consequently, the full text of 26 potential studies was screened to assess the eligibility and for inclusion in the review. See figure for study selection process.

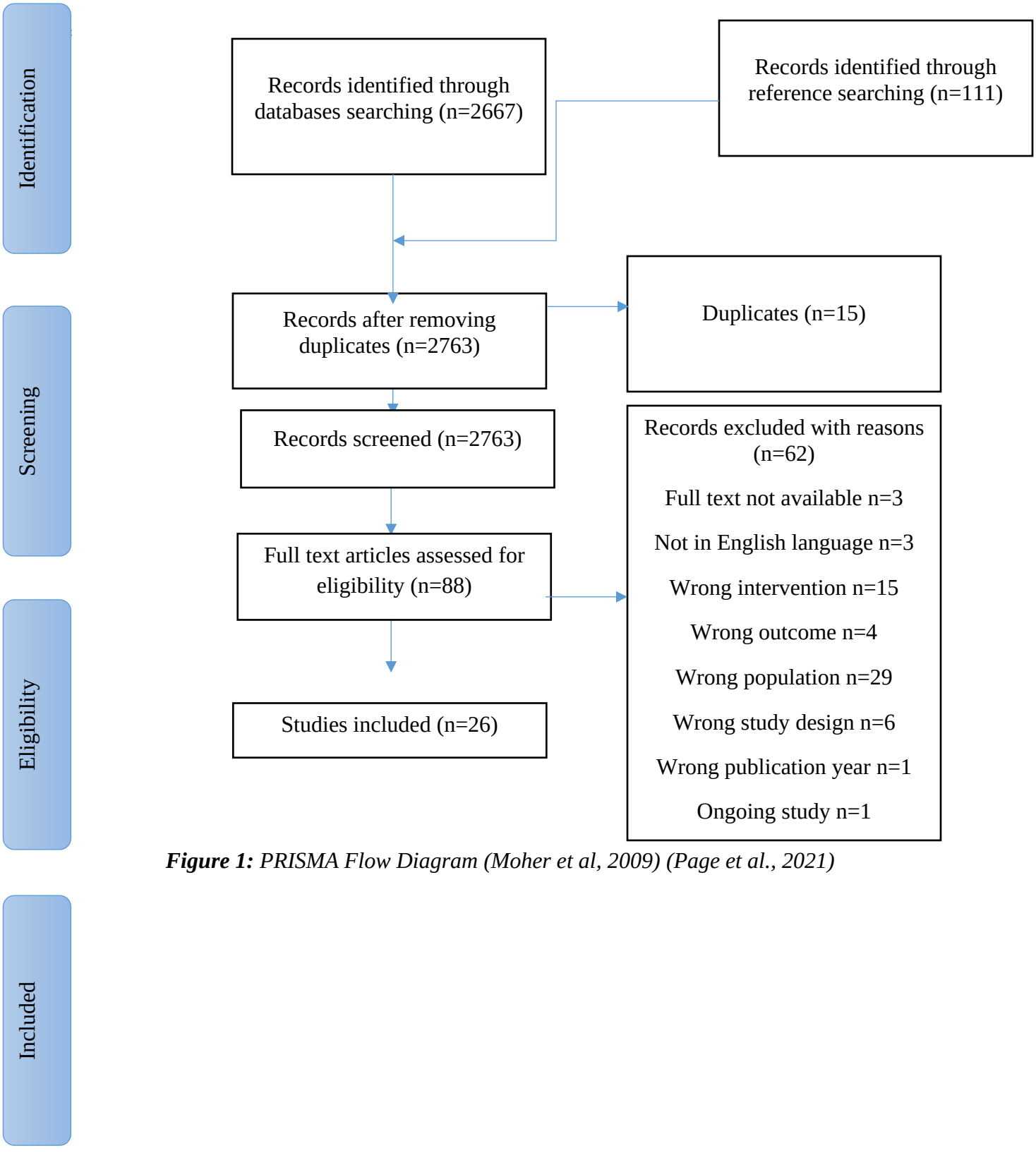


Figure 1: *PRISMA Flow Diagram (Moher et al, 2009) (Page et al., 2021)*

Characteristics of included studies:

Study design

Of the 26 studies included in the review, 69% (18/26) were randomised controlled trials and 31% % (8/26) used other research designs including quasi experimental (n=1), pre-post-test (n=3), qualitative (n=1) and mixed methods (n=3). Most of the studies were conducted in Higher Income countries (HICs) such as, USA (26%), Australia (23%), United Kingdom (11%), and Finland (11%).

Sample sizes of the studies ranged from 9 to 1452, with a mean sample size of 229. The studies measured one or more of the mental health related outcomes such as stress, depression, anxiety and burnout. See Table 2 for a summary of characteristics of included studies.

Characteristics of participants

Participants (n=5952) included in this review were public sector employees in various organisations, hospitals and educational institutions. Reported age of the participants in the range of 18-65.

Approximately half of the studies were conducted with employees working in different organisations (telecommunication, municipal, pharmaceuticals, technology, police and fire-department) and one third with hospital staffs (nurses, emergency medical dispatchers, doctors, and occupational health employees).

Most studies that reported the gender of the sample (n = 23) included a balanced mix of male and female workers. One study included only male, one had only females and five did not report the genders of the participants. See Table 1 for detailed description of participant's characteristics.

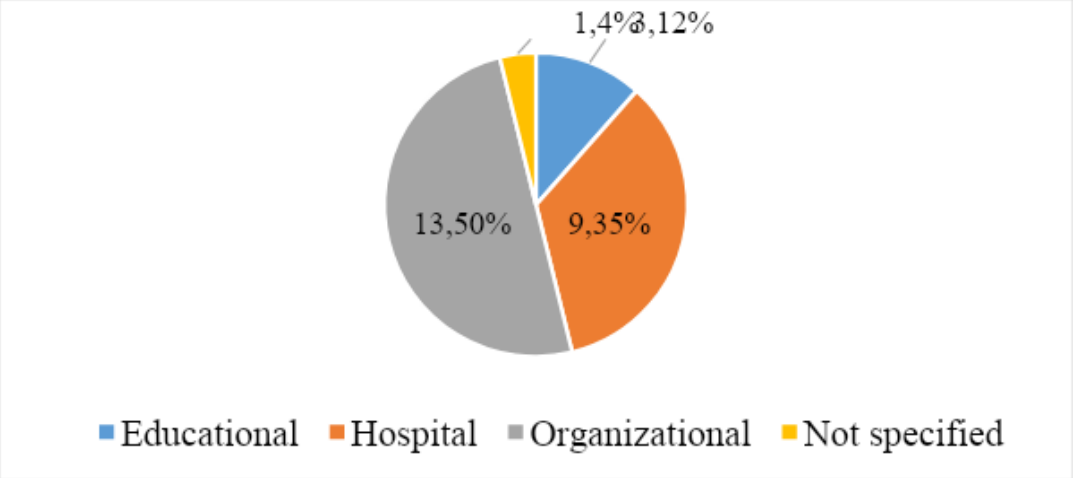
Table 1: Characteristics of the participants included in scoping review

Characteristics	Mean
Sample size*	229
Age (Categories)**	***f* (%)**
18-40	6 (23%)
41-65	10(38%)
18-65	7 (26%)
Gender	***f* (%)**
Male	1 (3%)
Female	1 (3%)
Both	25 (77%)
Not reported	5 (17%)
occupation***	***f* (%)**
Managers in different industries	4(15%)
Medical staff (Nurses, emergency medical dispatcher, physicians, social workers, physical therapists, and psychologists, mental health professionals overall, NHS related employees, gynaecologists)	10(38%)
Teacher	3(12%)
Police personnel from lower ranks (e.g., constables, head constables, assistant sub inspectors and inspectors)	1 (3.8%)
Municipal employees	2 (7.8%)
Tele communicators	1(3.8%)
Organisational worker (chemical companies' employee, HR marketing and branch staff office workers, pharmaceutical company related employee, space and technology)	5 (19%)

Notes: *Sample sizes ranged from 9 to 1452

**3 studies did not report the age

Figure 2: Work settings of intervention in scoping review



Characteristics of the interventions

A brief description on theoretical underpinning, delivery agent, dosage, and settings for each of the identified intervention follows. This is summarised in Table 3.

Theories and components

Interventions delivered in the included studies were based on different theories. Seven of them were based on the Cognitive Behavioural Theory (CBT) (n=7, 27%, (Martin, Sanderson, & Cocker et al., 2009; Kawai et al., , 2010; Kawaharada et al., 2009; Grime et al., 2004; Ojala et al., 2019; Ewers et al., , 2002; Dobie et al., 2016).

Other theories include mindfulness (n=10, 38%; (Kemeny et al., 2012; Aikens et al., 2014; Lilly et al., 2019; Kersemaekers et al., 2018; Kerr et al., 2019; Crain et al., 2017; Duchemin et al., 2015; Susan Slatyer et al., , 2018b; Shapiro et al., 2005; Bartlett et al., 2017) and behavioural and learning theory (n=1, 4%), (Hunter et al., 2019),

8 studies (31%, (Griffiths et al., 2016; Yung et al., 2004; Elder et al., 2014; Blake et al., 2013; Vuori et al., 2012; Page & Vella-Brodrick, 2013; Mache et al., 2017; Ranta, 2009) did not specify any theory and used components from multiple theories or primarily, used psychoeducation.

Cognitive Behavioural Therapy (CBT)

Cognitive behavioural therapy (CBT) is a widely used psychological intervention. It deals with the multiple problems by reducing irrational thinking which is the source of maladaptive behaviour patterns (University of Chicago, 2018). As the name signifies cognitive behavioural therapy is a combination of two different theories, the cognitive theory and the behavioural theory integrating the work of Albert Ellis on the behavioural component and Beck on the cognitive component.

CBT views psychological dysfunctions in terms of thinking patterns. The underlying idea is that an individual's cognition i.e., his unique patterns of thinking significantly affect his or her emotions and feelings and behaviour. Addressing the maladaptive thinking patterns can change their experience and behaviour and hence, help them slow down the automatic thinking processes, and enable them to carry out a more deliberative thought process which can improve decision making and behaviour. The therapy focuses on promoting more "situational awareness", recognition of high-stake situations and adopting reflective thinking (University of Chicago, 2018).

The CBT method attempts to enable the development of coping strategies in order to assist in problems solving and change unhelpful patterns of thinking, behaviours and regulation of emotions (Ewing et al., 2015). It involves multiple techniques like, problem solving skills, coping mechanism, rational emotional behaviour therapies, mindfulness based cognitive therapies and much more. It includes understanding your emotions and modifying them and treating them (Martinez et al., 2007).

The defining features of CBT curricula are its delivery by repetitive long term sessions utilising feedback and "homework" to promote understanding among participants about their own progress. Such sessions can be delivered on a one-on-one basis as well as in groups, and group sessions can be equally effective besides having the advantage of the lower administrative cost (Oei & Dingle, 2008).

CBT therapist usually offers eight to twenty-four weekly sessions, to help participants to understand their irrational thoughts, purposes and reasons for those thoughts, and to modify maladaptive behaviours.

The usual components of cognitive behavioural therapy are assessment and case conceptualisation, collaborative goal settings, structured sessions, psycho-education, application of CBT techniques and home assignments. “Here and now” is the most commonly used technique in Cognitive Behavioural Therapy (Martinez et al., 2007).

Table 2: Characteristics of the studies included in the scoping review

S. No.	Study (Author, year	Country	Sample	Study design	Population	Gender/ Age	Setting	Intervention	Mental health outcome
1.	Hunter et al/ 2018	Ireland	457	cRCT	Office-based occupations in public sector organisations	Mixed, 44(9·3)	Organisational/ office setting	The Physical Activity Loyalty Scheme (PAL) intervention	Mental wellbeing
2.	Kerr et al/ 2019	USA and Canada	149	Mixed method	Tele communicators	Mixed, 18-64	Telecommunication (9-1-1), organisational setting	The Web-based mindfulness intervention	Stress
3.	Crain et al/2016	USA and Canada	113	RCT	Teachers	Mixed, 46.9 (9.2)	Educational setting	Workplace mindfulness training (WMT)	Rumination, mood
4.	Griffiths et al/ 2016	Australia	255	RCT	Multi department	Mixed, 44.4 (11.2)	Organisational setting	Mental Health Guru (MH-Guru),	depression, anxiety, Depression and anxiety literacy, Depression and anxiety stigma
5.	Dobie/ 2015	Australia	9	Qualitative	Mental health professionals	Missing	Hospital setting	Mindfulness-based stress reduction (MBSR) programme	Depression, anxiety and stress
6.	Bartlett/ 2016	Australia	135	RCT (Pilot)	Manager, Associate, Clerical/service	Mixed, 18-55+ years	Not specified	Mindfulness at Work Program (MaWP)	Perceived stress, psychological distress,

7.	Ewers / 2002	United Kingdom	20	Quasi-experimental pre-test/post-test design	Forensic nurses	Mixed, (SD 6.67)	Hospital setting	Psychosocial interventions (PSI)	Burnout
8.	Duchemin/ 2015	USA	32	Controlled single-centre	personnel from medical centre	Mixed, M 44.2 years.	Hospital setting	mindfulness-based intervention (MBI)	Stress, Burn Out
9.	Yung/ 2004	Hong Kong	65	RCT	Nurse managers from different hospitals	Mixed, 35 or below, 36-40, 41 or above	Hospital setting	Cognitive relaxation	Stress, Anxiety
10.	Lilly/2019	USA, Canada	323	RCT	Active-duty emergency medical dispatchers	Mixed, 25-64 years	Organisational setting	mindfulness-based intervention	Stress
11.	Ojala/2018	Finland	779	Non randomised trial	Municipal employees	Mixed, 49.9 (7.8)	Organisational setting	cognitive behavioural intervention	Stress
12.	Elder/2014	USA	75	RCT	Teacher and school employees	Mixed, 36.1(not specified)	Educational settings	Transcendental Meditation	Stress, Depression, Burnout
13.	Kersemaekers/2018	Germany	425	Non-randomised pre–post	Pharmaceutical company related employee, space research and technology organisation related	Mixed, 43.9(8)	Organisational setting	“Working Mind”	Burnout, Perceived Stress

					employee, skin care products company related employee,				
	Blake/2013	England	1452	post-study design	NHS related employee	Mixed, 41.06(11.24)	Hospital setting	workplace wellness intervention	Mood
	Grime/2004	United Kingdom	48	RCT	NHS occupational health department employees	Mixed, 37 (8.27)	Hospital setting	Computerised cognitive behavioural therapy at work (beating the blues)	Anxiety, Depression
	Kemeny/ 2011	Missing	76	RCT	School teachers	Only females, 41.05 (10.48)	Educational setting	Meditation/emotion regulation training intervention	Negative Emotional Behaviour, Negative Affect, Rumination, Depression, and Anxiety,
14.	Slatyer/2018	Australia	91	Non randomised controlled trial	Nurses	Mixed, 47.57 (10.40)	Hospital setting	Mindful self-care and resiliency (MSCR) program	Stress, Anxiety and Depression, Burnout,
15.	Vuori/ 2011	Finland	718	RCT	Organisational settings (public sector, municipality)	Mixed, 50.1 (6.47)	Organisational setting	Resource-building group intervention	Depression, Burnout
16.	Kawaharada/ 2009	Japan	65	Non randomised	Office workers	Mixed, 38.1 (8.0)	organisational settings(enterprise)	Stress inoculation training program	Stress

				controlled trial					
17.	M. Page/ 2012	Australia	23	Mixed method design	Call centre branch staff, corporate employees	Mixed, 39.7 (10.0)	organisational settings (large government agency)	The Working for Wellness Program	Psychological Wellbeing,
18.	Aikens/ 2014	USA	89	RCT	Employee of The Chemical Company,	Not specified, 18 to 65 years,	Organisational setting	Mindfulness Program	Stress, Resiliency
19.	Mache/ 2016	Germany	78	RCT	gynaecologists	Mixed, 27.1 (2.1)	Hospital setting	Coping skill training intervention	Perceived Occupational Stress, Emotional Exhaustion, Emotion Regulation Skills
20.	Shapiro et al/ 2005	USA	38	Pilot RCT	Health care professionals (e.g., physicians, nurses, social workers, physical therapists, and psychologists)	Mixed, 18 – 65 years	Hospital setting	MBSR	Psychological Distress, Job related Burnout,
21.	Randhir Ranta/ 2009	India	20	A three-factor mixed design 4x2x2 (AxBxC)	Police personnel from lower ranks (e.g., constables, head constables, assistant sub	Only males, not specified	Police station	Multidimensional intervention	Stress

					inspectors and inspectors)				
22.	Kawai /2010	Japan	168	Single group pre-, post-test design.	Managerial, sales, clerks, technical, others, unanswered	Mixed, 39.3(8.7)	Organisational setting (cooperation with a business magazine)	Web based stress management program	Stress
23.	Martin/2009	Australia	249	RCT	Managers	Mixed, 18-50 years	Organizational setting	"Business in Mind"	Psychological Distress,

Cognitive behavioural therapy-based interventions included in the present review

CBT based interventions included in this scoping review involved cognitive restructuring, problem-solving skills, interpersonal skills (work relationships in everyday life), goal setting, self-monitoring, group reflection, guided discovery, scheduling of activities , breakdown of tasks, management of sleep, relaxation training, biofeedback, graded exposure, action planning, physical training, body movements, breathing awareness, breathing techniques, reflection exercises, psychoeducation on mindfulness, mindfulness practices, ABC model, writing and learning constructive ways of coping with stress. I will now briefly describe some of them.

'Business in mind' (Martin et al., 2009) is a CBT based DVD program (60 minutes) with accompanying guidebook comprised of four modules. The DVD demonstrates the skills and the guidebook includes tasks and handouts for helping individuals to apply the learnt skills in their daily life situations. In the first module, they learn about stress, coping mechanisms and the link between thoughts, feelings and behaviours. The second module includes strategies to enhance self-efficacy, hope, resilience and optimism of participants and involves various processes like "reflection", "goal direction", "pathway generation", "overcoming obstacles", "role modelling", and the "facilitation of preparedness and mastery". The third module covers "physical activity", "nutrition", "substance abuse" and "Work-life balance" and the last module consists of working on creating positive work environment, managing interpersonal stressors and development of emotional intelligence of the participants and their communication skills. The program takes 3 months to complete. Individuals also receive 30 minutes' telephone calls twice a month during the period to discuss the skills demonstrated and to resolve any difficulties arising.

'Web-based stress management program' (Kawai et al., 2010) is a program of four sessions of 10-25 minutes each designed to improve the psychological wellbeing of individuals. Each session is followed by quizzes to check the stress of the individuals.

'Stress inoculation training program' (SIT) (Kawaharada et al., 2009) is a form of CBT with a focus on stress management. Its purpose is to help individuals develop coping skills for solving daily life problems and deal with future difficulties. Individuals are encouraged to learn different strategies like "cognitive restructuring", "self-monitoring", "problem resolution" and "relaxation" in order to make them more confident in their coping skills and build their tolerance towards stress. These 60-minutes sessions

are delivered after a gap of four weeks. SIT has been significantly effective in the management of anxiety, anger and pain (Murphy, 1996; Meichenbaum & Deffenbacher, 1988).

SIT consists of three sessions i.e., psychoeducation, CBT based skills development relaxation techniques and practice of all these. The aim of the first session is to develop the individual's understanding of the concept of stress and enhance awareness of their own stress using a self-evaluation tool. Participants are encouraged to maintain a diary for monitoring themselves. They are asked to note down stressful situations they face, their physical and emotional reactions to the stress, the results of their coping strategies and any subsequent reflection on better ways to handle the situations. The purpose of the diary is to help the participants to notice positive things in their daily routines and to develop positive attitudes.

In the second session, the focus is on stress management and coping skills through lectures and trainings on cognitive restructuring and problem-solving skills. The individuals learn how to develop a balanced thinking and transform automatic negative thoughts with the help of their diary.

The third and last session is about application of learnt strategies in daily life. Individuals are encouraged to practice breathing and relaxation techniques learnt in their workplace settings. Individuals are grouped into small groups for discussion purpose. Group discussion helps in cross learning among individuals using their diary records.

'Beating the blues' (Grime, 2004) is a computer-based CBT program held over eight weeks with one session each week. The cognitive component includes "blocking automatic thoughts", "thinking errors and distraction", and "challenging unhelpful thinking". The behavioural aspects include "activity scheduling", "task breakdown", "problem solving", "sleep management", "relaxation training and biofeedback", "planning and prioritizing and graded exposure". Exercises for cognitive and behavioural aspects are designed in each session. A weekly progress report is generated for each user. At the end of the programme, goals are set for the future.

A Cognitive Behavioural Intervention Programme (Ojala et al., 2019) intervention held over 3 months with a session delivered every two weeks comprising of educational aspects and physical training aimed at improving aerobic condition, muscle strength, balance and coordination. Group discussion is also integrated in the intervention to review achieved goals. Work-related problem-solving skill are the main aspects of the program. Other components of the intervention include communication skills and

work relationship. CBT based interventions delivered in workplace have a focus on the issues affecting one's work ability.

'Psychosocial interventions' (PSI) (Ewers et al., 2002) is based on CBT delivered over the course of three months. The content of the intervention includes psychoeducation on stress, engagement skills, ABC model, guided discovery, and intervention strategies for different psychological conditions like depression and anxiety. The program was specifically designed in order to provide the participants with practical skills to enable them to reduce distress and improve their work performance.

Mindfulness based interventions

Mindfulness originally motivated by Buddhist practices, is defined in literature as a condition of being fully perceptive, paying attention to the events happening nearby regardless of any distraction and exhibiting consciousness without any sense of judgment (Bartlett et al., 2017). Since mindfulness is the capacity to figure out how to hinder hustling thoughts, and calm both one's brain and body, it can be rehearsed through multiple activities like meditation, yoga, breathing and reflection, and applied to all kind of senses such as auditory, tactile, and visual as well as emotions and thoughts. Mindfulness based stress reduction intervention have been proven effective for many physical and mental health conditions (Khoury et al., 2015; Chiesa & Serretti, 2009).

Table 3: Characteristics of Interventions included in the scoping review

	Study (Author, Year)	Psychosocial Intervention name	Theoretical underpinning of the intervention	Components	Dosage (overall duration of program, number of sessions and length of sessions)	Delivery agent/ facilitator	Mental health outcome	Setting	Format of delivery
1.	Hunter et al., 2018	The Physical Activity Loyalty Scheme (PAL) intervention	Behavioural and learning theory	• Self-monitoring • Goal-setting. • Self-regulation techniques • Prompts to behaviour	24 weeks (session number a length was missing)	Web based online	Mental wellbeing	Organisational / office setting	Individual
2.	Kerr et al., 2019	The Web-based mindfulness intervention	Mindfulness-Based Stress Reduction	• Meditation skills, such as body scan and loving-kindness	7 weeks,7 sessions of 20-30 minutes each	Web based online	Stress	Telecommunication (9-1-1), organisational setting	Group
3.	Crain et al., 2016	workplace mindfulness training (WMT)	Mindfulness-Based Stress Reduction	• Mindfulness practices • Body scans • Emotional regulation	8 weeks, 11 sessions of 2 - 7.5 hrs.	Mindfulness instructor	Rumination, mood	Educational setting	Group
4.	Griffiths et al., 2016	Mental Health Guru (MH-Guru),	Not specified	• Psychoeducation on depression and on generalised anxiety disorder.	2 weeks, 2 sessions of 30 minutes	Online	depression, anxiety, Depression and anxiety literacy, Depression and anxiety stigma	Organizational setting	Not specified

5.	Dobie/ 2015	Mindfulness-based stress reduction (MBSR) programme	Cognitive behavioural therapy,	• Body movements • Breathing awareness, • Reflection exercises • Psychoeducation on mindfulness	8 weeks, 15 sessions (length of sessions were missing)	Not specified	Depression, anxiety and stress	Hospital setting	Not specified
6.	Bartlett/ 2016	Mindfulness at Work Program (MaWP)	Mindfulness	• Identification of stress responses, • Mindfully working with difficult emotion • Body scan • Breath meditation techniques	5 weeks, 30 sessions of 20 minutes	Mindfulness trainer	Perceived stress, psychological distress,	Not specified	Both
7.	Ewers / 2002	Psychosocial interventions (PSI)	Cognitive behavioural therapy,	• Psycho education • ABC model • Guided discovery	3 weeks (missing)	Researcher and subject specialist	Burnout	Hospital setting	Not specified
8.	Duchemin/ 2015	mindfulness-based	Mindfulness stress reduction	• Mindfulness and yoga	8 weeks, 8 sessions of 60 minutes	Mindfulness instructor	Stress, Burn Out	Hospital setting	Group

		intervention (MBI)		practices with music					
9.	Yung/ 2004	Cognitive relaxation	Not specified	• Mental imagery (cognitive relaxation exercise (imagine the relaxation of different muscle groups)	4 weeks, 4 sessions of 20 minutes	Not specified	Stress, Anxiety	Hospital setting	Group
10.	Lilly/ 2019	mindfulness-based intervention	Mindfulness	• Meditation-based exercises (mindful movement)	7 weeks, 7 sessions of 20-45 minutes	Not specified	Stress	Organizational setting	Individual
11.	Ojala/ 2018	cognitive behavioural intervention	Cognitive behavioural therapy,	• Physical training • Group reflection • Goal setting • Problem-solving skills • Interpersonal skills (work relationships in everyday life)	12 weeks, 4 sessions (missing)	Medical staff	Stress	Organizational setting	Group
12.	Elder/ 2014	Transcendental Meditation	Not specified (components of psychoeducation and meditation)	• Meditation techniques • Breathing exercises	12 weeks sessions of 40 minutes (number of sessions missing)	Meditation trainers	Stress, Depression, Burnout	Educational settings	Individual

				• Waking-sleep states					
13.	Kersemaekers/ 2018	"Working Mind"	Mindfulness	• Mindfulness meditation (walking meditation, pausing meditation, body scan and compassion meditation. mindful communication, mindful meetings, mindful emailing and daily journaling. • Psychoeducation.	10 sessions of 150 minutes each	Meditation practitioners	Burnout, Perceived Stress	Organizational setting	Group
14.	Blake/ 2013	workplace wellness intervention	Not specified (components of psychoeducation and meditation)	• Yoga • Pilates, • Hula hoop, • Dancing • Tai chi • Exercise sessions (e.g., touch rugby, netball, pedometer challenges	5-year program (number of sessions and length was not mentioned)	Website, online	Mood	Hospital setting	Individual

				• Dietary intervention • Regular health campaigns • Community interventions • Relaxation therapies (e.g., massage, meditation).					
15.	Grime/ 2004	Computerised cognitive behavioural therapy at work (beating the blues)	Cognitive behavioural therapy,	• Cognitive restructuring • Activity scheduling • Task breakdown • Problem solving • Sleep management • Relaxation training • Biofeedback • Graded exposure • Goal setting	8 weeks, 8 sessions (duration of session missing)	Online	Anxiety, Depression	Hospital setting	Individual

				• Action planning					
16.	Kemeny/ 2011	Meditation/emotion regulation training intervention	Mindfulness	• Mindfulness training, • Yoga. • Emotional regulation • Cognitive restructuring	8 weeks,16 sessions of 150 minutes each	Not specified	Negative Emotional Behaviour, Negative Affect, Rumination, Depression, and Anxiety,	Educational setting	Group
17.	Slatyer/ 2018	Mindful self-care and resiliency (MSCR) program	Mindfulness-Based Stress Reduction	• Psychoeducation • Mindfulness practices (e.g., body and breath; body scan; mindful movement and stretching; sitting with the breath, body and thoughts, breathing space, mindful eating)	11.5 hours programme, consisted of 4 sessions each were of 1.5 -1.75 hours long	Clinical psychologist	Stress, Anxiety and Depression, Burnout,	Hospital setting	Group
18.	Vuori/ 2011	Resource-building group intervention	Not specified (components of social support and psychoeducation	• Social modelling • Gradual exposure, • Role playing	1 week, 5 sessions of 4 hours each	Trainers from HR departments to be trained at Occupational Health.	Depression, Burnout	Organizational setting	Group

19.	Kawaharada/ 2009	Stress inoculation training program	Cognitive behavioural therapy,	• relaxation training • self-monitoring practices • Breathing techniques.	12 weeks, 3 sessions of 60 minutes each	Occupational health physician (a psychologist) and an occupational health nurse during working hours	Stress	organizational settings(enterprise)	Group
20.	M. Page/ 2012	The Working for Wellness Program	Not specified (components of social support and psychoeducation,	• Group discussion • Activity books • Goal setting	6 weeks, 6 sessions of 60 minutes each	Author (researcher)	Psychological Wellbeing,	organizational settings (large government agency)	Group
21.	Aikens/ 2014	Mindfulness Program	Mindfulness	• Mindfulness practices (walking meditation, stretching postures • breathing • Identification of thoughts • Problem solving.	7 weeks, 7 sessions of 60 minutes each	Mindfulness trainer	Stress, Resiliency	Organizational setting	Individual
22.	Mache/ 2016	coping skill training intervention	Psycho education, skill building	• Psycho-education,	12 weeks, 12 sessions of 90 minutes each	Not specified	Perceived Occupational Stress, Emotional	Hospital setting	Group

				• Experiential exercises, • Role plays • Problem solving • Emotion regulation strategies			Exhaustion, Emotion Regulation Skills		
23.	Shapiro et al., 2005	MBSR	Mindfulness	• Meditative practices (sitting meditation, body scan, Hatha yoga, which consists of stretches and postures, breathing space, a and loving kindness)	8 weeks, 8 sessions of 120 minutes each	Clinical psychologist	Psychological Distress, Job related Burnout,	Hospital setting	Group
24.	Randhir Ranta/ 2009	Multidimensional intervention	Not specified	• Stress management (relaxation training) • Self-management and mood management • Relaxation	1 week, 3 sessions of 60 minutes each	Not specified	Stress	Police station	Individual

25.	Kawai/ 2010	Web-based stress management program	Cognitive behavioural therapy,	• Use of music • learning constructive ways of coping with stress • Writing • Cognitive restructuring	4 sessions of 10-25 minutes each (overall duration was not mentioned)	Not specified	Stress	Organisational setting (cooperation with a business magazine)	Individual
26.	Martin/ 2009	"Business in Mind"	Cognitive behavioural therapy,	• Mindfulness practices • psycho education,	12 weeks, 5 sessions of 60 minutes each	Telephone facilitator	Psychological Distress,	Organisational setting	Individual

Mindfulness interventions included in the present review

Mindfulness techniques include body scanning, breath meditation techniques, sitting meditation, hatha yoga, mindfulness-based exercises, mindfulness meditation , mindful communication, mindful meetings, mindful emailing, daily journaling, psycho-education, mindfulness training, yoga, identification of stress responses, mindfully working with difficult emotions, emotional regulation, cognitive restructuring, problem-solving skills, identification of thoughts, stretches, breathing, breathing space and loving kindness. I will now briefly describe such interventions included in the review.

'Meditation/emotion regulation training intervention' (Kemeny et al., 2012) is a 42 hours group training program held over eight weeks which includes didactic presentations, discussions, and practicing meditation and emotional skills. Three meditative practices are included i.e., concentration, mindfulness and directive practices. Other topics covered include understanding emotions and their elicitors, understanding the link between emotion and cognition, and techniques for self-recognising emotional patterns. The specific components of the intervention include trainings for improving concentration and mindfulness, promotion of empathy, yoga and conceptual discussion on values, meaning of life, recognition of emotional triggers etc.

'Mindfulness' (Aikens et al., 2014) program is a seven-week simple mindfulness-based intervention. This program has been divided into 3 parts. The first part includes audio exercises on mental fitness, focusing techniques, mindfulness practices (seated focus exercises, body scan, walking meditation, movement exercise) and performance-oriented skills (stress management, mindful communication and "mindful" problem solving). In the second part of the program, a survey is carried out whereas the last part consists of a customised text messaging system.

'*Web-based mindfulness intervention'* (Kerr et al., 2019) seems to be a better option for individuals like 9-1-1 tele-communicators because of their work schedules which make it easier for them to have web-based training rather than in-person trainings. The intervention has one session per week over a seven-week period. Each session has a brief overview of the content of 20-30 minutes followed by 10-14 minutes daily of audio guided practice to teach meditation skills (like body scan, loving kindness, awareness of breathing and breathing space) as well as one or two mindfulness practices aimed at incorporating these skills in daily life.

Week one introduces mindfulness with exercises focusing on eating and breathing. Week two focuses on improving observation skills (i.e., judgment about environment, people, objects) with exercises on reconnecting to the physical body and noticing any tendency to be caught up in judging thoughts. Week three focuses on the importance of patience and how patience can be helpful in dealing with stress and includes short breathing exercise for reliving the present moment. Week four aims to develop understanding of 'non-striving' and includes practice of mindful movement. Week five discusses influence of the thoughts on the mood, feelings and interactions with exercises on awareness of breadth and body. Week six focuses on learning how to be kind towards self and others and emphasises on associated barriers. Finally, the practice of kindness is taught by design phrases to encourage self-reflection, acceptance and openness to oneself.

'Mindfulness based stress reduction' (MBSR) (Dobie et al., 2016) comprises of eight weekly sessions of two to three hours of duration and independent practice. In MBSR, 15 minutes daily guided experiential practice, along with simple body movements is undertaken along with breathing awareness and reflection exercises of 10 minutes and fortnightly 30 minutes' psycho-education sessions. (Shapiro et al., 2005) also uses the same intervention.

'*Mindfulness at Work Programme'* (MaWP) (Bartlett et al., 2017) is a MBSR based program which includes sessions on physiology of stress, developing skills for identifying and intercepting personal stress responses, mindfully working with difficult emotions and people, and dealing with challenges and changes at work. Body scanning and breath meditation techniques are also included. It has five sessions delivered over five weeks with a total duration of seven and a half hours. All sessions focus on meditation i.e., body scan and breathing allocating ten minutes for each activity for six days in the first two weeks. The duration is increased to 20 minutes in the subsequent weeks. Session 1 helps to understand mindfulness at work, session 2 talks about working with body in mind, session three helps in developing mindful communication, session 4 teaches dealing with difficult people and emotions and the last session talks about mindful working.

'*Workplace mindfulness training'* (WMT) (Crain et al., 2017) is a MBSR based program for educators aimed at developing mindful awareness and self-regulation of thoughts, emotions, sensations, and behaviour and developing compassion and forgiveness. Guided mindfulness practices, activities, lectures and discussions, and homework assignments are included in this program. The WMT consist of 11 sessions and takes 8 weeks to complete. It includes activities to foster mindfulness and self-compassion

in order to better cope with stress. Examples of these activities are mindfulness practices, body scan meditation etc. Psycho-education on the regulations of emotions and stress through mindfulness is also covered. Total duration of the program is 36 hours with each session of 2 and a half hours' duration except session 2 and 9 which are each seven hours long.

'*Mindfulness-based intervention'* (MBI) (Duchemin et al., 2015) is a mindfulness-based stress reduction program over eight weeks including mindfulness meditation, relaxation and yoga practices. Duration of each session is sixty minutes except for last session which is longer (120 minutes) because of addition of mindful eating component. Its components are "body scan", "gentle stretching", "yoga", "progressive relaxation", "eating meditation", and "formal meditation" followed by twenty minutes daily practices.

'Mindfulness intervention' (Lilly et al., 2019) is a MBSR based intervention and consists of seven modules covered in seven weeks. Each module is completed in 20-30 minutes and covers meditation exercises (mindful movement). It mainly differs from conventional MBSR intervention in terms of having a shortened duration.

'*Mindful self-care and resiliency (MSCR) program*' (Slatyer et al., 2018b) is based upon the theory of mindfulness-based stress reduction. It is a full day workshop type intervention with 4 1 and a half hours long sessions and 3 weekly follow up sessions of about two hours each. Total duration of the program is eleven and a half hours. The first two sessions include psycho-education and the next two include mindfulness introduction. The mindfulness practices conducted include; body scan; mindful movement and mindful eating.

'Working Mind' (Kersemaekers et al., 2018) based on traditional mindfulness programs, is two-day long training workshop followed by eight two and a half hours' sessions. The programme encourages participants to carry out a daily ten minutes' practice of mindfulness. It also includes psycho-education on mindfulness and meditation practices.

Behavioural and learning theory-based interventions

Behavioural and learning theory involves self-monitoring, goal-setting, techniques for self-regulation and improvement of behaviour. *'The Physical Activity Loyalty Scheme (PAL) intervention'* (Hunter et al., 2016) is based upon behavioural and learning theory, incorporating different behaviour

change strategies. Its distinguishing feature is the points and rewards system in response to achieving daily targets related to physical activity and behaviour. It also includes techniques like self-monitoring, self-regulation and prompts to behaviour. PAL is a 6 months long intervention and individuals are encouraged for to practice physical activity 2.5 hours every week. It provides regular motivational emails, and feedback tailored to specific needs of the group and individual like information on nearby walking routes and links to related resources on the internet.

Psychoeducation and unspecified interventions

(Colom, 2011) defined psychoeducation as a psychological intervention for mood disorders and called it "a simple and illness-focused therapy with prophylactic efficacy in all major mood disorders". Psychoeducation is "the process of providing education and information to those seeking mental health services".

Studies which didn't specify a theoretical basis included components from different theories such as psycho-education on depression and on generalised anxiety disorder, mental imagery (cognitive relaxation exercise (imagine the relaxation of different muscle groups), meditation techniques, breathing exercises, waking-sleep states, yoga, Pilates, hula hoop, dancing, Tai chi, exercise sessions (e.g. touch rugby, netball, pedometer challenges), dietary intervention, regular health campaigns, community interventions, relaxation therapies (e.g., massage, meditation), social modelling, graded exposure, role playing, group discussions, activity book, goal setting, problem solving, emotional regulation strategies, experiential exercises, stress management, self and mood management.

Synthesis of various theoretical models

Although the two main conceptual methodologies used in interventions on workplace mental health issues are mindfulness and CBT, there were interesting hybrid models in a number of studies included in the scoping review. For example, in the study of Kawaharada (2009) on civil servants in Japan developed the Stress Inoculation Training programme (SIT) which had three phases. Each phase was comprised of a one-hour session and dealt with education, cognitive behavior skills development and relaxation training respectively. The first session was aimed at providing psycho-education, particularly related to the concept of stress as manifested in the lives and work of the participants. The purpose of the second session was to learn skills to cope with stress. This session itself was divided into a lecture, a cognitive receptive training and a problem-solving skills training. The third session was directed at

learning the application of coping skills and relaxation in day-to-day life. This session included a lecture on the theoretical background of relaxation, practice of breathing techniques and other methods for relaxation in the workplace. Throughout these sessions, participants were asked to share their experiences with each other which found an important component of the training programme. Participants were also asked to maintain self-monitoring diary records which provided them an opportunity to reflect and record their practice of the tools learned during the workshops. The intervention also highlights the importance of group discussions for dealing with mental health issues. Another study by Kawai (2010) used a four-session programme which comprised of psycho-education and group discussions based upon cognitive behavior therapy.

Another interesting intervention was developed by Grime (2004) in a study of NHS workers. The study used developed a specific CBT programme "Beating the Blues" which was found effective in accelerating psychological recovery in employees with recent stress related absenteeism. This programme is notable for its interactive nature and the use of computer technology. The computerized programme generated a weekly report of the stress based upon self-rating by the users.

An interesting intervention developed for promoting workplace mental health in small medium enterprises was the "business in mind" programme used in by Martin (2009). The intervention is delivered with the help of a DVD programme and a guidebook and involves skill development within the CBT framework. The four modules of the intervention are aimed at stress management, enhancing psychological capital, overcoming barriers to a healthy lifestyle and creating a positive work environment. The intervention was accompanied by a website which provided additional resources to participants to help them further their personal development.

Delivery agents:

Majority of the interventions were delivered by mindfulness instructors (n= 6). Most of the studies reported that delivery agents were the same instructors who developed the intervention and that they were certified mindfulness practitioners having 9 to 35 years of experience. (Crain et al., 2017); (Bartlett et al., 2017; Duchemin et al., 2015; Elder et al., 2014; Kersemaekers et al., 2018; Kawaharada et al., 2009).

Among the studies included in the scoping review, five were e-based intervention i.e., the Physical Activity Loyalty Scheme (PAL) intervention, The Web-based mindfulness intervention, Mindfulness Program, Mental Health Guru (MH-Guru), workplace wellness intervention and Computerised cognitive

behavioural therapy at work (beating the blues). In these interventions, DVDs, videos, lectures, and other guides were uploaded on the recommended website and participants were given email IDs and passwords to access the material (Blake et al., 2013; Griffiths et al., 2016; Grime, 2004; R. F. Hunter et al., 2018; Kerr et al., 2019).

Three interventions included in the review were delivered by psychologists (Kawaharada et al., 2009; Shapiro et al., 2005; Slatyer et al., 2018b). Three other interventions were delivered by researchers (Ewers et al., 2002; Page & Vella-Brodrick, 2013; Vuori et al., 2012) while one intervention was provided by a telephone facilitator (Martin et al., 2009).

Seven studies did not report any information about who provided the interventions (Aikens et al., 2014; Kawai et al., 2010; Kemeny et al., 2012; Lilly et al., 2019; Ranta, 2009; Shapiro et al., 2005; Yung et al., 2004). In one study, intervention was given by multiple delivery agents i.e., a doctor, an occupational physiotherapist, an occupational psychologist, and a nurse (Ojala et al., 2019).

Intervention delivery format

46% (12/26) of the interventions in the current review were delivered in group format (Crain et al., 2017; Duchemin et al., 2015; Kawaharada et al., 2009; Kemeny et al., 2012; Kersemaekers et al., 2018; Mache et al., 2017; Ojala et al., 2019; K. M. Page & Vella-Brodrick, 2013; Shapiro et al., 2005; Slatyer et al., 2018b; Vuori et al., 2012; Yung et al., 2004).

38 % (10/26) of the studies opted an individual setup for intervention delivery (Lilly et al., 2019); (Aikens et al., 2014; Elder et al., 2014; Ruth F Hunter et al., 2016; Kerr et al., 2019) (Blake et al., 2013; Grime, 2004; Kawai et al., 2010; Martin et al., 2009).

The remaining 12% of the studies (3/26) of the studies did not specify their format of delivery (Dobie et al., 2016; Ewers et al., 2002; Griffiths et al., 2016). Only one study i.e., 4% of the total studies (Bartlett et al., 2017) reported using both individual as well as group format of intervention delivery.

A closer look revealed that 3 group format interventions, 3 individual format one, along with the sole intervention having both individual and group format in its study design made use of mindfulness interventions. Three group format studies used mindfulness-based stress reduction intervention (MBRS).

Similarly, three group format and two individual format researches use psycho-education interventions. Two group format and three individual format interventions were based upon cognitive

behavioural therapy. One individual format delivered intervention was based upon behavioural and learning theory. Two studies using cognitive behaviour therapy-based interventions did not specify the format in which they were delivered it.

Dosage of the interventions

Most of the studies reported adequate information about duration and frequency of the sessions, and overall program duration (n=21). Homework practices were assigned in most of the studies. Detailed information about dosage of the intervention is given in table.

Table 4: Dosage of interventions included in the scoping review

Character	Mean
Average Session Number*	7.80 (5.98_
Average Session Duration**	92.14 minutes (97.70)
Average Programme Duration***	7.95 weeks (4.89)

*Notes: *Session numbers range from 2-30*

***Session duration range from 15 to 150 minutes*

****Program duration ranges from 1-96 weeks (Overall program duration in one study was of 5years)*

Barriers and limitations

Most of the participants reported that it was difficult for them to engage in the interventions because of being overworked. They indicated that lack of time and hectic work routine as the major challenges in engaging with an intervention at work.

In other studies, restricted budget, bureaucratic and organizational requirements, and the perceived need for financial investments made it difficult to implement psychosocial training at work (Mache et al., 2017).

Organisations which comprised of blue-collar employees found it difficult to schedule group activities on account of conflict with their work which was being carried out in various shifts. (Vuori et al., 2012).

Most of the studies (Aikens et al., 2014; Duchemin et al., 2015; Ewers et al., 2002; Mache et al., 2017; Ojala et al., 2019) were limited by their small self-selected, sample size or convenient sample size that can make it difficult to forecast if the studies have implications for the mental health of a larger sample size.

Another limitation of some studies (Aikens et al., 2014; Duchemin et al., 2015; Griffiths et al., 2016) was the variations in demographics, in terms of motivation, education, compensation, and employer support causing doubts on the generalisation of results.

Another obvious limitation of some studies (Kemeny et al., 2012; Kersemaekers et al., 2018) was the absence of a randomised control group study design resulting in incompleteness of the data, somewhat small amount of data and or having the randomisation done at the individual level rather than departmental level.

In some studies (Dobie et al., 2016; Kawaharada et al., 2009; Kawai et al., 2010; K. M. Page & Vella-Brodrick, 2013; Slatyer et al., 2018b) there was no control group and data were reported on the basis of observations from treatment group only making the results susceptible to the influences of sensitisation, practice, or any other carryover effects.

Some studies were limited because of the specialised nature of the target population like (Ewers et al., 2002) exclusively studied physicians or nurses and hence results were difficult to generalise and predictions about whether the implications of study applicable to other groups of mental health were not possible.

Another study (Hunter et al., 2019) did not monitor variations in mediating variables that could cause low power, multiple testing and unreliable results.

Studies (Elder et al., 2014; Slatyer et al., 2018b) carried out at a single site also demonstrated limited generalisability of the results.

One limitation observed in the follow-up studies included was that either the study was not completed, resulting in the reduction of the sample size making it too small for the follow-up measurements or so extended that it can possibly influence the results and could no longer be significant (Aikens et al., 2014; Mache et al., 2017; Vuori et al., 2012).

Quality assessment of included studies

Methodological rigorousness of the included studies has not been done because the goal of the scoping review was limited to determining the range of qualitative and quantitative evidence available on the topic of interest and represent the data visually as mapping or charting sheets. The distinguishing feature of scoping review vis-a- vis systematic review is that it provides an overview of existing evidence without carrying out a formal quality assessment of the studies included (Peters et al., 2015b).

Inter-Rater reliability between different coders

Inter-rater reliability between different coders was calculated by Kappa statistics. The Cohen's Kappa value of 0.803 indicates considerable agreement between multiple coders while making decision of inclusion and exclusion. This value was statistically significant (McHugh, 2012).

Table 5: Inter-rater reliability in the scoping review

Raters	**ICC (95% CI)**	**F test with true value 0**			
		Value	**df1**	**df2**	**P-value**
100 articles	0.803 (0.73 – 0.85)	5.26	99	396	0.00

Discussion

The Scoping review allowed us to explore the breadth and depth of the existing literature and mapped and summarised d the evidence with an aim to identify the knowledge gaps in the area. It could also be the basis of future systematic study review on the issue. Any such future systematic review would address the issues which have not been tackled in the scoping review and further build upon its findings. While the scoping review has been able to map the are available literature and outline the heterogeneous

body of knowledge relevant to the topic of research, the systematic review would be able to gather evidence from studies pertaining to the focused research question. A systematic review will also be able to undertake a more in-depth qualitative appraisal of the studies identified in the scoping review.

The scoping review provided with an overview of different psychosocial interventions which have been used to addressed to mental health issues at workplace. This formed the basis of decision to a psychosocial intervention to be adapted and evaluated in the study. The scoping review formed the basis of these discussions on the possible components of such an intervention, its theoretical underpinning, delivery agents, dosage, duration and format.

As we can see from a number of studies which we discovered during the scoping review, the more successful interventions for workplace mental health issues are those which are specifically designed for the target population and are multicomponent in nature.

I had discussions with various stakeholders and particularly the faculty of the Civil Service Academy, former instructors and students of the Academy, senior as well as junior civil servants belonging to various occupational groups and a group of psychologists with exposure to psychosocial interventions. This helped me in developing the ideas on the requirements criteria which any such psychosocial intervention should meet.

The two major theories which formed the basis of the interventions covered in the scoping review were mindfulness and Cognitive Behavioural Therapy. It was noted that mindfulness was an increasingly established concept in psychological interventions. However, CBT as an established psychological paradigm might be more suitable for such interventions. Moreover, the mindfulness-based interventions mostly concern themselves with addressing stress in workplace. The interventions covered in the scoping review which were based upon CBT more often included problem-solving skills and interpersonal skills. Any intervention that does not include the skills which the civil servants would consider important for their career advancement including others like problem solving etc. might not have the same kind of acceptability. Such an intervention should also include a psychoeducation element.

In terms of methodology, the scoping review noted that most of the studies on the psychological interventions carried out to address workplace mental health issues used the randomised control trial as the research design. This point was noted for discussions while selecting an appropriate study design in

Chapter 5. I also noted a preponderance of studies in the high income developed countries and a few studies in the low income and developing countries.

None of the studies in the scoping review dealt specifically with middle-level management civil servants. Most of them are included employees working in very narrow fields like telecommunication, municipal administration, pharmaceuticals, technology, police and fire department, and the hospital staff. This study population, on the other hand, comprised of civil servants who were well educated and were entering at the middle management level. They also belonged to different occupational groups which had a variety of job specifications.

This is also an interesting population because of their unique status in Pakistani society and their role in the country's governance and development.

The scoping review also highlighted the variety of delivery agents used to deliver interventions to address mental health issues at the workplaces. Most of these were professionals who had extensive training in the intervention as well as its theoretical basis. In the setup of this study, using professionals might not be as valuable on account of the limited professionals available as well as the reaction of the civil servants to the presence of mental health professionals. This would give an impression of delivering a therapeutic intervention whereas the purpose of our intervention is primarily preventive. The use of E-based interventions would also not be advisable in this population because of difficulties in ensuring fidelity and compliance. This could be the subject of future research.

In terms of format, majority of the interventions covered in the scoping review used the group format. This seems to be more appropriate in the workplace setting on account of the group format’s ability to allow free discussions between the participants themselves and avoid any notion of differential treatment in view of the widespread stigma associated with mental health issues.

The average number of sessions in the interventions studied in the scoping review was seven with the average duration of each session being 92 minutes. The average program duration was eight weeks. However, I was aware of the wide range associated with all these figures. Session numbers ranged from 2 to 30 and the duration ranged from 15 to 150 minutes. Similarly, the program duration ranged from 1 to 96 weeks with one program extending to even five years. Still the average figures guided us as to the advised duration of any other psychological intervention in addressing the mental health issues of civil servants.

The scoping review also provided with an insight on how to avoid the limitations of earlier studies conducted on interventions to address mental health issues at workplace. Major limitation in most of the studies was the cost of conducting the intervention and the lack of engagement by the study population. This can be improved by fine tuning and projecting the objectives of the intervention in terms of developing skills necessary for the career of the civil servants rather than addressing mental health issues.

The scoping review also highlighted the challenges of delivering a psychosocial intervention in real life settings. Many of the studies included in the scoping review highlighted the limitations of resources including financial as well as material resources for the delivery of the intervention. For example, Martin (2009) used the "business in mind" intervention which relied upon the use of a DVD and computer which at that time was not available to many participants and resulted in a low participation and high dropout rate.

Similarly, a limitation of the study conducted by Kawaharada (2009) was the limited time available for the study. It was not clear whether the effects of the intervention remain after a longer period. We were also mindful of this limitation while conducting our study as the participants were attending a six months long induction course and it would be difficult to ensure compliance of the responses to outcomes after this as they would disburse to their own respective specialized training centres. Moreover, their focus on their training programme created a challenge for the study. The study by Grime (2004) was also limited by the high dropout rate which in its turn is connected to the cost, time and resources available for conducting the study. The study by Dobbie (2015) also noted the limitations due to having a small convenience sample and absence of data regarding the durability of the observed affects and future longer to evaluation of the intervention. On the other hand, Ojala (2018) noted that employee engagement can be built at work through meaningful experiences and by enabling the workers to understand the purpose of their work and the particular intervention which was being conducted during the study. The challenges of participant's engagement were also manifested in Kawai (2010), through high number of dropouts. The study could not identify the reasons for these dropouts as it did not have a qualitative element. Crain (2016) also noted the need for future studies to determine whether the effects of the intervention are sustained over time consistently.

The study of the limitations which were faced in previous studies provided us an insight of the pitfalls that we needed to avoid while conducting our study as well as the necessary components for a psychosocial intervention at workplace for civil servants in Pakistan.

Based upon the discussions above, key requirements from a suitable intervention were identified as the following:

- Should be of relatively short duration
- Should take into account the specific culture
- Should involve trainers with cultural competence
- Should not treat civil servants as patients
- Avoid stigma and discrimination
- Allow learning from group members

Selection of a suitable intervention civil servants

Discussions with stakeholders based upon the findings of the scoping review of literature led us to Problem Management plus (PM+), one of the psychological interventions developed by WHO, as part of its Mental Health Gap Action Programme (mhGAP) (Dawson et al., 2015). Problem management plus has many features which makes it suitable for a study involving civil servants in Pakistan.

For one, PM+ is a short, low-intensity, trans-diagnostic psychological intervention for health in addressing a range of psychological as well as practical problems identified by the participants themselves (Dawson et al., 2015; WHO, 2016a). Both problem-solving and behavioural treatment techniques have been integrated in the intervention resulting in flexibility as well as a strong evidence base (Bennett-Levy, Farrand, Christensen, & Griffiths, 2010). The name "Problem Management Plus" indeed reflects its aims to improve the management of practical and common health problems of the participants with the "plus" referring to the inclusion of evidence-based behavioural strategies. (Dawson et al., 2015; WHO, 2016a)

The core strategies of the PM+ intervention are: (1) managing stress; (2) managing problems; (3) get going, keep doing; and (4) strengthening social support. It also includes a psychoeducation component on common reactions to adversity (Dawson et al., 2015; WHO, 2016a).

Studies in low and middle-income (LMIC) countries have identified PM+ as particularly suitable for their high demand-low resource contexts on account of its short duration, flexibility to be delivered in individual or group format, task shifting and its being a trans-diagnostic intervention (Sangraula et al., 2018).

A key feature of the intervention which makes it suitable for the study is task shifting. Despite using elements of CBT, PM+ simplifies them for communities who do not have specialists for delivering

more complex interventions (Dawson et al., 2015). The possibility to deliver the intervention after giving a short training to non-professionals is a great comparative advantage in developing countries like Pakistan where per capita healthcare support is very low.

Moreover, PM+ has a group format as well as the individual based format, which is based upon the same strategies but also has the additional benefits of allowing for peer interaction and utilising the potential of group members to be therapeutic agents to other group members (Yalom, 2005). A meta-analysis concluded that group cognitive behavioural interventions are as effective as interventions carried out on individual basis (Cuijpers, Van Straten, Warmerdam, & Smits, 2008). Due to the ability to reach larger numbers of people, the group format offers a potentially scalable and cost-effective approach for delivery of the intervention. Delivery in a group format also avoids stigmatisation and encourages free discussions.

Another noteworthy feature of PM+ is its trans-diagnostic approach which applies "the same underlying principles across mental disorders, without tailoring the protocol to specific diagnoses" (McEvoy, Nathan, & Norton, 2009). This approach can be valuable because most people have comorbidity and this approach allows the intervention to address multiple problems at one time (Wilamowska et al., 2010). One more advantage is that this approach reduces the need for making differential diagnoses and developing multiple treatment manuals for different disorders for LMICs (L. K. Murray et al., 2014).

PM+ is also one of the few psychological interventions, which have been developed and tested in Low- and Middle-Income Countries (LMICs) and across various geographical and socio-cultural contexts (Dawson et al., 2015; Keus Van De Poll et al., 2020; Rahman, et al., 2016; Thilina & Yadurshini, 2020). Socio-cultural adaptations of PM+ have been carried out in a number of LMICs and their effectiveness has been established, confirming that PM+ can provide a template which is adaptable to various contexts and can overcome the barriers of socio-cultural acceptability for improving access to effective treatment in LMICs.

The intervention has also been evaluated in primary care population in Pakistan and significant improvement has been found in depressive symptoms and anxiety (Rahman, Riaz, et al., 2016). In the KP province of Pakistan, individual and group versions of PM+ were shown to be effective in reducing symptoms of anxiety, depression and post-traumatic stress in both men and women (Hamdani et al., 2017a; Rahman et al., 2016). Another study showed that the PM+ programme when delivered in a group format

by non-mental health specialists helpers resulted in significant improvement in psychological well-being of women with CMDs (Khan et al., 2019).

A 5-session group intervention adopted for SME entrepreneurs suffering from conflict situation in KP and FATA areas of Pakistan was developed based on the intervention Saraf, 2019. which was also embedded within the adaptive leadership framework (Heifetz et al., 2009). These adaptations provided a useful basis for the study as ours was a non-clinical population interested in career advancement and leadership skills.

On the basis of the scoping review and stakeholder consultations, I found that PM+ meets the key requirements from a suitable intervention identified by the stakeholders. It seems to be a good choice to form the basis of development of an intervention for the target population. Table below summarises these findings.

Table 6: Requirements of an intervention for Pakistani civil servants and features of PM+

Requirements of an intervention for Pakistani civil servants	**Features of PM+**
Should take into account the specific culture	PM +has been adapted for LIDCs including Pakistan. Further adaptations for the study population are described in Chapter 4.
Should involve trainers with cultural competence	Task shifting
Should not treat civil servants as patients	Name does not identify it as a psychological intervention.
Avoid stigma and discrimination	Name and content do not make it seem like a Psychotherapy
Allow learning from group members	Group version available
Should be of relatively short duration	5 sessions only

Conclusion

A scoping review carried out to identify interventions to improve the mental health of civil servants did not find any previous research on addressing work-related psychological issues among civil servants in Pakistan. However, on the basis of the scoping review and stakeholder consultations, I found PM+ to be a good choice to form the basis of development of such an intervention. It meets the key requirements from a suitable intervention identified by the stakeholders.

This study proposes to bridge the gap identified in the literature review by developing a feasible and culturally appropriate intervention for this population and evaluating it.

Before going on to describing the development and adaptation of the intervention for the study population, I will set the stage by briefly describing the aims and objectives of the study in the following chapter.

Chapter 3: Aims and objectives of the research

Macbeth: *Canst thou not minister to a mind diseased,*

pluck from the memory a rooted sorrow,

raze out the written troubles of the brain,

and with some sweet oblivious antidote cleanse the stuffed bosom of that perilous stuff which weighs upon her heart.

Doctor: *Therein the patient must minister to himself.*

William Shakespeare

Chapter 3: Aims and objectives of the research

This thesis began with an overview of the significance of mental health, the impact of common mental disorders in the workplace, and the cost of workplace stress in terms of the health of employees as well as their productivity. I also referred to some studies on the prevalence of workplace stress and mental health issues among civil services, mostly in developed countries. Finally, I discussed the significance of addressing mental health issues in Pakistan and found that while the demand for such mental health interventions is high, the resources available are stretched.

For a postcolonial developing country like Pakistan, the civil service carries a disproportionally high burden of responsibility for national development and their performance and productivity is affected by the state of their mental health. It is therefore important to identify appropriate interventions which can be cost-effective as well as evidence-based and culturally adapted to address mental health issues in the civil servants of Pakistan.

In Chapter 2, a scoping review was carried out to identify interventions to improve the mental health of civil servants. I did not find any previous research on addressing work-related psychological issues among civil servants in Pakistan. This study proposes to bridge the gap by developing a feasible and culturally appropriate intervention for this population and evaluating it.

Before moving ahead, it is important to clearly state the aims and objectives of the study. The aim of this study is to evaluate the effectiveness of an intervention for improving psychological well-being among a group of newly inducted civil servants in Pakistan.

In line with the aim, the objectives of the study are

- development of a feasible and culturally appropriate intervention targeting Pakistani civil servants under training at Civil Service Academy, Lahore;
- evaluation of the effectiveness of the intervention in improving psychological well-being in this population.

This leads us to the primary hypothesis of the study which is that in the group receiving the intervention with usual training at Civil Services Academy a reduction in prevalence of psychological distress and increase in coping skills will be seen as compared to the group receiving usual training only.

The secondary hypotheses are that in the group receiving the intervention along with usual training, there will be an improvement in psychological well-being, coping skills, and psychological capital compared to the group undergoing usual training only.

In the following Chapters, I will describe the methodology adopted to meet the objectives of the study and test the hypotheses. Chapter 4 concerns the development of the intervention for the study population. This is followed by Chapters 5 which describe the methodology used for evaluation of the adapted intervention.

Chapter 4: Intervention development and adaptation

دل ناداں تجھے ہوا کیا ہے
آخر اس درد کی دوا کیا ہے

Translation
O silly heart of mine, what happened to you
What is, after all, the end to your misery

Ghalib, Classic Urdu poet

I lied and said I was busy.
I was busy;
but not in a way most people understand.
I was busy taking deeper breaths.
I was busy silencing irrational thoughts.
I was busy calming a racing heart.
I was busy telling myself I am okay.
Sometimes, this is my busy -
and I will not apologize for it.

Brittin Oakman

Chapter 4: Intervention development and adaptation

The scoping literature review in Chapter 2 showed that there is no off-the-shelf psychological intervention available for the target population for this study - the trainee civil servants of Pakistan undergoing a six-months induction training Common Training Programme (CTP), which is held annually at the Civil Services Academy (CSA), Lahore. However, based upon stakeholder consultations, I was able to identify the Problem Management plus (PM+) as a suitable evidence-based psychological intervention to be considered. One of the major strengths of this intervention is that it has been successfully adapted for different population groups including those in non-western societies (Rahman, Hamdani, et al., 2016).

Although PM+ has been earlier adapted for various target populations around the world including a group of entrepreneurs in KPK Province, Pakistan. (Saraf, 2019) the specific cultural, socio-political and professional context of the population of the current study was markedly different from the populations which had earlier received it. Therefore, it was important to develop and adapt the intervention for this target population

In this Chapter, the adaptations in this psychological intervention for its effective implementation in trainee civil servants of Pakistan will be described. I will also discuss the rationale behind these adaptations. But first I will briefly dwell upon the need to adapt such interventions and how it can be done,

Why adapt?

There are variations in mental health across different cultures and its relations to the individual's way of life, values and world views (Fernando & Weerackody, 2009). In this connection, the role of 'Expectations' and 'attitudes' in the definition of "illness" needs to be taken into account. Therefore, an appreciation of the role of culture is needed to understand the confluence of social and biological factors behind the development and expression of illness (Barnes et al., 2002; Piccinelli et al., 1997; Wilson et al., 2007).

Culture is usually defined in literature as the "world views and ways of life pertinent to a group of people" (Baldwin & Lindsley, 1994). Over the years it being seen as a set of flexible, continuously developing and dynamic system of values and world views instead of merely a closed system of traditions (Fernando, 2004).

One definition which attempts to capture the various elements of culture terms it as "a socially transmitted or socially constructed constellation consisting of practices, competences, ideas, schemas, symbols, values, norms, institutions, goals, constitutive roles, artifacts, and modification of the physical environment" (Fiske, 2002). The definition encompasses observable entities like patterns of behaviours, cultural symbols and artifacts as well as cognitive entities like shared beliefs and norms (Barrera Jr et al., 2013).

Culture influences the health of the community through cognitive beliefs about bodily functions and disease processes as well as ideas about possible treatments. Understanding the culture entails an awareness of the individuals' norms "collectively being created in the here-and-now, in the context of the here-and-now" (Fernando, 2004).

What is Cultural adaptation?

Different terms have been used in research methodology while considering culture in the process of developing psychological interventions. These include 'cultural sensitivity', 'culturally appropriate', 'cultural adaptation' and 'cultural competence'. The common denominator is that all of these terms take into account linguistic and cultural factors while carrying out development of psychosocial interventions (Bernal & Sáez-Santiago, 2006). "Culturally sensitive research" essentially refers to the understanding of the importance of acknowledging the cultural context throughout the different phases of the scientific process (Malgady et al., 1990).

All psychological interventions are developed in specific cultural contexts and therefore, can not be "One size fits all" by nature to be applied universally to all cultural groups without any change (Pendersen & Hensen, 2003) highlighted that as all behaviour is learned within a cultural context; an effective intervention cannot ignore the cultural context of the patient. Several meta-analyses have also confirmed the greater effectiveness of culturally adapted psychological interventions in comparison with those which have not undergone the cultural adaption process (Benish et al., 2011; Griner & Smith, 2006). One study found that interventions delivered in patient's mother tongue were twice as effective than those delivered in English (Griner & Smith, 2006).

Cultural adaptation process, on one hand, tries to uphold the fidelity to the evidence-based intervention and on the other hand incorporates elements of culture to make the intervention more acceptable and effective as well as contextually and culturally relevant and meaningful for the target

group. (Barrera Jr et al., 2013; Bernal, Bonilla, & Bellido, 1995; Chowdhary et al., 2014; Falicov, 2009). The generally accepted definition of cultural adaptations is: "The systematic modification of an evidence-based treatment (EBT) or intervention protocol to consider language, culture, and context in such a way that it is compatible with the client's cultural patterns, meanings, and values" (Bernal et al., 2009).

Adaptation is basically a compromise between two extremes. On one side is the so-called "universal" or "top-down" approach which considers the original evidence-based intervention applicable to all sub-cultural groups and on the other is the "culture-specific" or "bottom-up" approach which calls for having separate interventions for each particular sub-cultural group (Falicov, 2009).

Cultural adaptation of the interventions is an ethical responsibility of the researcher as it reduces the risk of interventions or treatments intruding or transgressing individual cultural values and norms (Bernal et al., 1995). Implementing intervention without cultural adaptation could lead to unintended harmful practices and distrust in medical care (Cabassa & Baumann, 2013).

Issues in cultural adaptations of interventions

Washington & McLoyd (1982) identified various aspects of the intervention as important for ensuring external validity or generalization in research particularly involving ethnic minorities (Washington & McLoyd, 1982). These are classified as cultural, interpretative, population, ecological and construct validity. "Cultural validity" identifies specific "rules" which have an influence on the behaviours of individuals, groups or systems. "Interpretative validity" takes into account the influence of the motivation, background, goal and the methods adopted for achieving these goals on the individuals' action. "Population validity" considers the extent of generalization possible from studying a small sample of the population. "Ecological validity" takes into account the similarity of the investigator's and the participant's environmental perspective. "Construct validity" encompasses all the different type of validities described above (Bernal & Sáez-Santiago, 2006).

Methods for culturally adapting psychosocial interventions

Researchers have developed numerous models for cultural adaptation of interventions which all in one way or the other provide a systematic view of the process and cover the design implementation and evaluation framework. In this section I will discuss some of these models.

Process Model of Cultural Adaptation (Rodriguez, Baumann, & Schwartz, 2011)

This model for conducting the cultural adaptation comprises of three phases as well as ten specific target areas and is summarised in the following table. Within each phase of the process, there are elements of evaluation, revision and re-invention (Rodriguez et al., 2011).

Table 7: Three Phased Process Model of Cultural Adaptation (Domenech-Rodriguez & Weiling, 2004)

First Phase	Revision phase: Collection of information on the needs and interests of the target population. At the same time, establishing a double track communication with key stakeholders in the target population.
Second phase	Evaluation
Third Phase	Re-invention: Using the observations made and the data collected in the previous phases to develop a new intervention.

(Bernal et al., 1995) Framework of Cultural adaptation

The most popular adaptation model is known as the "Ecological Validity Model (EVM)" or the "Bernal's framework" (Bernal et al., 1995). This model developed in a study on Latin Americans proposes eight dimensions of psychosocial interventions to be considered when culturally adapting them. These dimensions are language, persons, metaphors, content, concepts, goals, methods and context. The framework identifies changes in the surface as well as deep structures of the intervention. The surface dimension matches the interventions content and messages to observable social and cultural behaviour whereas the deep dimension relates to the effective social, cultural and historical environments on health behaviour. (Bernal et al., 2009; Resnicow et al., 2000).

The Bernal framework provides a template for adaptation of psychological interventions and making them culturally sensitive (Bernal & Sáez-Santiago, 2006). It is a systematic approach for anchoring and "culturally cantering" these interventions and making them externally valid. The eight dimensions to be considered while adapting interventions are described in the table below.

Table 8: Dimensions for Culturally Adapting Psychosocial Intervention for Hispanics (Bernal et al., 1995)

Dimensions	Description
Language	Adapting language which is appropriate in the cultural context
Persons	Establishing relationship between the target population and the deliverers of the intervention while taking into account the differences and similarities of ethnicity and culture
Metaphors	Reframing the concepts based upon the culture of the target population
Content	Revising the content to make it appropriate in terms of the culture of the target population
Concepts	Ensuring that the concepts introduced are compatible with the culture of the target population
Goals	Revising the goals of the intervention taking into account the culture
Methods	The methods as well as procedures used in the intervention should be culturally appropriate
Context	Taking into account the specific circumstances related to society, psychology, politics or economy of the target population

(Barrera & Castro, 2006) Framework or the Heuristic framework of cultural adaptation

This model was developed during a trial on evaluating the effectiveness of culturally adapted interventions in the context of engagement of the participants (Barrera Jr & Castro, 2006). It provides a

process which allows the integration of all the dimensions of the "Ecological Validity Model" in an operational and systematic way. The table below summarises the model.

Table 9: Order of Investigations in Cultural Adaptations (Barrera Jr et al., 2013)

Order of investigation	**Methods**
Information gathering	Carrying out detailed review of the literature and consultations with focus groups
Preliminary adaptation	Modification of the intervention based upon data collected in the earlier stage
Testing the adapted intervention	Pilot trial
Refinement of adaptations	Evaluating the culturally adapted intervention qualitatively and quantitatively

This approach aims to provide for an integrated methodology for cultural adaptation of interventions combining a top down as well as bottom down approach. The four-stage sequence of cultural adaptation of the intervention starts with the "top-down elements" and passes it through scrutiny and analysis by the target population as well as members of the specific cultural group members incorporating a bottom-up approach as well ultimately resulting in an adapted version which can be evaluated through further quantitative and qualitative studies (Barrera Jr et al., 2013).

DIME (Design, Implementation, Monitoring, and Evaluation) model

It is a relatively recent model, developed by the Applied Mental Health Research (AMHR) Group in 2000. The DIME model comprises of a series of activities combining evidence-based programming, monitoring and evaluation of the intervention. The model aims the provision of a rational basis for local programming and generating data for future adaptations. The manual comprises of 6 modules which result in a comprehensive road map for cultural adaptation based upon qualitative participatory techniques and involvement of experts along with community members (APHR, 2013). However, this methodology is time consuming and labour intensive and therefore, was considered impractical for the purposes of this study. I did, on the other hand, cover the different elements of the model in my own framework for adaptation.

Cultural adaptation of PM+ for trainee civil servants in Pakistan

Understanding the process of development of the intervention and its specific nature would inform others interested in tailoring this or other interventions to other specific cultural populations. Therefore, I undertook to document the process of adaptation of PM+ intervention for trainee civil servants as faithfully as possible. This could assist future researchers in adapting this or similar psychological interventions for other groups of civil servants or other populations in Pakistan and elsewhere. Developing this resource is an important outcome of this study.

I used the four steps of (Barrera Jr & Castro, 2006) Framework to develop a process to culturally adapt the intervention for use in CSA in line with the Bernal Framework. The adaptation also covered the main elements of the DIME methodology. However, the processes were adapted in accordance with the specific requirements of the target population and the study as seen in the following table.

Table 10: A four-step process to adapt PM+ in CSA

Steps	Description	Tools	Process
Step 1: Information gathering	Gathering relevant pre-existing Collecting information (e.g., demographic and socio-economic characteristics, coping mechanisms)	Desk review	Literature Review Discussions with a senior civil servant with training experience at CSA
Step 2: Revision of material	Revise PM+ protocols to identify components for adaptation based on the Ecological Validity Model.	Eight-dimension matrix of the Ecological Validity Model	Manuals were highlighted for further discussions
Step 3: Stakeholder consultations	Develop a discussion guide based on Step 2 and use it to interview local specialists, community members and implementers to elaborate and/or validate previous findings.	To and Training Manuals was used as a Discussion guide	Read through Workshop with a group of senior civil servants with training experience at CSA, psychologists CSA faculty and junior civil servants who have recently graduated from CSA and not part of the study and Training of Trainers workshops in which mock workshops were held
Step 4: External evaluation	Evaluation of the intervention by two independent experts with a focus on the extent to which it has been able to incorporate the cultural context of the target population		A senior clinical psychologist and a senior civil servant who had formerly taught in the CSA faculty

Step 1 Desk Review

In the first stage of development of the intervention, a rapid desk review was undertaken. This covered peer-reviewed as well as grey literature like news articles, non-governmental and governmental reports etc. Information on the demography, socioeconomic status, culture and general and mental health of the intervention population was gathered, following the outline developed in studies by the WHO and the United Nations Refugee Agency (WHO, 2012, Greene et al 2017). This approach allows for a quick, efficient and comprehensive review.

The desk review began with an overview of the socioeconomic status of the target population, the existing mental health and psychological support available as well as the barriers to accessing mental health care. The study was conducted at Civil Service Academy (CSA), Lahore, Pakistan, a residential training institution which provides an induction training called the Common Training Programme (CTP) to newly selected civil servants belonging to all twelve occupational groups of the Central Superior Services (CSS) of Pakistan. As of 2018, there were a total of 6,395 employees working in Basic Scales 17 to 22 in 14 occupational groups in Federal Government of Pakistan. It may be noted that two of these groups OMG and Secretariat group have been merged and Economist group does not do CTP. Hence, there are 12 groups in CTP.

Among these occupational groups Inland Revenue Service is the largest group followed by Pakistan Administrative Service, Police Service of Pakistan, Pakistan Audit & Accounts Service and others as shown in the bar chart below. Of these, there are 1139 female employees in total (about18%).

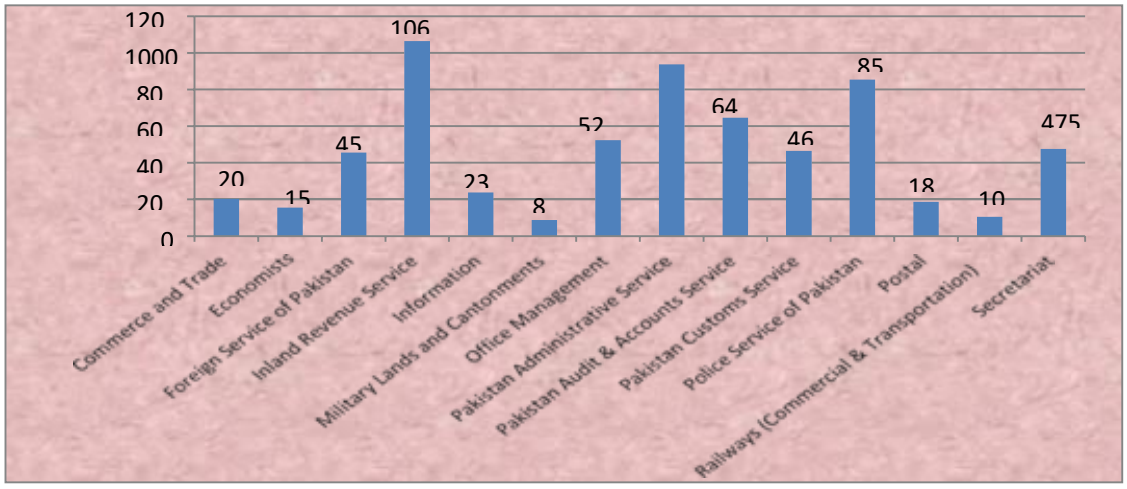


Figure - Occupational Groups of the civil service of Pakistan. Source Establishment Division, Government of Pakistan

Brief History of the Civil services of Pakistan

The Civil Servants Act, 1973 defines civil servant as" a person who is a member of an All-Pakistan Service or of a civil service of the Federation, or who holds a civil post in connection with the affairs of the Federation".

Pakistan's civil bureaucracy traces its history to the prestigious Indian Civil Service, the so called 'steel frame' of British colonial rule in India. Addressing the British Parliament in 1922, Lloyd George had famously said," If you take that steel frame out of the fabric, it would collapse". There is one institution we will not cripple, there is one institution we will not deprive of its functions or of its privileges; and that is the British Civil Service of India' (Jones, 1997).

Right from the beginning, the expectations of the nation from the civil bureaucracy were high. The civil service considered itself to be the flag bearer and touchstone of national interests and saw certain privileges and authorities as a matter of right. They were seen as a national institution which would provide continuity of governance and public service. The founder of Pakistan and its first head of state Quaid-e-Azam Muhammad Ali Jinnah in his address to Gazetted Officers in Chittagong in March 1948, called upon them to ignore their affiliations to their community, caste or creed and consider themselves "the servants of Pakistan" (Sayeed, 1958). He warned: "You are not of the dominant class; you are of the servants. Make people feel you are their servants and mates, uphold the highest level of honesty, dignity, equality and fair play". In another informal chat in Peshawar in April 1948, he urged civil officers to "Do your work, courageously and sincerely, as servants to the people and the government. Governments are

created, governments are destroyed, prime ministers are coming and going, ministers are coming and going, but you are holding on, and so there is a very big responsibility on your hands" (Majid et al., 2020).

In the formative years of Pakistan, civil servants arguably played an even more important role than during the British rule. Three out of the first four provincial governors were from the civil service and two of them presided over cabinet meetings (Sayeed, 1958). One reason for this could be that while the elected arms of the state suffered a major disruption in the turmoil of the partition, the bureaucratic and the military organs were able to retain their institutional structure (Jalal, 1990). The early bureaucracy was appreciated for standing "when other segments of society faltered and collapsed…. conduct(ing) the business of government and … help(ing) to forge a new state" (Ohiorhenuan, 1978).

The bureaucratic elite exploited the vacuum of political leadership in the wake of Quaid's death in 1948 and Liaqat Ali Khan assassination in 1951 and took over the reins of the state. A civil servant Ghulam Muhammad stepped in as Governor General and paved way for fellow civil servants Ch. Muhammad Ali, Bogra and Sikandar Mirza, as Prime Ministers. The sixties saw the civilian bureaucracy and the army gradually dominating the evolving structure of the state at the expense of elected politicians (Sayeed, 1958). The military bureaucracy co-opted the "overdeveloped" civil bureaucracy (Alavi, 1972) resulting in a military-bureaucratic oligarchy" which worked together to further "depoliticise Pakistani society" thus impeding political development (Jalal, 1990). Under the militancy regime headed by Ayub Khan, the two most modern institutions of the country, the bureaucracy and the military, set her on course on a path of development, but perhaps also on a path which eventually led from one military rule to another (Akbar, 2005).

The bureaucracy by its attitude as well as actions aggravated the frictions between the East and West Pakistan starting with the early declaration of Urdu as national language, issues of resource distribution and a marked imbalance in representation of the two wings in the higher bureaucracy (Kennedy, 1987). Despite the quota system being in place as early as 1950, Bengalis, who were 54 per cent of the population, were no more than one-third the total strength of the CSP in 1965 (Braibanti, 1966).

The reforms of the bureaucracy undertaken in 1973 by Bhutto attempted a significant overhaul of the structure of the civil bureaucracy by removing constitutional protections to the civil bureaucracy, which supposedly insulated it from political interference. At the same time, the erstwhile Civil Services of Pakistan who were the proud descendants of the colonial Indian Civil Service was dismantled. This

resulted in amalgamation of the small 500 strong elite cadre with other service groups by abolishing a separate entry point for them. The well-knit hierarchy of the CSP cadre was further broken down by Zia-ul-Haq who promoted lateral entry as well as vertical and horizontal movements between the service groups (Shafqat, 1999). These reforms did enhance political control on the civil service besides taking away its insulation and exclusivity and shattered its internal cohesion. However, they still left the overly elaborate, non-transparent and discretionary processes and procedures of bureaucratic conduct very much intact (Aly, 2007).

Later, Musharraf's local government system attempted to make bureaucracy accountable to the elected heads of local governments (Cheema, 2005) Under the political governments since 2007, the civil service made a comeback of sorts but fears of uncertain accountability and job insecurity continue to haunt it.

Major issues in the civil service of Pakistan

The desk review identified some of the major issues facing the Civil Service of Pakistan today as they relate to this study.

Elitism and self-image

Although salaried employees, civil servants in Pakistan are similar to entrepreneurs in the sense that they tend to consider themselves personally responsible for the successes of their organizations identify strongly with their work more strongly, and work harder and longer than ordinary salaried employees (Parasuraman & Simmers, 2001). Like entrepreneurs, they feel indispensable and work long hours even over the weekends at times (Bradley & Roberts, 2004). Similarly, there is tendency to not differentiate their work lives from their family and social lives (Parasuraman & Simmers, 2001).

Civil servants of Pakistan also have an exalted self-image of being leaders of society (Rokach, 2014) conclude that individuals in leadership positions, be it in education, government or business, display a greater vulnerability to stress, alienation, loneliness, and emotional turmoil. These factors could subsequently manifest in health problems, adverse social and familial relationships and low productivity. Role ambiguity, role conflict, workload- all of which are considered as job stressors and have been associated with an increased incidence of CMDS in workplaces (Fox et al., 2001) are common for Pakistani civil servants.

Pakistan's civil services inherit the glorious imperial traditions of Indian Civil Service officers who were expected to live exemplary lives aloof from the masses while maintaining a constructive working relationship with them (Jones, 1997). This behaviour was aptly captured by former President Ayub as creating “a superior class of somewhat denationalised individuals who could maintain proper distances and rule with awe and disdain under the cover of public service” (Khan, 1961). Scholars describe it as a "souring pyramid" with a "refinement of calculated gradation" incorporating "both the Hindu caste system and the English class system" (Jones, 1997).

Detractors of the CSP call this detachment “aloofness” and “snobbery”. But others considered this as an essential posture for “whoever wields power in Pakistan”. The need for the official to be physically detached from parochial loyalties and to adhere to an abstract, impersonal notion of equity was stressed. In fact, he was urged to “exaggerate the drama of his detachment” (Braibanti, 1966). Authors like (Shafqat, 1999) justify the insulation of bureaucracy and its somewhat elitist character in the interest of objectivity and neutrality. However, others like Braibanti (1966) criticise the “exaggerated notion of detachment” of the civil services as being remote disconnected and divorced from objective realities of the population, it is meant to serve. The remoteness of Pakistani public bureaucracy from the public is rooted in its original setting up by colonial masters, whose objective was to rule and not to serve. After the creation of Pakistan, this metamorphosis from being a ‘steel frame’ of ruling elite to a genuine ‘public service’ organ for ameliorating the masses never really came to pass (Ohiorhenuan, 1978).

However, the years did see a change in socio-economic profile of the civil services in Pakistan. This was the result of urbanisation, greater availability of higher education opportunities and political populism. About 70 percent of the entrants to the civil service in the early days belonged to the middle-class while 25 percent were from the upper or owning families (Braibanti, 1966). By 1987-97, 88 percent of the entrants were from the middle class and only 4 percent belonged to the upper or land-owning class. The Civil Services of Pakistan were now older in age, had more diverse education and belonged to mostly the middle class (Kennedy, 1987). Over the years, new entrants to the civil services of Pakistan are more politicised, practical and adaptable then before and many of them can be termed as “the elites of merit, achievement and excellence” (Shafqat, 1999). Still, they continue to be conscious of being members of an “elite governmental club”. This cohesion, organisational capacity for continuity of policies, and maintaining a semblance of stability continue to be the distinguishing features of the Civil Service of Pakistani bureaucracy and result.

Representative character

Provincial and Regional quotas originally prescribed in 1973 and reviewed a number of times since then allocate only 7.5% of the total seats on the basis of merit. Rest of the induction posts are distributed among the provinces on the basis of their population 50% to the Punjab, 19% to Sindh (with sub-allocation of 60:40 between Urban and Rural Areas), 11.5% to KPK, 6% to Baluchistan province, 4% to Northern Areas and FATA and 2% to AJK. 10% of each provincial quota is reserved for women. The quota system has been quite effective in ensuring a regional diversity of the civil bureaucracy, though complaints of under representation in the higher echelons of bureaucracy persist (Aly, 2007). Moreover, the representation granted to social and regional groups through quotas etc. called passive representation does not necessarily translate into the ability to actually represent these groups i.e., active representation.

Status of civil service in society and polity

The pervasive control of the civil services of Pakistan on all activities carried out by the government is noteworthy. For example, Pakistan Administrative Service (PAS) control 80% of the state land and the price of land set by 'deputy commissioner' is still a benchmark across the country. The other 20% is controlled by the military but regulated by another civil service occupational group, the Military Lands & Cantonments group. Law and order is theoretically under the authority of the provinces but supervised by the federal Police Services of Pakistan (PSP). Other occupational groups have their own exclusive domains of statecraft like foreign affairs Foreign Service Pakistan (FSP), revenue collection (Pakistan Customs and Inland Revenue Services) and financial control (the Pakistan Audit & Accounts Service).

Over the years, the economic and financial incentives of bureaucrats have eroded. A study comparing the emoluments of civil servants with the private sector by World Bank (1998) found the financial package of a senior federal secretary to be half of a Managing Director in a domestic corporation. This disparity leads to low morale, poor performance and encourages corruption and has had a negative effect on service delivery and bureaucracy's ability to act as a national institution and to attract talent.

The process of selection of new entrants to the civil service begins with the CSS exams which is conducted by the Federal Public Service Commission (FPSC) annually. The nine-member FPSC in 2018 was headed by a chairman from PAS who had joined through lateral entry from the military and included six former officers of the PAS, two retired FSP officers and a retired Major General. The FPSC members

also interview the candidates who pass the written examination. The written examination carries 1,200 out of the maximum of 1,500 marks of the process. The success rate of the CSS exam has dwindled over the years as can be seen in the table below:

Table 11: The success rate of the CSS exam

Year	Total candidates	Finally qualified	Pass percentage
2011	9063	786	8.6
2012	10066	788	7.8
2013	11406	220	1.94
2014	13169	377	2.86
2015	12176	376	3.11
2016	9643	202	2.09

Source : Federal Public Service Commission

In the nationwide CSS examination held in 2017, out of the 9391 candidates who appeared in the written test, only 312 passed .310 Candidates finally qualified after the interviews and out of these 261 candidates were recommended for appointment (155 males and 106 females). This resulted in a pass percentage of a mere 3.30 % (Siddiqi, 2017). Some commentators see this failure rate as verifying the perception of the whole process being “an elitist, forbidden exercise” while others would argue that it is a merit-based system providing equal opportunities to all the classes of the society.

Studies on the motivation of officers joining the civil services in Pakistan make a disappointing read. The general perception is that the historic motivations of "power, prestige and job security” for adapting the civil service as a career had nosedived as a result of various half-hearted reforms. A study on the motivations of new entrants of the civil servant brings out a gloomy picture. It identified these motivations to be a misperceived view of the status of the civil service as compared to the past, unemployment, corruption and nepotism (Wilder, 2009).

Diminishing powers

The supposed decline in bureaucratic conduct is to be seen in the context of its historical colonial legacy and the changes in the society and politics in Pakistan over the past thirty years. Most of the civil service reforms conducted over these years have been somewhat of a disappointment. The 1973 reforms of Bhutto aimed to rebuild by destroying ancient things "grown false and idolatrous" and did somewhat succeed in "bending the steel frame" (Jones, 1997). Musharraf's local government system made bureaucracy at the local level accountable to the elected heads of local governments with the military abandoning the bureaucratic control model and assigning wide ranging functional responsibilities and resources to locally elected politicians (Cheema, 2005). Serving and retired bureaucrats strongly criticised these developments saying that, "the civil servants at the service delivery level have been overly politicised, while policy planning at the federal level is left to the least sensitised and lesser intellects."

However, the CSP/DMG renamed as the PAS group seems to have risen from the ashes. In many ways, the civil service reforms of 1973 and Musharraf's only resulted in a nomenclatural change (Jones, 1997 Cheema, 2005). The bureaucracy although less coherent as institution than the pre-1970 period, retains a bloated sense of elitism and has at times benefited from the elite capture rather than being a force for accountability, impartiality and good governance.

Fissures and conflicts

Several fissures plague the civil services of Pakistan. The foremost is the debate between central and provincial bureaucracies. The British felt that responsible government would not function successfully if "the steel frame of the services" secure in rights and privileges, and used to an atmosphere of prestige and unquestioned obedience, was not beyond the control of the local ministers. The successors of the British rule in Pakistan followed the same thinking.

The role of bureaucracy, repeated martial laws, feudal structure and the vacuum of political leadership results in the reluctance of the federal government to delegate powers to provinces fearing the weakening of its administrative, political and financial control over decision making on issues of larger national interest. The federal civil service considers itself a vehicle for national integration, in an ethnically plural society. This is contrary to the doctrinal basis of federal system that a strong central government should control only broad, national policy, and operational aspects should reside with the provinces. This approach has resulted in an ensuing tension between the Provincial and central bureaucracies.

Then there are inter service rivalries. The 1973 Administrative reforms integrated the different federal services in order to provide for equal pay scales for all the occupation groups but did not follow up with uniform career opportunities and promotional prospects. This has led to a simmering rivalry between different occupational groups. Each occupational group has complaints from the others at times affecting their ability to serve the public as a cohesive unit.

Another area of debate is the choice between generalists and specialists. Technical experts in fields like agriculture, health, engineering, education, forests, etc. complain against the dominance of the Macaulayan generalists. Experts feel that with the modern demands of these professions require specialisation and management cannot be divorced from the specialised nature of their assignments. This is a major debate in civil service reform proposals.

Training of civil service of Pakistan

Officers from all federal occupational groups undergo compulsory residential training at Civil Services Academy (CSA) Lahore, which is called “Common Training Programme" of about 9 months before going to their respective specialised training institutes. In the CSA, trainees coming from various parts of the country are encouraged to socially integrate. One reflection of this is the way the academy allocates rooms in the residential hostels and forms syndicates for study. Many participants of the CTP reflect on the training programme as their first chance to see the cultural and linguistic diversity of Pakistan. This results in developing an esprit de corps in spite of different backgrounds. After CTP, each occupational group gets specialised training related to their own jobs prior to entering the field.

The experience in the Academy sometimes results in marriages between participants. Female officers have shown preferences for marrying from within the civil service. One interviewee explained this by saying “it is otherwise difficult to find a husband who would accept his wife having a more prestigious job than his”. This is interesting as it shows that service identity assumes priority over ethnic, regional or caste identities.

Conclusions of the desk review

Our desk review highlighted the key structural changes in the civil service of Pakistan as well as in the Pakistani society and politics which have affected the character of the civil bureaucracy over the years and need to be considered in the development of the intervention. These are briefly as follows:

- The bureaucracy, although less coherent institutionally as compared to the 1960s, retains a bloated sense of elitism and has at times benefited from the elite capture rather than being a force for accountability, impartiality and good governance.
- The internal cohesion of Pakistan's bureaucracy has declined, as a result of the erosion of informal networks after 1973.
- The political environment in the Zia and Musharraf periods encouraged an extended but fragmented clientele's network.
- Civil servants in Pakistan in some ways are similar to entrepreneurs and unlike salaried employees as they typically strongly identify with their job, work harder and longer and have a tendency to not differentiate between their work and family/social lives.
- Role ambiguity, role conflict, workload- all of which are considered as job stressors are common for Pakistani civil servants.
- The erosion of the economic and financial incentives has led to low morale, poor performance and a negative effect on service delivery and civil services ability to attract talent.
- The half-hearted attempts at reforms have resulted in the study population being disillusioned and uncertain about their future, despite retaining a sense of elitism and being entrenched in the elite capture of the state.

Step 2 Revision of material

The researcher, himself a civil servant, went through the manual of PM+ along with a senior civil servant from IRS who had experience of teaching at CSA covering the eight dimensions of the proposed adaptations under the Bernal framework. This resulted in a basic amended structure which reflected the requirements and expectations of trainee civil servants for such an intervention.

One major decision taken at this stage was to rename the intervention as psychosocial skills development workshop. The stigma attached to stress and psychological and mental health issues meant that it might not be acceptable if it was presented as a mental health intervention. Similarly, the therapy sessions are called "Training workshops" and the delivery agents, "trainers and facilitators". The necessity for this adaptation was further verified by the extensive stakeholder consultations. Other adaptations made will be described in detail later in this chapter in the context of the different dimensions of the Bernal Framework.

Step 3 Extensive Stakeholder engagement

Consultations were held with a diverse group of stakeholders including the CSA administration and faculty, recently graduated officers of CSA and civil service officers in the field. I also consulted a number of junior civil servants who were not part of the study. We also included prospective trainers and co-facilitators in the consultations. This was a group of 12 people (male and female) including were members of the CSA faculty as well as civil servants from the outside the faculty. Table 20 provides an overview of their profiles. The workshops included stakeholders who had some interest on involvement in the mental health of civil servants. The diversity of the stakeholders made sure that a variety of views were incorporated. The researcher took notes of the discussions and organized them according to the various themes discussed. However, there was no rigorous qualitative or participatory methodological approach applied which was weakness of the adaptation process.

This was a major challenge of conducting a research study in real life settings. Applying rigorous qualitative methodology would not be possible within the scope of this PhD study and the complete process of development of an intervention and its evaluation through a randomized control trial could not have been completed. The completion of the process was important in order to gain the support of the stakeholders particularly the administration and faculty of the Civil Service Academy. They only supported the whole study as a part of the study these workshops were being run in the Civil Service Academy.

The results of the consultation workshops were recorded by me as well as audio-recorded. I undertook a rudimentary analysis by identifying the important themes which were discussed in the stakeholder consultations. However, the study was limited as it did not use a specific qualitative or participatory methodological approach. If we had adopted a rigorous methodological method, we might not be able to conduct the intervention and complete a randomized control trial within the parameters of this PhD. The conduct of the intervention was important for ensuring the support of the participants and the CSA faculty for the whole project. In case we have just completed a rigorous qualitative study, we might not have gotten the support that we were able to get. While the absence of such a rigorous approach was necessitated by the real-life settings in the academic and evaluative environment, it was a major limitation of the study.

Apart from the trainers and facilitators, consultations were held with members of the faculty who were not involved directly in the training of the intervention like those involved in the administrative

affairs of the CSA. In addition to this, I had involved some former members of the faculty and recent graduates of CSA. There was a variety of age groups involved as those recently graduated from CSA were closer to the age group of the participants while most of the faculty had 5 to 15 years of work experience. We were mindful that some of the ideas of the stakeholders would be outdated and clouded by their own relationship with the participants. However, since we had the benefit of having a diverse group, we were able to avoid the limitations on account of these power relationships. Another important aspect which I have highlighted at various points in this thesis is that the civil service views mental health issues through their effects on their lives and careers. There is a strong belief that somehow more stress is essential for motivating the civil servants. However, there is also an understanding that undue stress could affect their performance. There was a strong element of "machoism" (irrespective of the gender) in the civil servants which resulted in their inclination to "push ahead" despite mental health difficulties and workplace stress. Civil servants were inclined to pushing such mental health issues under the carpet because of the stigma associated with them and the self-image of the civil servants. This was a major challenge which we needed to overcome.

First of all, a presentation was made to the management and faculty of CSA to discuss the possibility of holding some kind of psychosocial intervention during the regular CTP. We highlighted the importance of dealing with various of forms of stress and mental health, in the Civil Services of Pakistan. A number of possible psychosocial interventions which could be used for dealing with these issues including the PM+ intervention was discussed. Discussions with stakeholders verified the conclusion of the scoping review regarding its suitability for this population.

This helped in enhancing the acceptability of the intervention besides providing input for the adaptation.

This was followed by an on-site read through workshop with key stakeholders and trainers. The stakeholders consisted of CSA faculty and some civil servants who had recently graduated from CTP. The faculty had the experience of dealing with various groups of civil servants in a training setting as the CTP is held annually and was therefore able to anticipate the possible reactions to various aspects of the intervention. The recent CSA graduates were in a position to assuage the feelings and reactions of the junior civil servants. In all these interactions stakeholders were encouraged to question and suggest adaptations. By this process I were also able to get their support for the conduct of the workshops and gain the confidence and respect of the trainers/facilitators so that they take the process seriously.

Consultations in the Training of trainer's process

The training of trainers' sessions also provided an opportunity to discuss the adaptations. The prospective trainers/facilitators comprised of civil servants as well as members of faculty and civil servants from the outside the faculty and a number of young psychologists of the newly recruited civil servants peer age group. The process began with a two-day workshop including simulation exercises and role play and discussions on the effectiveness of the intervention as well as useful adaptations.

A session just before each workshop was also held with trainers/facilitators to review the learning and retention of the concepts as well as to brief them on the particular workshop being conducted that day and reflect upon the changes required. After the workshops, all trainers/ facilitators and the CSA management gathered for feedback, preparation for the next sessions and dissemination of the lessons learnt. At this stage, the reactions of the trainers/facilitators were fresh and they were able to recall all the lessons that they had just learnt and the difficulties faced. Throughout the process, the trainers were encouraged to relate their own experiences or present relevant ideas within the framework of the workshops.

Since it was a group of 15 to 20 people, there was diversity of views and at times the ideas presented by one trainer was rejected by others. The group worked on a consensus basis and only ideas with majority support were used in the adaptation process.

WhatsApp group

A WhatsApp group among the faculty and trainers/facilitators was also formed to generate and discuss ideas for adaptations.

Written comments

At the end of the training of trainers, trainers/facilitators were given opportunity to give their views in writing in case they felt that they have not had enough time for discussion in the sessions or were more comfortable giving their opinions in writing.

Key results of consultations

In the consultation process, I asked a series of questions as seen in box which reflected the themes identified by the desk review and preliminary discussions. The purpose was to identify the challenges

being faced by the potential participants of the study, their perceptions of psychosocial skills, its effects and any successful or unsuccessful methods of dealing with stress being adopted by them in the past.

Box 2: Discussion points for stakeholder consultations

What are the psychosocial challenges faced by civil servants?

How do you see the effect of stress and mental health issues on civil servants?

Do you have any acquaintance in the services who show signs of stress or mental illness?

What are the methods you previously adopted for dealing with stress?

Which one of these strategies was unsuccessful or successful and why?

The stakeholders were a heterogeneous group, with a variety of backgrounds. But, the 'feeling of distress' on account of a challenging work environment was found to be common. They indicated an unrecognised burden of psychological distress. This also highlighted the need to develop intervention for trainee civil servants which incorporates components related to contextual challenges, family problems and personal wellbeing.

The four key themes that emerged from the consultations were the importance attached to dealing with stress, perceived causes of stress, its manifestations and its impact on civil servants and the strategies used by them to deal with stress. These themes are not mutually exclusive, rather they are interlinked with one leading to another.

Importance of the issue

Most of the participants were aware of mental health issues facing civil servants and realised the importance of having an intervention to address such issue. However, the reasons for supporting an intervention for mental health of civil servants were varied. Stakeholders realised that there was a human need for addressing the psycho-social issues resulting from work related stress. As one stakeholder said, "You are human beings *first". (CSA faculty member, female)*

I found a wide spread perception about the circumstances of the civil services being extremely stressful. As one participant said,

“Civil Servants are squeezed in stressful situations throughout”. (PAS officer, male)

Another said,

“They are stressed, because they come in direct contact of the public and their different problems and because their work load is higher”. (Police officer, male)

However, most of the participants believed in the capacity of the civil servants to deal with stress. The value of the intervention was acknowledged as a preventive measure. As one participant said that, *"It is good to share concerns early at this stage." (PAS officer, female)*

One significant reason for supporting having such workshops was the need to create awareness, in order to " pre-empt the issues, de-stigmatise mental health issues, build resilience and provide an opportunity for catharsis”. A participant of the training of trainers' workshop said that,

" You can’t overcome stress unless you are willing to do it. (CSA faculty member, female)

Another trainer said that,

"It is important to break the taboo; normalising the issues" (visiting trainer, male)

Another said

"Currently, there are no such workshops being conducted, so even if there are, their effectiveness is questionable" (CSA faculty member, male)

There were naysayers too who denied the need for such workshops saying

"Because stress in civil service is manageable on our own" (CSA faculty member, PAS officer, male)

While talking about the impact of stress, most of the participants talked about its implications for the life and career of civil servants. One participant said that,

"Yes, tragic incidents in near past, situational analysis, continued & recurring process and poor personal relationships can lead to stress.” (PAS officer, female)

Most of them related stress to their jobs like one said that,

"With power, comes a lot of responsibility and stress." (PAS officer, male)

Table 12: Results of consultations on importance of Mental Health for Civil Servants

Themes	Sub-themes	Examples
Importance of the issue	To create awareness	*You can't overcome stress unless you are willing to do it*
	To pre-empt the issues	*"It is good to share concerns early at this stage."*
	To de-stigmatize mental health issues	*You're human beings first*
		"It is important to break the taboo; normalizing the issues"
	To build resilience	*Civil Servants are squeezed in stressful situations throughout.*
		Because they come in direct contact of the public and public has different problems.
		Because their work load is higher.
	To provide an opportunity for catharsis	*"It is good to share concerns early at this stage."*
		"It is important to know we are not alone and have the chance to share the problems we face"

Perceived sources of stress

In the consultations, I found that the civil servants linked their stress with their issues related to their work as well as the way it impacts other aspects of their life. They saw political pressures, financial pressures and the difficulties in maintaining a work life balance as major sources of stress. One participant said that civil servants were "*Always dealing with new situations and fire-fighting".* Some blamed *"*the over-ambitious career competition among the civil servants" for rising stress and mental health issues.

Many of the participants of this study as well as the stakeholders were conscious of the social pressures on civil servants which led to stress. As one faculty member said, *junior civil servants are facing*

a considerable degree of peer pressure as well as pressure from the families at times unrealistic *expectations*. A major source of stress was said to be pressure from the society regarding their status and life style. Some junior civil servants highlighted the stress as a result of their change in lifestyle after entering the civil service and difficulties in adopting the change.

Other sources of stress identified were personal relationships, lack of work autonomy, financial incentives and security of tenure, possibility of displacement, judicial activism, media pressure and lack of appropriate training to deal with these situations, particularly, the lack of time management skills.

The discussions with trainee civil servants revealed major complaints against the training environment in the Civil Services Academy and blamed it for their stress. Some of the comments made by trainee civil servants during the consultations process which reflect this perception are reproduced below:

> *"CSA has a lot of stress – mental and physical." (PAS officer, female)*
> *"In the environment inside CSA, you are constantly under surveillance which is a major source of stress". (FSP officer, male)*
> *"CSA is an ideal recipe for depression." (Secretariat officer, male)*

While carrying out the consultations and subsequent intervention sessions, the trainers were careful not to get entangled in this debate and asked trainees to put aside their frustration with the training schedule or the administration of CSA. This was important to make them understand that the intervention was meant to provide them with tools which could be useful to them throughout their life and career and not just at CSA. On a more pragmatic note, they also discovered that allowing the junior civil servants to continue with their rants against CSA, would deprive them of the required support from the administration and faculty of CSA who were not used to such kind of criticism and felt that this would make it difficult for them to continue with the rest of the CTP.

The Table below summarises the results of the consultations regarding perceived sources of stress.

Table 13: Results of consultations on perceived causes of stress

Major perceived causes of Stress	Professional	Change of circumstances
		Loss of face
		Loss of belief in one's own capabilities
		Poor Time Management
		Scarcity of time
		Pre occupation with other issues
		A shortage of resources vs expectations
		Differences in the reality and the dream of the civil services viz-a-viz salary and power
		Competition with other powerful institutions
		Political pressures
		Not being able to achieve your professional dreams
		Damage to your ego
		Suspended in reality
		Inability to differentiate between mundane and policy issues
		Identity crises
		Loss in a dream world (when I was ---)
		Unrealistic targets
		Result of genetic pre disposition
		Absence of a coping mechanism
		Feeling of hopelessness within the system
		Over thinking
		Compromising on principles
		Work life imbalance
		Politicization of bureaucracy
	Social	Peer pressure
		Parents and families Pressure

		Association with a global phenomenon
		Breakup
		Depression of friend
		Adaptability issues
		Change of life style
	Family	Expectations of family members regarding finances and demands for time
		Family disputes
		Absence of support from family
	Lack of opportunities to develop skills	Lack of Technical skills
		Lack of time management Skills
		Poor financial management
		Poor psychosocial skills
		Poor soft skills (communication skills, inter personal skills)
	Issues with CSA	Morning PT
		Class after lunch
		Can't sleep early
		Long academic session
		Home sickness
	Problems specific to females	Discrimination in postings
		Peer pressure on marriage
		Household responsibilities

Perceptions of the manifestations of stress and mental health issues

The perceptions of the civil servants about stress were interesting. Most of them acknowledged it as a natural phenomenon. However, it was seen as an issue affecting the career and life conditions of the civil servants. Its impact on health was relatively undermined. Some participants did however note the uncomfortable and unpleasant feelings as a result of stress. There were not so forthcoming as to the physiological and physical aspects of stress like its effects on appetite, sleep, general health dark circles, dizziness, hair loss, laziness, premature ageing and head and neck ache.

Most of the participants agreed that the productivity and decision making of civil servants was being affected by stress. The effects of stress identified included impact on health behaviour and family. Some also mentioned that some officers were known to take out their frustrations on their family and this resulted in divorces and breakups. However most believed stress was not unsurmountable and some stress was desirable. One member of the faculty said that it *"depends upon officers - good officers cope better with stress and reach new heights".*

Most of them knew someone in the civil services who had shown signs of stress or mental illness. Some of the examples given as listed below were quite extreme while others rather mundane.

- *I have a PAS friend who can't give proper time to her kids (PAS officer, female)*
- *I know a junior officer who had divorce because of his career (faculty member, male)*
- *There was a police officer who got threatening letters after he refused to succumb to political pressure. He was subsequently transferred which resulted in mental health issues. (faculty member, male)*
- *A PAS officer who was AC in Giligit-Baltistan had to send his family back to his hometown due to life threats. (faculty member, female)*
- *An FIA investigator involved in a major case got killed resulting in great stress for the rest of the officers involved in the investigation (Police officer, male)*
- *One civil servant committed suicide due to work life pressures (numerous officers based upon newspaper reports)*
- *A civil servant got transferred multiple times because of not following the illegal orders of his superiors and as a result went through depression (faculty member, male)*
- *Lawyers in the District Court attacked a field officer. He was able to survive due to the timely intervention of police but was asked to go on long leave by his superiors. This damaged his mental health. (PAS officer, male)*
- *AC Sargodha was locked in her room for many hours because she could not get out as religious extremists had besieged her office (PAS officer, female).*

The following table summarises the results of the consultations regarding perceived manifestations of stress.

Table 14: Results of consultations on the manifestations of stress

Manifestation and impact of perceived distress	Professional	Decreased productivity, increased nervousness, lack of interest and concentration related to work issues
		Lack of clear decision making
		Generic response to conditions beyond routine
		Not capable of dealing with the challenges
	Health	effects on appetite
		sleep
		general health
		dark circles
		dizziness
		hair loss
		laziness
		early aging
		head and neck ache.
	Personal /Social	Brings out the worst in your personality
		Loss of composure
		Agitation in mood
		A disturbed diet or sleep
		Family issues
		Feeling out of place

Strategies used to deal with stress

A variety of strategies were used in the past by participants to deal with stress. These included social and religious activities and distraction by hobbies etc. Among the social strategies adopted by the participants to deal with stress, the most important was talking to friends and family. The trainee civil servants also realised the importance of sharing problems with others. As one participant said, "It is important to know we are not alone and have the chance to share the problems". (PAS officer, female)

However, most of them were apprehensive that such sharing with peers could lead to exploitation by friends or colleagues who were also competitors in the future. Others had used various hobbies and distractions to deal with stress like travelling, sports, food, listening to music, playing with pets, watching movies, or social media, swimming, shopping and other entertainment activities. One participant talked about highlighted her strategies to deal with such a situation as engaging in a different activity like going out with friends, going to the riverside or sleeping which made her successfully forgot what happened.

A number of participants found smoking to be useful stress buster as one said that, *" Smoking gives you a break from the routine and also allows you to socialize with others who smoke ". (PAS officer, male)*

There was an interesting use of social media as a tool to deal with stressful conditions. Not only is it an important source for information on mental health issues and distracting videos etc., one participant interestingly told that she felt relieved when she changed her status on Facebook.

Religion and spirituality were also an important tool for dealing with stress. These included, praying (Namaz), listening to inspirational talks, spirituality, meditation, yoga etc.

Talking about some of the unsuccessful and counter-productive strategies used for dealing with stressful conditions, participants identified the following

- *Thinking again & again*
- *Negative thoughts*
- *Sleeping pills*
- *Taking it out on your friends and siblings.*

When asked for suggestions for how to conduct psychological interventions for civil servants, the responses received included the following

- *Teaching should be less theoretical*
- *"Verbal workshops are not productive"*
- *It should include role playing with mock situations*
- *It should use more case studies*
- *One on one interactions with psychologists should be carried on*
- *Personalised mentoring and -one to one sessions should help*
- *There should be personalised counselling sessions for mentally vulnerable people counselling sessions should be made mandatory*
- *There should be regular screening or periodical assessment of civil servants for mental health. There should be frequent breaks*

As one trainer said, *"* based on observation, one thing that I am sure of is that the most difficult thing in life is to share and express concerns about small things that significantly deteriorate life functioning and relationships because taking help, guidance is usually associated with fear of stigmatization and prejudice specially in our society*"*. The table summarises the key findings of the strategies used by civil servants in the past stakeholder consultations.

Table 15: Results of consultations on the strategies used

Strategies used	Behavioural	Sleeping,
		Swimming,
		Inspirational talks
		Role play
		Case studies.
		Yoga, meditation
		Music
		Different kinds of hobbies, Pets
		Engaging in a different activity
	Social	Talking with friends, families,
		Watching movies, shopping and other entertainment.
		Travelling, sports, food, spirituality,
		Movies
		Smoking:
		Status change on Facebook
	Counter-productive	Thinking again & again
		Negative thoughts
		Sleeping pills

These discussions provided the basis for development of the training curriculum besides providing useful insights into the problems faced by trainee civil servants working in challenging settings.

Step four External evaluations

Following the stakeholder consultations process, external evaluation by experts was done to assess the extent to which the cultural adaptations made as a result of the earlier steps were satisfactory. I consulted a senior civil servant and a psychologist with considerable research experience of psychological interventions. The evaluation process also led to a number of additional recommendations. For example, it was suggested that real life case studies of civil servants may be used in the training manual and it should refer to women as well as men throughout the examples. The external evaluators also suggested to use examples from various occupational groups.

Details of the adaptations

I will now describe the adaptations made under each of the eight elements or dimensions of the Bernal framework undertaken to make the intervention externally valid (Bernal & Sáez-Santiago, 2006; Chowdhary et al., 2014).

Bernal framework theme No 1- Language

Language is seen as "a carrier of culture" and a major component of cultural knowledge. Treatments delivered in the mother tongue of the target population supposedly result in an integration of culture in the intervention (Rathod et al., 2020; Sue & Zane, 1987). The Language dimension is related to culture as well as the expression of emotional experiences, mannerisms and verbal style. Mental health care providers who are not aware of the cultural norms of the target population are likely to misinterpret the expressions of emotions by the participants and this could have an impact on the effectiveness of the treatment (Barona & Santos de Barona, 2003; de Barona & Barona, 2006). For example, Echeverry (1997) points out that even among Latinos based in the US with a functional proficiency of English, communicating intimate emotional personal matters is difficult. A culturally centred language must be culturally appropriate and syntonic, not just a mechanical or "decentred" translation and takes subtle differences in regional, or sub cultural groups into consideration. It is for this reason that delivery of mental health interventions through bilingual agents is preferred to using interpreters.

<u>Translation into local language</u>

Recognizing idioms of distress is important to establish rapport and build empathy between delivers and recipients of psychological interventions (Nichter, 1981). These idioms are also important to ensure that interventions without due attention to local ethnopsychologies do not inadvertently increase stigma and hinder provision of healthcare (Khort & Hruschka, 2010). Idioms of distress are defined as ‘‘adaptive responses or attempts to resolve a pathological situation in a culturally meaningful way.’’ Idioms can be somatic complaints, possession and other culturally significant experiences.

However, owing to the peculiar nature of our target population, translation of the workshops into Urdu, the national language of Pakistan, was not considered necessary. All the presentations in the first session of each workshop were made in English. The participants, all trainee civil servants had a minimum graduation level of education, had passed a highly competitive examination conducted in English and were undergoing a training in English. Therefore, there was no need for translating the intervention into

Urdu. In fact, there is a certain "snob value" attached to English language in the Pakistani society particularly in this elitist subset.

There were exceptions though. An Urdu word Ghan Chakkar (eye of the storm or whirlwind) was used to explain the adversity cycle. This added some local flavour and generated interest. Also, the activities held in the second session of each workshop were conducted in a fluid bilingual format, allowing the participants to use English as well as Urdu. There was no use of any provincial language in order to make people from all provinces comfortable treat them equally and to acknowledge the federal character of the population.

Use of local idioms and non-technical terms

Although the participants have yet to have any real job experience as a civil servant, many of them had jobs before and even those who did not, were already visualizing themselves in their future roles. Therefore, it was important that all the examples were related to the lives and careers of the civil servants. The use of the subtitle kept the part "My Life My Career" also catered to this. Emphasis was placed on the impact of stress on the careers of civil servants. I also avoided the use of the word stress. Instead, I used the term Psychosocial Skills development based upon detailed discussions with stakeholders. Similarly, sessions were replaced by workshops and therapists by trainers/facilitators to highlight the non-clinical nature of the population.

PM+ had few technical terms to begin with due to its task shifting nature and being a low intensity intervention. These terms were replaced by simple English terms in order make them understandable by the lay trainers and facilitators.

I did not use any Urdu translations of the technical terms during session, Although Urdu is the national language of Pakistan, most educated people are not familiar with academic and technical words in Urdu as English is the language of delivery in most of their academic life. Therefore, stress, depression and anxiety remain as such throughout the workshops including the bilingual discussions. I did not attempt to define these terms, rather introduced the concept of treating mental health as a continuum (Patel et al., 2018).

Bernal framework theme No 2- People

This dimension in the Bernal Framework considers the relationship between clients and the therapist. Differences and similarities of ethnicity, race and culture between the client and therapists need to be acknowledged. Echeverry (1997) argues that the expectations between the two parties need to be clear from the start. For example, the Latinos cultural value of *personalismo,* assumes a caring and constant presence of the healthcare provider (Barona & Santos de Barona, 2003). It is important for a culturally-centred therapist to be familiar with such cultural aspects so that he or she can make the client aware of the limitations of his or her role and avoid unfulfilled expectations or misunderstandings which could disrupt the delivery of the intervention.

Gender Matching

The workshops had trainers of both genders in this study to enhance its acceptability in the co-educational atmosphere of CTP. Although Pakistani culture is generally gender sensitive, the female trainers or trainees in CTP would not be comfortable with the separation of genders during training in line with their self-image of "progressive post feminists". In such a scenario, the female trainee officers would feel that they are being considered unequal to their male colleagues.

However, in the breathing sessions, gender matching became necessary. The female trainers despite working and generally being comfortable with a mixed gender setting, were embarrassed to perform the breathing exercises with the male participants. This seemed to be more due to their hierarchical relationship with the participants than a gender issue.

Group matching

The trainers came from a variety of backgrounds including civil servants on deputation to CSA, non-civil servant faculty members of CSA and psychologists from local universities. While forming the sub-groups, care was taken not to include many officers from the same occupational groups or on the basis of their gender or regional background as throughout the CTP, no study group is constituted on this basis. Doing so in case of the intervention will make it stand out and render it unacceptable. The CSS officers pride themselves on the federal nature of their career and are at times at pains to purposefully disown their provincial or regional affiliations. Similarly, as explained earlier, the females are more likely to be willing to participate if treated equally. Unlike some earlier adaptations, there was also no need to separate the married and unmarried participants.

Another important dynamic to observe is the affiliation to different occupational groups. While all the trainee civil servants are of the same rank and are at the beginning of their careers, different occupational groups differ in social status, perceived snob value and career prospects. For example, the three service groups of Pakistan's Administrative Service, Police Service of Pakistan and the Foreign Service of Pakistan are traditionally considered to be elite groups. Many trainees in other groups might even reappear in the CSS examination in order to go to these groups. The mixing of occupational groups was important to ensure that no one has the feeling of being left out or perceives a bias towards one group or the other. The fact that the civil servants among the trainers also belonged to different occupational groups also helped in building a rapport between the trainers and participants.

Cultural competency of trainers

The use of trainers from the same cultural and career background as the trainee allowed more possibilities of interaction and kept the interest of the group alive. It was noticed that at this stage, trainee civil servants were only interested in a training which could possibly be useful to their future career. The presence of senior civil servants among the trainers and facilitators helped in making the workshops seem relevant to their future careers. The shared experiences allowed for genuine empathy and contributed to the trainee-trainer relationship.

The trainers who were civil servants were able to draw upon their personal experiences during their career to help illustrate the importance of the workshop and the skills being developed. The presence of senior civil servants among the trainers also focused the discussions and discouraged venting out of negativity towards CTP as the trainers were able to normalize the trainees' feelings of stress and apprehension. Such trainers/facilitators conveyed the message to the trainee civil servants to understand that there is no stigma attached to having psychosocial problems and their presence, is not a reflection of one weakness or an "un-officer like behaviour".

The conduct of workshops by presenters with whom civil servants were already familiar also helped trainees to continue their progress throughout the CTP as the same presenters were conducting other training modules as well and interacted with regularly.

As explained earlier, the presentation part of the intervention was delivered in English and the activities were conducted in a bilingual atmosphere. The elitist mindset of the newly recruited civil

servants meant that presenters with a poor grasp of English language or a provincial accent were not taken seriously. This factor was considered in the selection of the trainers.

It was also important to select trainers who were more likely to be respected by the participants and were energetic and warm by nature. Despite their diverse background they had one thing in common; their willingness to experiment with a new form of delivery as well as to address the psychosocial well-being of civil servants.

Trainer-trainee relationship

The trainee civil servants had been selected through a country wide competitive exam where more than 10,000 people had appeared in the exam and only 260 had been selected with a 3% pass rate (Siddiqui, 2017). Therefore, they considered themselves justified in expecting a certain degree of respect from the trainers. Group management and Basic Helping skills were an important part of the training of trainers[3].

As most trainers were already involved in the training of civil servants, they already had experience of managing the groups. However, the trainers needed to de-learn some rules of the CSA and allow more open discussions in the intervention. The frank discussions in the workshops were a far cry from the usual lecture-based training of CTP. This was counterintuitive to the CSA culture where junior civil servants were officers “but still” under training. In CSA the term used for trainee civil servants is "probationers "which implies they are still in the process of becoming a permanent member of the civil service.

It is important to set the group rules in the beginning but not set them in stone. Some rules included in the adapted manual are:

- Participants need to be reminded to adhere to the time schedules given
- Break times can be used as a tool to return to interrupted group discussions
- Stick to the timetable provided as the trainees have other training commitments as well. It allows the discussion to remain focused and productive. While the trainers/facilitators might feel that they have to more to share with the trainee civil servants, the trainees have many other commitments and they would not fully concentrate in the case the workshops exceed the given time.
- Trainers should always thank for their contribution before moving on.
- Everyone should have a turn to talk in the group.
- Trainees already aware of these strategies should be respectful to their colleagues.

- When giving examples, do not include identifiable names or stories to ensure confidentiality.
- Avoid cross taking, give everybody who wanted to speak a chance to speak without any fear and encourage all criticism.
- In case of a trainee's transgression or overwhelming the discussion, he or she should be politely told to focus on the task at hand.
- It should be made clear that disclosing any psycho social issue during that the workshop will not have any reflection on trainees' future career. "What happens in the workshop, remains in the workshop"
- The answers given during the workshop will not reflect on their performance within the CTP or shared with faculty. This training workshop is not meant for their assessment but to give them tools for addressing psychosocial problems during their life and career.

Size of group

Unlike the original intervention, a larger group of the size was considered to be more appropriate. This allowed greater interaction among the participants and gave them room to have more fruitful discussions with diverse perspectives. On the other hand, the facilitators of the discussions have to make sure that every participant in the activity's session gets a chance and participants do not shy from expressing themselves or sharing their problems.

The larger groups comprised of about 40 to 50 participants whereas the smaller groups comprised of 12 to 15 participants each. It was important to have a larger group in the first segment of each workshop for practical purposes while having a smaller group was important for holding vibrant discussions. In the larger groups, the lecture was delivered by one trainer whereas three facilitators were present in the room and joined the delivery of the intervention as required from time to time.

Use of non-Mental Health professionals

The trainers/facilitators were a mixed group and included faculty members of CSA which consists of civil servants who are on deputation as well as faculty members who are permanently based in CSA and have an academic background. Out of the three delivering the main presentations in the first sessions; one was a permanent faculty member. The other two were visiting faculty members conducting various sessions but not employees of the CSA. The facilitators were also a mixed group of psychologists, civil servants, and faculty members. Supervision was provided by more experienced professionals.

The task shifting model using non-Mental Health professionals as trainers has the possibility to cater for the shortage of professionals as wells as avoid the stigma attached to seeking help for psychosocial difficulties.

Management of family role

This intervention was conducted in a residential training set up with no opportunity to involve the families. However, during the workshops especially in workshop 3, the importance of family and other social support in addressing psychosocial difficulties was emphasised. Family is an important source of social support in Pakistani culture. However, participants also blamed their families for putting them under pressure.

Bernal framework theme No 3 -Metaphors

Metaphors are the shared symbols of a particular culture. For example, (Muñoz, 1982) proposes incorporating artifacts belonging to the culture of the client in the therapist's office. Similarly, (Zuñiga, 1992) suggests the use of "dichos", a term signifying idioms or proverb used in therapy.' The conduct of the intervention in CSA and the use of civil servants with similar cultural and careers provided a background for use of common metaphors.

Use of stories & local example

Examples from the civil service were consciously used to illustrate the psychosocial issues and possible solutions. For this purpose, the civil servants among trainers narrated their own stories and the stories of their colleagues who have suffered stress and how it had affected their lives and jobs. This was important to ensure effective participation by the trainee civil servants who were all geared up to take up their new positions.

Some sayings or proverbs were also used like "Don't wait for the perfect moment, take the moment and make it perfect", giving the example of the volcano or pressure cooker to emphasis timely redressal of stress etc. In order to ensure its acceptability, the workshops were made an integral part of the CTP, though unlike other modules of CTP, participants were not evaluated.

Case study examples were developed through stakeholder consultations and training of trainers which use hypothetical situations from careers of various occupational groups of the civil service and included in the annex to the training manual.

In order to build the significance and relevance of the intervention in the eyes of the participants, more emphasis was placed on the impact of stress on their careers as civil servants. Examples from certain known leaders and civil servants were also used to normalise and destigmatise stress. For instance, the example of Prince Andrew who had confessed suffering from depression was quoted to make the participants aware that there is no need to be ashamed of having such problems. Some extreme examples of reaction to stress captured the attention of civil servants, like the case of Deputy Commissioner Gujranwala who had committed suicide some time ago supposedly due to job pressures.

Bernal framework theme No 4-Content

This dimension refers to integration of values, customs, and traditions of the clients into different phases of the intervention, beginning with the planning and assessment stage, allowing for sharing of experiences between the target audience and the delivery agent.

Incorporation of local practices

It was important to conduct the intervention in a format with which the participants as well as the delivery team were comfortable and which matches with the norms of CSA so that participants take the intervention seriously. CTP is primarily a lecture-based training programme. I, therefore, decided to hold the first part in presentation format but later sessions were discussion based.

Openness towards other methods of problem solving and stress management

It was important to acknowledge the prior knowledge of trainees. In case the participants say that they already know this information or they can learn this information from the internet, the trainer does not have to get defensive. He or she should appreciate this and say that it is possible that you might know or you can access it from the internet or other sources but the purpose of this workshop is to share this information with all the participants and to make sure that they all have the opportunity practice these tools.

Trainers must acknowledge that there were also other methods of problem solving and stress management and the aim was not to debate their comparative advantages or disadvantages. However, the purpose of the workshops was to introduce the easiest and simplest methods of stress management and problem solving and make the participants aware of the importance of these issues and tools for their lives

and careers. Since they were well educated and intelligent people, they could further Google similar tools or research on their own. The more important thing was to practice the tools in their daily life.

Addition of therapy modules to address cultural factors

Before the training started, I had arranged a number of interactions with stakeholders. In this case there were two lectures/presentations. The first by Dr Usman Hamdani of the Human Development Research Foundation focused on the importance of this kind of workshops for civil servants. This allowed us to gain the support of the faculty and leadership of the civil service academy who provided the facilities and incorporated the training program into the CTP.

The research study supervisor Dr Atif Rahman also delivered a lecture to the trainers/facilitators which focused on the evidence base of these training workshops and the importance of mental health for a successful career. The purpose of this presentation was to gain the support of the trainers/facilitators who would later on deliver the workshops. It also helped the trainers/facilitators to prepare themselves for answering similar questions by the trainee civil servants.

Before beginning of the intervention, both arms of the study were briefed on the importance of the exercise and urged to cooperate by effectively participating and filling in the questionnaires. This was important to ensure that either group does not feel that it is getting any special treatment.

Similarly, at the end of the five sessions, another session with both arms was conducted by the researcher to thank the participants for their views and request them to fill in the questionnaires. It was explained that this was necessary in order to collect evidence for the effectiveness of the workshops to decide if it can be used in future CTPs or courses for relatively senior civil servants and with which modifications. I stressed on the participants that this would be their valuable contribution towards improving the training and performance of civil servants and addressing an important loophole in the civil services training courses. The participants were encouraged to ask questions and suggest changes which helped the adaptation process.

As this was an educated non clinical population, discussion on the concepts and the evidence-based research behind PM+ was important to gain the respect of the stakeholders. The workshops were presented as a first step towards a major overhaul of the civil service training by focusing on the hitherto neglected psychosocial aspects.

Seating arrangements

For the first part of the session which consisted of presentations, a class room setting was used. For the second part of the session which consisted of the sub groups for discussions and activities a round table setting was used. The civil servants were taken out of their class rooms into a round table format which would allow them to have a free discussion. It would also give the feeling of everybody being an equal participant and no one getting a greater visibility like in the class room setting. The training of the trainers' sessions was also organised in round table setting in order to engage the participants.

The participants were allowed to choose different examples of problems themselves in the activities session which will be then shared with the larger group in the third session. The potential strategies of the third workshop Get Going Keep Doing were revised to be culturally appropriate, i.e., listening to music, praying etc. It was also pointed out that the civil servants themselves could share successful methods of coping and this might be more in tune with the realities of the civil services of Pakistan rather than just allowing them to copy what they discovered on the internet or through self-books.

Explaining the theoretical basis of the intervention

On the basis of discussions with stakeholders, various issues in the intervention were identified which needed to addressed during the workshops. These included

- Introducing the concept of emotional intelligence which allows a person to reorganised and regulate emotions in order to deal with challenging situations.
- Providing rationale for talking therapy rather than medication. In Pakistan medicated solutions are expected with little awareness of the effectiveness of psychological therapies.
- Addressing apprehensions on utility of workshops in case of serious illnesses like suicidal thoughts or depression. These workshops are meant for subclinical populations and to address a relatively mild form of stress. In case of serious problems, participants could confidentially allow us to refer them to a panel of psychologists so that they could be provided with more professional help and medication, if necessary.
- Addressing the concern that psychosocial issues and the reaction towards stress was based upon individual chemical and genetic makeup.
- Explaining the choice of a group intervention instead of individual intervention by saying that that the group interventions have the advantage of creating awareness and providing

certain tools without naming any individual for his or her tendency to not effectively cope with stress. This was important to avoid stigmatisation. Group therapy would allow those who have such tendencies as well as those who were successful in dealing with such stress to share their ideas and help each other. Group intervention would also maintain privacy of those facing problems.

Bernal framework theme No 5 - Concepts

This dimension refers to the constructs to the theoretical framework of the intervention to be used in treatment. The consonance between culture and context while presenting the problems of a client and conceptualizing and communicating to him or her is very important for the credibility of the therapist and hence, the treatment efficacy (Bernal et al., 2009).

Addressing stressors

Addressing the stigma attached to mental illness is important. This stigma is based on traditional notions of CMDs as well as their possible impact on the participants' assessment during the CTP and future career. It was further enhanced by the possible effect of admitting stress on their future careers. Therefore, data obtained during the intervention as well as the results of the questionnaires were not shared with the Academy. This was repeatedly made clear to the participants to make sure that they freely and frankly share their opinions. Trainers stressed that they should give honest answers to all questions and "no answer is wrong".

Social concepts

Special attempts were made to ensure that the participants do not consider symptoms of stress to be unusual or the expression of feeling of stress to be a sign of weakness "as an officer". For this purpose, the trainer civil servants narrated their own stories and the stories of their colleagues who have suffered stress and how it had affected their job.

There was a detailed debate on the sources of stress for civil servants, Trainee civil servants identified these sources to be tough rules and regulations, social pressure, fear of failure, peer pressure, fear of unknown future, unrealistic expectations, time constraints, importance of self-image building and uncertainty.

Distracting of the conversation towards complaining about the CSA was avoided. When the participants were asked to make problems trees and identifying sources of stress, initially they mostly highlighted issues they were facing in the CSA and CTP. However, later on, they starting focusing more on general life issues and possible career issues. It was important not to let them get trapped into discussions on training-based stress issues as this would only lead to a negative atmosphere since these were unsolvable problems. As a result of the intervention, there would be no change in the training program and the participants would feel that their whole feedback has gone down the drain. The trainers emphasised that the workshop was not meant to take feedback on the CSA but rather develop some life skills among the participants, they started opening up in a better manner. The presence of senior civil servants also focused the discussions and discouraged venting out of negativity.

Religious concepts

The Islamic concepts of belief in God and his wisdom and the finality of the day of judgment were acknowledged as possible relaxation and stress management tools. The possibility of using prayer time for stress management was also pointed out. Religious rituals provided an opportunity for stress management similar to meditation. The concept of Taqdeer (fate) or God's will was a useful coping method for acceptance of stressful conditions. The Sufi concepts of stoicism also helped in coping with stressful conditions.

Concept of good stress

The participants repeatedly question asked whether stress was bad in nature? We acknowledged the importance of eustress for better performance. The focus of these workshop was to address stress which was affecting the performance or behaviour of the civil servants.

Leadership tools

The training curriculum incorporated the adaptive leadership framework as well. (Heifetz et al., 2009). This made it relevant to the lives and careers of civil servants as well as the academy. The adaptive leadership framework was used within the context of the PM+ intervention in workshop 2 while developing an understanding about the problems being faced by the civil servants and how to address them. The concepts of having a balcony view versus a ballroom view and emphasizing on solvable rather

the non-solvable problems was used. These became an integrative part of the workshop No. 2 which dealt with problems solving.

Bernal framework theme No 6 -Goals

This theme refers to agreement between the therapist and the target population on the objectives of the intervention taking into account their values, customs, and traditions (Bernal et al., 2009)

As the participants were selected thought nation-wide competitive exam, they have a strong self-image of being the intellectual elite of the country. At this stage of their life, they were willing to give time for only issues which could be relevant to their future careers.

The trainee civil servants were not interested in anything which did not reflect on their performance of the CTP or not have any effect on their future career. While I could not share the data with CSA because of ethical concerns and because I did not want it to influence the answers to the questionnaires, I was able to assure them of the practical utility of these workshops through the presence of trainers/facilitators who are senior civil servants. Prior to the workshops there was a session with the whole CTP in which the civil servants were made aware of the importance of these workshops, the concepts of workplace stress and how it affects their careers by the researcher who himself is a senior civil servant.

The overall objectives of workshops were reflected by renaming the programme to Psychosocial Skills development workshops. This nomenclature highlighted the non-clinical state of participants and created an image of training rather than therapeutic sessions. This enhanced acceptability of the intervention.

All examples used in the workshops were related to the lives and careers of the civil servants. The use of the subtitle kept the part “My Life My Career” also catered to this. Similarly, sessions were replaced by workshops and therapists by trainers/facilitators to highlight the non-clinical nature of the population.

Table 16: Nomenclature changes in the intervention

Original	**Changed to**	**Purpose**
PM+	Psychosocial Skills development	Highlighting the non-clinical status of participants and the real-life training setting
Session	Workshop	To emphasize that these are training, not treatment sessions
Client	trainee participant	Reflect the Non clinical population
Therapist	Trainer/facilitator	As above

It is important to note the following messages conveyed by these nomenclature changes:

a) These workshops are training, not treatment sessions.

b) These were meant for skills development and advancement of careers of the participants.

c) It was acknowledged that this group was not pre-diagnosed with any mental health issue.

During the process of intervention delivery, references to these goals were repeatedly made with a focus on how each strategy applied to case-studies from lives, and careers of civil servants. Another goal was creating awareness of mental health issues at workplace.

There were certain participants who felt that this group therapy would not be of any use and those who need psychosocial skills development need to be provided with individual help. However, most of the participants felt that this workshop is helpful in order to; (a) develop awareness of these issues and (b) encourage those who are having problems attend individual sessions by removing their inhibitions and de-stigmatizing the issues.

Clarifying goals

As the CTP is primarily a knowledge-based training programme, participants expected information from each session. I explained that the purpose of the workshops is to provide the civil servants with tools to deal with psychosocial problems and workplace stress, which is likely to occur during various phases of their career and make them successful in their career and life. Senior civil servants introduced the intervention as an effective and evidence-based program for stress and problem management for problems occurring in everyday life of civil servants in Pakistan. The purpose of this intervention was to introduce simple tools and the actual success of the process depends upon how effectively these tools are practiced on a daily basis.

Many of the participants were familiar with other stress management techniques and would suggest more complex methodologies. Trainers acknowledged that the simplest and easiest to use stress management techniques were selected. The reason is its easy availability for everyone whether he or she has any previous experience or understanding of stress management tools or not.

Another reason is that being an easy to use and simple tool, there would no excuse of not using it regularly. While there are many more complicated and complex tools for stress management, available in literature like mindfulness, mediation, etc., these methods require more training and time and might not be suitable for everybody. Trainers should add that they do not recommend only this particular stress management tool and in real life any suitable method can be used

The importance of practicing and reinforcing the ideas was stressed upon many times in order to make participants realise that it is not the complexity of the learning which is important but the fact that they have to make these tools part of their daily life. In fact, it was pointed out that if the participants could not practice of these simple tools, then it would to be much more difficult for them to practice the more complex ones.

Extending goals

It is important to emphasize the significance the workshops in the training program and addressing these issues for the careers and lives of civil servants. It was also important to emphasize that the data collected which will be able to guide us for the preparation of such workshops for CSA as well as for participants of other civil service training programs. This will give them a sense of purpose as the

participants would get a feeling, they are part of an effort to improve civil service training and performance.

There was a question as to how this workshop was relevant to stress caused from different sources. It was explained that the workshop was primarily trans-diagnostic in nature that is it ignores the diagnosis or origin of the psychosocial problems.

Another question was its relevance to all occupational groups with different nature of jobs. It was explained that it was not possible to address to a specific occupational group in such a gathering. The examples used were more general in nature but primarily related to the government sector.

The intervention does not project itself as targeting psychologically distress but adopts a" universal" approach and focuses on skill development for a non-clinical population, living and working in very stressful conditions. The intervention thus gives the trainee civil servants a skill set to apply to stressful circumstances occurring in their daily lives and careers.

Bernal framework theme No 7- Methods

This dimension refers to the procedures to be followed for achieving the treatment goals. The development of culturally centred treatment goals is expected to incorporate procedures congruent with the client's culture as well and to enhance acceptability of the therapy.

Adaptation of training of trainers

The training module was shortened and spread out as the trainers were busy doing many other things and could not devote too much time to these sessions. Instead of having a four-day training session it was decided to conduct a two-day training session followed by pre and post workshop sessions and discussions on WhatsApp. This allowed a reiteration of the lesions and avoided putting too much demand on the schedule of the trainers.

The training session just before the workshop allowed reviewing the learning and retention of the concepts as well as briefing on the particular workshop being conducted that day. This was followed by ongoing training of trainers and facilitators in the actual session by master trainers. Post workshop sessions conducted with the participation of all the presenters and facilitators helped in gathering feedback, preparing for next sessions and dissemination of the lessons learned.

Two types of the trainers were classified as a result of the training of training workshops and the related process. Firstly, were “the trainers or presenters” who conducted the knowledge-based sessions of the workshops in the bigger groups (Houses). Secondly, “the facilitators” were trainers who were not able to conduct standalone presentations at this stage; but led the activities and discussions in the smaller groups in the second sessions. These facilitators can later become full trainers after practice.

Three session format workshops

The workshops were conducted in a three-session format.

The first session also termed as the “plenary session” consisted of presentations made to a group of about fifty trainee civil servants. In this setting presentation of the key concepts of the particular session of the workshop was made by a presenter/trainer. The other three or four facilitators were present in the session also and intervened as, when and if required. These sessions were held in “Houses” in a classroom setting. Houses are large lecture halls used for conducting group wise lectures during the other courses of the CTP for about 50-80 participants. They were named after the great leaders of Pakistan's independence movement like Sir Syed House, Jinnah House, Iqbal House, Johar House and Liaqat House. In these sessions, Power Point presentations were used to convey the main concepts in a classroom setting in the first sessions. These presentations are attached as Appendix to the manual and contain all the material needed by trainers adapted in accordance with the needs of the civil servants as well as the charts and graphs.

For the second session, the participants were divided into smaller groups of 10 to 12 each where participants will sit around a round table in the library or elsewhere. In these sessions there were no presentations. However, guidelines for discussions are displayed as slides on the screen so that the participants remain focused. Handouts have been prepared for the facilitators to enable them to ask the questions for pondering upon. Participants will be given time limits for discussions for each set of questions. The main points of the discussions will be noted down by one of the participants.

Finally, the trainee civil servants were brought into the larger setting in the Houses for the third session of the workshop and asked to discuss the gist of their discussions with their colleagues in the larger groups by making presentations.

Shortening duration of sessions

The training sessions workshops were shortened in time as it was felt that longer workshops would lose the attention of the participants who were in full time training. This was done through reducing the introductions, games and videos etc. The Table below summarises these changes.

Table 17: Overview of Workshops durations

Workshop or session	Duration in Group PM+	Duration in the workshops
Workshop 1: Managing stress	2 Hrs.	1 hours 30 minutes
Workshop 2: Managing problems	2 Hrs. 33 minutes	1 hours 30 minutes
Workshop 3: Get Going, Keep Doing	2 Hrs. 30 minutes	1 hours 30 minutes
Workshop 4: Strengthening Social Support	2 Hrs. 15 minutes	1 hours 30 minutes
Workshop 5: Staying well and looking forward	2 Hrs. 17 minutes	1 hours 30 minutes

Use of Videos and pictures

Unlike the original PM + intervention, it is not suitable to use videos in these workshops as this would affect the seriousness with which the trainee civil servants are taking the workshop. A video would also create the impression that not enough hard and original work has been done in the preparation of the training workshops. Therefore, it is important to use presentations but not videos. The trainee civil servants need to be made aware that the trainers have something of special value to impart which they have worked hard upon. Videos appeared to be time fillers for them.

Very few pictures were used in the presentations. The reason for this was that the target population was a well-educated group, and the use of some of the pictures would be considered a bit childish. However, the trainers did use some of the flowcharts to describe the adversity cycle etc.

Changing settings

For the first part of the session which consisted of presentations, a class room setting was used. For the second part of the session which consisted of the sub groups for discussions and activities, a round table setting was used. The Civil Servants were taken out of their class rooms into a round table format which would allow them to have a free discussion. It would also give the feeling of everybody being an equal participant and no one getting a greater chance like in the class room setting.

This setup allowed for a focused learning and practice of the psychological psychosocial skills management workshops by the training civil servants first.

Size of groups

There were four larger groups for the first and third sessions in which the number of participants was around 50. Each group was divided into four subgroups each of around 12 each. It was discovered that a smaller group would not allow greater exchange of ideas as there was no room for diversity. However, a bigger group would not be suitable for practicing the ideas and activities. This was different from the PM+ in which around eight participants are led by one coach. There were about 12 participants in each subgroup but there were two trainers/facilitators per subgroup to allow them to support each other and to have more vibrant discussions.

Data collection

An online data collection strategy was adapted. At the beginning of the series of workshops, the questionnaires were presented to the participants and they were asked to answer the questions online. The data was stored directly on the HDRF web server which ensured confidentiality and safe storage of the data. The participants were ensured that the answers to the questionnaires were not to be shared with the Civil Service Academy and would not affect their assessment would not have any reflection on their performance during the Civil service as the common training program.

Participant engagement adaptations

Buy in of the intervention was ensured by the involvement of the senior civil servants among the faculty was useful to reiterate the message that there is no stigma attached to having or confessing to having stress and explaining the scientific basis of the workshops is important for gaining the confidence of the trainee civil servants for example, the breathing method has a chemical basis for relaxation.

Use of WhatsApp

There was a general agreement that WhatsApp group would not be appropriate to make during the sessions. Firstly, the groups formed were randomised not natural groups. There was no natural affinity or friendship between the groups which would give them the confidence to share their problems with each other. They were worried that other members of groups, being their competitors, would use the knowledge of them of problems against them. Secondly, during the training, civil servants would be exposed to different strategies step by step and they would not be able to utilize them effectively if they share with each other half baked. There was also a research concern about possible contamination of data because of the sharing of information among the two groups. However, participants might be more comfortable in making a WhatsApp group of their own in which they can decide the participants and share their problems and workout solutions.

At the end of the workshops a set of resources and literature on stress management, problem solving and psychosocial skill development was shared through WhatsApp. This was not done in the beginning to enable them to focus on what was happening in the presentations. Sharing of articles through WhatsApp provided a convenient form of continuing the learning outcomes of the intervention. However, it was important to do sharing through a broadcast group to respect everyone's privacy and not allow unnecessary discussions.

Addressing the group dynamics

It is important not to allow the discussions in second session to go wayward and keep them focused on the flow of workshop and not let the participants get carried away. The trainers/facilitators are primarily moderators and not lecturers or talk show hosts. They should avoid engaging in a fruitless discussion with the participants or trying to lecture them. The participants would like to be acknowledged as equal partners. This was welcomed by the participants as this is different from the general culture of CSA. If

participants deny the utility of the workshops and tries to drag the trainer into unnecessary arguments, trainer must avoid getting off the track and should not let them waste the time of the group.

One more argument used against the workshop is that this cannot of as much help as medication or individual therapy sessions. To this the trainers can reply that it is true that many people would need medical or individual therapy and this workshop is not a substitute for that kind of help. However, the group workshop can help individuals to identify a problem without attaching any stigma. It also can also deal with low intensity issues. Secondly, the workshops are aimed at giving you psychosocial skills to help yourself rather than get it from outside.

Structural adaptations

Note taking was encouraged as this was the norm in CSA and allowed more effective participation in activities. However, only designated note taker would take notes during the activities to make sure nobody loses focus. Some facilitators noted that the note takers were left out of the discussions. The facilitator needs to make a conscious effort to make sure this does not happen. Flip charts can also be used as note pads too.

It was important to integrate the workshop as a part of the training program as otherwise it would not be taken seriously. However, we stressed it will not evaluate participants.

Adaptation of techniques used to deliver treatment

As the participants were literate and in a training environment, use of presentations made the workshop more acceptable. In the larger setting of the first session of the workshops, Power Point presentations were used these presentations contained all the material from the manual adapted in accordance with the needs of the civil servants as well as the charts and graphs.

The importance of giving a one week break in between each of the workshops was questioned by many trainers / facilitators as well as participants. It was explained that this is important to allow them time to reflect upon their learning and to practice the tools which they had learnt during the workshops. The idea of reflective learning was relatively new for many of the participants particularly those who had not studied outside Pakistan. However, this was generally well accepted after the explanation.

Bernal framework theme No 8- Context

This dimension broadly covers the socioeconomic and political contexts of the target population. This includes a variety of cultural processes like acculturative stress, migration, socioeconomic development, societal safety networks etc.

Increase accessibility

The intervention was delivered during the CTP, an important induction level training for civil servants in Pakistan. The workshops were held on Friday evenings, the last day of the week to integrate the intervention into the existing schedule of the training program. The scheduling of the intervention on Fridays had a mixed reaction. On one hand, the participants felt they could be flexible with the time of the discussions but on the other hand, they were already tired, having been up since 5 O'clock in the morning with various physical and academic exercises, they felt they could not devote it enough energy and motivation.

Ensure acceptability

Presenters included faculty members as well as senior civil servants and recognised the need to have a positive narrative to enable participants to undertake the intervention. The decision to keep the sessions ungraded and hosting the data outside the CSA website as well as holding pre workshop sessions helped in building the confidence of the participants and fulfilling the objective of the workshops.

Ensure compliance

CSA faculty played an important role to support attendance compliance. Reminders were sent on emails to attend the sessions and practice tools.

Specific adaptation relating to the setting

The intervention was conducted in the usual settings of CSA so less logistical arrangements were required. However different settings were used for different sessions as explained earlier. The deliverers of the intervention need to make the target group comfortable in sharing their inner feelings and true difficulties.

Table 18: Summary of the major adaptations made to PM+

Dimensions	Description of main adaptations made
Language	Using English and bilingual mode
	All the presentations in English. activities in a fluid bilingual format
	No use of any provincial language
	Technical terms retained or replaced by colloquialisms
Persons	Senior civil servants as trainers
	No gender matching except in breathing sessions,
	Trainers from a variety of backgrounds including civil servants on deputation to CSA, non-civil servant faculty members of CSA and psychologists from local universities.
	Not divided into subgroups on the basis of gender or regional background or occupational groups
	Use of trainers from the same cultural and career background as the trainees
	Reassure that disclosing any issue during the workshop will not have any reflection on their future career
	Establish a link to their professional performance and the development of psychosocial skills
	Assure that the workshops are not meant for assessment but to give tools for addressing psychosocial problems during future life and career.
Metaphors	Using culturally appropriate concepts
	Use of stories & examples from the civil service Some sayings or proverbs like the volcano or pressure cooker to emphasis timely redressal of stress etc. More emphasis on the impact of stress on their careers

Content	Using culturally appropriate content
	Incorporating the principles of PM+ and the adaptive leadership framework
	First part was held in presentation format but later sessions were discussion based.
	Openness towards other methods of problem solving and stress management
	Addition of session with all participants before the workshop
	Workshops presented as reform of the civil service culture
	For presentations, a classroom setting was used. For discussions and activities, a round table setting
	Participants allowed to choose examples of problems themselves
	Potential strategies of the third workshop were revised to be culturally appropriate, i.e., listening to music, praying etc.
	Explaining the theoretical basis of the intervention
	Examples from different occupational groups
	All the examples were related to the lives and careers of the civil servants
	Use of the subtitle “My Life My Career”
	Use of the term “Psychosocial Skills development trainers' workshops” etc.
Concepts	Addressing the stigma
	(Do not consider the expression of feeling of stress to be a sign of weakness “as an officer”.)
	Complaining about the CSA avoided
	The Islamic concepts of belief in God and his wisdom Taqdeer
	Religious rituals for stress management
	Sufi concepts of stoicism
	Concept of good stress and bad stress
Goals	Link with Career goals

	Overall Objectives of workshops reflected by renaming to Psychosocial Skills development workshops.
	Clarifying goals to provide tools to deal with psychosocial problems and workplace stress to introduce simple tools and the success depends upon practice
	Addressing issues for the careers and lives of civil servants to guide the preparation of such future workshops and as an effort to improve civil service training and performance.
	The concepts and the evidence-based research behind PM+ was presented
Methods	Division of each workshop in the
	Presentation's handouts
	Three sessions
	Two types of the trainers were prepared
	Shortening duration
	No Use of videos
	Very few pictures used
	Variable settings (classroom and discussion)
	Engagement by Involvement of the senior civil servants and explaining the scientific basis of the workshops
	Use of WhatsApp for trainers
	Only designated note taker would take notes during the activities
Context	Integrated into the CTP
	Held on Friday evenings
	Larger group of the size for presentations

Adaptations in training and supervision

In the study, I used a cascade model for training of trainers and facilitators to enable them to deliver the workshops to trainee civil servants. This model was specially adapted to the needs of the trainers who

were not professional psychologists. This model also helped in enhancing the acceptability of the intervention.

The Training Model broadly follows the cascade apprenticeship model (L. K. Murray et al., 2011), as outlined in Table below

Table 19: Adaptation of apprenticeship Model for Mental Health Interventions

Components of the apprenticeship model	Application in the study
Selection of apprentices	Recruitment of trainers/facilitators in consultations with CSA faculty.
Training	Training according to the training of trainers' manual for Psychosocial skills development workshops.
	Cascade training in the intervention to group of a mixed group including civil servants, faculty, psychologists.
Application of training "on the job" under direct supportive supervision	Trainers and facilitators practice conducting the workshop under supportive supervision from master trainer.
Ongoing expansion of training, knowledge and skills under supportive supervision	Ongoing coaching of trainers and facilitators during the workshops by master trainer.
	Monitoring of delivery of the workshops through observation.
Manual problem solving	Post workshop sessions to discuss the issues in delivery of the intervention.
	Consultations to respond to challenges of embedded research within the training programmes.

Reference: (Murray et al., 2011)

A detailed manual was developed for conducting training of trainers which is attached as an Appendix 6 to this thesis.

The training of trainers' process began with a two-day workshop including simulation exercises, role play and discussions. A session just before each workshop was also held with trainers/facilitators to review the learning and retention of the concepts as well as to brief them on the particular workshop being conducted that day. After the workshops, all trainers/ facilitators and the CSA management gathered for feedback, preparation for the next sessions and dissemination of the lessons learnt.

Training of trainer workshop

The training of trainer's workshop consisted of 2 days class-room training adapting various forms of teaching like classroom lectures, group discussions, role plays and activities. The workshop followed a collaborative learning model, where the participating trainers were encouraged to suggest adaptations on the basis of their earlier experiences. The master trainers were encouraged to use a mix of teaching approaches for the diverse groups of trainers and use examples which the trainers can relate to.

Trainers' profile

The prospective trainers and co-facilitators consisted of a group of 12 people (male and female). Among them were members of the CSA faculty as well as civil servants from the outside the faculty. Some of the faculty members were also civil servants on deputation whereas few of them were not civil servants but had been teaching at CSA for some time. There were a number of young psychologists in the group too from various educational institutions of Lahore. These young psychologists were nearly of the same age group as the newly recruited civil servants. Being a peer group, they could relate to the junior civil servants.

Selection of trainers

On the second day of the training of trainers' workshop, participants were allowed to conduct a complete intervention as trainers with the rest of the group acting as trainee civil servants. The fellow trainers were encouraged to give feedback on their conduct. The top three trainers getting the best feedback from master trainers were allowed to make presentations whereas the rest were assigned to lead the activities sessions.

Table 20: Characteristics of trainers

Trainer No.	Gender	Age (Years)	Education level	Employment
1	Male	35	LLB	CSA faculty part time
2	Female	34	MSC Psychology	CSA faculty part time
3	Male	43	PhD Management	CSA faculty full time
4	Female	29	MSc	Psychologist
5	Male	27	MPhil	Psychologist
6	Female	40	PhD Physics	CSA faculty full time
7	Male	43	MA	Civil servant
8	Female	34	MA	Civil servant
9	Female	32	MA	Civil servant
10	Female	29	BSc	Civil servant
11	Male	33	BA	Civil servant
12	Female	42	MPhil CBT	Psychologist

Conclusions

The adaptation of PM+ psychology intervention for trainee civil servants was done using a four-step process which had earlier been used in certain studies for its cultural adaptation in humanitarian contexts. The simple systematic adaptation process can provide a guideline for future researchers and academics as well as trainers. The process was iterative in nature allowing for the incorporation of evolving social and cultural constructs and understanding. Detailed manuals and presentations have been developed for the intervention as well as the training of trainers' workshop and are attached in Appendix 5 and 6.

In line with the twin objectives of the study, this Chapter described the development of a feasible and culturally appropriate intervention targeting Pakistani civil servants under training at Civil Service Academy, Lahore. In the following Chapter, I will explain the methodology used for its evaluation, the second objective of the study.

Chapter 5: Methodology

الفاظ پرکھتا رہتا ہے
آواز ہماری تول کبھی

Translation

You measure my words all the time

Try once to weigh my voice too

Gulzar, contemporary Urdu poet

Chapter 5: Methodology

In earlier part of this thesis, I had highlighted the significance of mental health issues for employee productivity. In Pakistan the demand for such mental health interventions is high and the resources stretched. As a postcolonial developing country, Pakistan relies upon the civil service disproportionally for national development and their performance and productivity is affected by the state of their mental health. It is therefore important to identify appropriate cost-effective, evidence-based and culturally adapted interventions to address mental health issues in the civil servants.

The aim of this study is evaluation of the effectiveness of an intervention for improvement in psychological well-being among a group of newly inducted Pakistani civil servants.

In the previous chapter, I described the development of the adaptation. In this chapter, I will explain the methodology used to evaluate the effectiveness of the developed intervention in the target population.

Hypotheses

In accordance with the aims and objectives of the study described in chapter 3, the primary hypothesis is that a reduction in prevalence of psychological distress and increase in coping skills in the intervention group receiving the intervention along with usual training at Civil Services Academy, will be seen as compared to the control group receiving usual training only. The secondary hypotheses are that there will be an improvement in psychological well-being, and psychological capital in the intervention group compared to the control group.

While talking about the methodology used to evaluate the intervention, I will cover the research design, the study settings and populations, ethical considerations of the study, and outcomes. I will begin with a brief discussion on the research design used in this study along with the rationale for its selection.

Research study designs for evaluation of the intervention

Evaluation of interventions can be done by either randomised or non-Randomised approaches. Each one has its own advantages and disadvantages (Manun'Ebo et al., 1997; Olatunji et al., 2007; Torgerson, 2001) which were carefully considered before selection of design for the study.

Non-randomised trials

These trials differ from randomised trials through the absence of randomisation. Their key advantage is their practical and logistic simplicity. They can be done on fewer subjects and require less time and resources to implement. However, the possibility of a selection bias and uncontrolled confounding factors limit the interpretation of their results of these trials.

Non-Randomised trials can be classified into various types depending upon the nature of comparisons. These are pre/post intervention comparison, intervention vs. control comparison and adopters vs. non-adopters' comparisons.

Pre/post-intervention comparison compares the outcomes before and after the intervention is introduced in the study population. This methodology compares outcomes as well as risk factors in the two intervals which provides useful information about the effectiveness of the intervention. However, without a control group, it is not possible to attribute the changes in the outcome clearly to the intervention and the changes could be on account of an independent variable irrespective of the intervention.

"The intervention vs. control comparison" design compares the intervention arm with the control group and caters for confounding factors, that still carries the possibility of a selection bias in the recruitment process. This bias can result in differences at the baseline between the intervention and control groups and makes attribution of the observed changes in the outcomes to the intervention dubious.

"Adopters vs. non-adopters' comparison" type of research carries out a comparison between individuals adopting the interventions with those individuals who do not do so. In reality, this study can be counted as a "risk factor study rather than an impact study". The study does not cater for confounding factors because of the different characteristics of the two groups.

Randomised trials

This design is considered the gold standard for evaluation of interventions. Its distinguishing feature is the presence of randomisation which results in outcomes which do not follow a deterministic pattern. Such trials are considered effective as compared to other methodologies in establishing a causal relationship between the intervention and the outcomes of the study because of their ability to address confounding variables and potential selection bias. The flip side is that Randomised trials require greater level of management, time and resources to implement as well as a greater level of commitment from

researchers and participants of the studies. Interestingly, the scoping review described in Chapter 2, noted that most of the studies on the psychological interventions to address workplace mental health issues used the Randomised control trial design.

Randomised controlled trials can be classified as individual or cluster Randomised controlled trials.

In an individual Randomised controlled trial, the intervention and controlled groups comprise of individuals and the analysis is done on an individual basis. Although, these trials address the confounding variables and selection bias, they carry the risk of contamination, particularly if carried out in community settings. Contamination refers to the spread of information between the intervention and controlled groups and could result in outcome changes in the controlled group and an under-estimation of the intervention effect. Contamination can happen through participants, deliverers of the intervention or other means.

On the other hand, in the cluster Randomised controlled trials, the comparison is done on a group basis with the intervention given to Randomised groups and similar groups not receiving the intervention acting as controls. This design can take care of potential contamination issues on account of the geographical and administrative distances involved (Keogh-Brown et al., 2007). The difficulty with these trials is that since members of the cluster cannot be treated independently, a bigger sample is required to demonstrate the effect of the intervention. This makes them expensive, lengthy, complex and unsuitable for the purposes of this study.

Choice of study design

I rejected the idea of holding a non-Randomised trial due to the risk of a selection bias and potential confounding factors. Among the two types of Randomised trials, cluster Randomised trial would be less susceptible to contamination (Keogh-Brown et al., 2007), but it would be difficult to execute, and be much more complex. Usually, a pilot study is required beforehand to explore the likely problems and strategies to overcome them (Adams et al., 2004). The study would also need to recruit a bigger sample. Therefore, it would be impractical for the purposes of the study which was limited by the time and resources available,

Therefore, a two-arm single blind, individual Randomised controlled trial was conducted to evaluate the effectiveness of the adapted PM intervention in trainee civil servants in Pakistan. The trial arm received the group intervention (adapted for newly inducted civil servants) as well as induction

sessions (CTP) while the control arm received the induction sessions only. The "induction sessions" (CTP) consisted of series of lectures on governance, public sector management, research methodology, basic information technology, government regulations, economics and public finance.

The trial was conducted from 1st November 2018 till the first week of March 2019 and was registered prospectively on clinicaltrials.gov (NCT03762421).

Study settings and population

The study was conducted at Civil Service Academy (CSA), Lahore, Pakistan. CSA a residential training institution which provides the Common Training Programme (CTP) to newly selected civil servants belonging to the twelve occupational groups of the Central Superior Services (CSS) of Pakistan. CSA is headed by the Director General, a senior civil servant of BPS 22 (the highest rank in Pakistani bureaucracy). The study participants comprised of the 45th CTP batch, which commenced training at the CSA in October 2018. During their six months stay at the academy, trainees acquire knowledge and competencies necessary for meeting the challenges of their careers in public service. Since the new entrants to the civil services have diverse educational and regional backgrounds, the CTP serves as a foundation course for all officers. It also, at least theoretically, brings all occupational groups at the same baseline.

CTP is held annually since 1973 at CSA, a residential training institution that trains on average about 250 civil servants every year. However, the exact number of trainee civil servants and the proportion of the occupational group depends upon the requirement of the government in that particular year. CTP is a turning point for civil servants as it builds a foundation for their future careers. Belonging to the same CTP forms an important social and professional connection and civil service officers continue to identify themselves with their CTP number throughout their career.

The history and unique features of the Civil Services of Pakistan as they relate to the study was discussed in Chapter 4 while describing the development of the intervention. The Central Civil Services consist of twelve occupational groups, Pakistan Administrative Services, Customs Group, Income Tax Group, Accounts Groups, Foreign Services of Pakistan, Police Services of Pakistan, Military Land & Control, Postal Services, Railway Services, Office Management Group and Commerce & Trade Group.

Recruitment procedures

The Faculty Collaborators in CSA contacted the individual trainee civil servants for permission to share their email addresses with the researcher in order to allow him to contact them for the proposed study. Participants were assured that their contact details will be shared only with the research team. The trainee civil servants who agreed to be contacted received an email from the candidate with information about the study (Appendix 1). The candidate gave his phone number and e-mail address in the research information sheet in case they may wish to discuss any aspect of the study.

Participants were given 72 hours to decide on whether they would like to take part in the trial or not. In either case (willingness to participate in the study or declined consent), another e-mail followed thanking them for their time. However, if no response was received within 72 hours, two reminder e-mails were sent within a week. Participants agreeing to take part in the study consented electronically, generating an electronic consent and trial enrolment forms.

Inclusion and exclusion criteria

The trial included all trainee civil servants present at the Civil Service Academy, Lahore at the time of the trial who had given their consent to participate in it voluntarily.

Any Pakistani citizen between the age of 22 to 28 with a minimum of Bachelor level education in any faculty discipline can appear in the CSS examination. However, the age is further relaxed for those who have earlier served in the government sector therefore the age of the current group was between 22 to 35. These are civil servants belong to all regions of Pakistan. Although the exam is competitive and merit-based, there are regional as well as religious and gender-based quotas. The participants of the trial were, therefore, all citizens of Pakistan, both males, and females, aged between 22 to 35 years with at least 14 years of education. They all passed the Civil Superior Services (CSS) examination held in 2018, a country-wide competitive examination and had been assigned to one of the federal level occupational groups but have yet to carry out their official duties.

Trainee civil servants who were suffering from a physical health condition which did not allow their participation in the intervention workshops (such as infectious disease etc., as assessed by Director Programme of the academy) were excluded from the study.

The eligible consenting participants were registered with the researcher and copies of the consent and trial enrolment forms containing participant details emailed to an independent randomisation centre.

Randomisation

In this study, the unit of randomisation was individual trainee civil servants with equal number of trainee civil servants randomised into intervention and control groups. The participants were randomised with the help of a computer software, to either the intervention or control arm on a 1:1 basis by an independent researcher who did not participate in any other aspect of the study. The allocation was concealed. Each consenting eligible participant was assigned a Trial Number, and intervention allocation emailed separately to the Faculty Collaborators with a copy saved with the researcher for record purpose. The criteria used for randomisation was the age, gender, previous years of service or experience, region and occupational group.

Masking

In this study, PI (Principal Investigator), outcome assessment team and trial statistician were not aware of the allocation of study to the intervention or control group. All other team members including project manager and intervention facilitators were aware of their allocation status.

Control group

The control group received routine trainings at the Civil Service Academy which comprised of mainly classroom lectures. These sessions include lectures on public sector management, basic information technology, economics and public finance and official rules and procedures of the government of Pakistan. These lectures are held in a training and evaluative environment and the results have a serious impact on the future careers of these civil servants.

Data and Safety Monitoring Plan

A Data and Safety Monitoring Plan covers all the activities undertaken in order to protect the subjects, data and study. This plan also includes individual stopping rule and study stopping rule which identify the markers when the participation of a particular individual or the whole study could be terminated. It also covers theme measures put in place to protect participants against any risks as a result of the study as well as data security measures.

Any research should take into account physical, psychological or social risks to participants, and monitor adequately the data integrity, individual privacy and confidentiality of data, completeness of documentation etc.

Stopping rules

The trainers included a few trained psychologists who were authorized to stop the trial for individuals or even suggest scraping the study at all if they see any risk to the health of the participants. As described later, we also had a referral plan for those who were seen affected badly by the disclosure during the interventions or discovered a serious mental health issue in the process.

Data collection

Consenting participants were assigned an identification number and asked to click on a link through the CSA websites dashboard which took them to an encrypted site which guided them through the baseline assessment. A similar procedure was used for the post-intervention and 3-month assessments. All data was anonymised, and only the researcher had access to participant IDs.

At all three-time points assessments included Patient Health Questionnaire (PHQ-9), Brief-COPE, Generalised Anxiety Disorder scale (GAD-7), Psychological Capital Questionnaire (PCQ) and WHO-5 wellbeing index (See the section on outcome measures later in this Chapter for a more detailed description). All instruments were self-reported by the participants electronically by the trainee civil servants responding through a link on the CSA website, which took them to a separate secure online questionnaire. Consent was reconfirmed electronically at the start of each assessment.

Data protection and confidentiality

A primary ethical concern of the trial was to protect the data shared by study participants in the course of the research. This was also important to protect research participants from possible or perceived reprisals from CSA. For example, their disclosure of a mental illness or distress could affect their evaluation in the CTP. Therefore, I did not share any individual scores on the outcomes with CSA or any member of the faculty.

Online assessments were completed using a secured encrypted link. Data was stored on a web server hosted on password protected Google Cloud. Data was exported from the web server and stored to a password protected computer at HDRF only accessible by the researcher and research supervisors. No

personal identifying names or details were recorded and data was fully anonymised and coded. The identifying key (a list connecting names to numbers) was kept in a separate, secure locked location in the researcher's office. The data was entered into a data-analytic computer program (SPSS), without the identifying key. Appropriate firewalls, encryption, and password protection were used for network-connected devices used to store or manipulate study data. No attributable data will be used in this thesis or any following publications.

Data management plan

The assessment questionnaires were completed online through a secured encrypted link. Data was stored on a web server hosted on Password protected Google cloud and exported from the web server at the end of each day. Exported data was stored in password protected computer, only accessible by the researcher and the primary supervisor.

The data and safety monitoring plan involved the continuous evaluation of safety, data quality and data timeliness. Incoming data was cleaned and compiled on a regular basis and examined for unusual or unexpected patterns. The researcher and the primary supervisor conducted continuous review of data and participant safety at their monthly meetings.

Anonymised raw data was securely transferred to the HDRF database, cleaned and checked by the researcher. Data monitoring and quality assurance procedures were put in place both at the local site and HDRF level and overseen operationally by the researcher. The researcher was responsible for monitoring procedures during the conduct of the trial including enrolment, data collection, subject safety and wellbeing as well as data confidentiality.

Voluntary informed consent

Voluntary informed consent refers the ethical requirement of researchers to inform any human subject on the nature and implications of the study and the rights of the participants. Importantly, potential participants should be allowed to exercise their free will to participate in the study or decline (US Department of Health Human Services, 1979). All participants were required to provide electronic informed consent. Consent procedure emphasised the voluntary nature of participation, the right to withdraw from the study at any point without penalty, and the use of anonymised data in publications. Subsequently consent was reconfirmed by adding a check box at the beginning of each assessment at time

of post-intervention and follow-up assessments, this resulted in a process of continual consent aimed to ensure participants have the opportunity to raise concerns about their on-going participation or withdrawal from the study.

A key ethical consideration was the voluntary joining of the trial and absence of compulsion from CSA. For this purpose, the right to decide not to participate in the study was made explicit in the initial e mail by the researcher and the research information sheet sent through e mail (Appendix 1), highlighting that there will be no penalty for non-participation and that participants have the right to withdraw their consent to participate at any time. Management of this mistrust was an important challenge and required careful handling. This issue was recognised and addressed right from the planning stage with additional precautionary measures being taken while research was going on. Participants were also made aware that they can report unethical research practice to HDRF or the University of Liverpool.

Refreshments at all research events were provided by CSA. No incentives were offered for participation.

Risk of coercion to consent and involuntary participation

Given that the study is based at the CSA and initial contact was made through the CSA faculty who were also responsible for the evaluation of the trainee's performance in CTP, it was important to guard against perceived institutional pressure to participate in the study. It was also important to show sensitivity towards their concern that their answers during the workshop may reflect on their performance within the CTP, which has an effect of their careers. (The marks obtained in CSS examination CTP along with those obtained in the final examination after the specialised training determine the seniority of civil servants within their batch.) It had to be made absolutely clear that this training workshop is not meant for their assessment and is primarily to give them tools for dealing with potential problems.

Nevertheless, research conducted in training and evaluation-based settings does carry a risk, which needs to be accepted. For example, in the current study some trainees expressed the apprehension during data collection, that the research team might be collecting information to pass onto the CSA faculty which could be used for their evaluation. This was despite the information about confidentiality, anonymity and protection of rights being provided repeatedly. Subsequently, the research team put additional focus and attention on the potential participant’s rights, confidentiality/anonymity and importantly the participant's free will in agreeing or disagreeing to participate at any phase of the research. In addition, these

reassurances were repeated prior to the start of the assessment questionnaires and verbally at the start of each session making them aware of the measures taken to protect the confidentiality of the data.

Privacy:

Participants were repeatedly assured in all the sessions that their assessments data was not to be shared with anyone other than the research team and no individual data will be used in the publications. All information and consent materials were written in English as the participants were proficient in English.

Risks and benefits

Risk to the research team and trainers

While carrying out research on sensitive topics, the potential impact on researchers should also be assessed (Dickson-Swift, James, Kippen, & Liamputtong, 2007). This is important for prevention of burnout in researchers (Kinard, 1996). In the study, questions related to mental health and trauma carried the risk of vicarious trauma, a term used to describe the trauma to researchers and trainers asking difficult questions (McCann & Pearlman, 1990).

Risk to the participants

I do not expect that the programme will have any negative effect on the participants. However, it is possible that thinking about their feelings and well-being (while completing the assessment) may make them feel distressed, fearful or tense for a little while. Therefore, they were made aware that they may skip any questions which make them uncomfortable. They were also informed that if they felt stressed and needed to talk to someone about their feelings, they had access to Dr Hamdani at the Human Development Research Foundation (HDRF), a trained psychiatrist.

Benefits

The trial was expected to lead to embedding the intervention into routine trainings at the CSA as well as in training of other branches or at other levels of the civil servants. Key research findings were shared with CSA and participants involved in the study without sharing any individual assessment. Subsequent to the study, CSA decided to incorporate this programme in the routine CTP. I am hopeful that this would lead to capacity building in the civil services of Pakistan and enhance their ability to cope with stressful conditions.

Ethical oversight

International guidelines for carrying out research involving human participants need to be ethically reviewed carefully (ESRC, 2012, MRC, 2004). Prior ethical approval for this study was obtained from the Institutional Review Board of the Human Development Research Foundation, Pakistan and University of Liverpool's Central Ethics Committee. All research materials were developed in conformity with the research ethics, guidelines of the University of Liverpool and HDRF, Pakistan. These multiple levels of ethical review gave both institutions an opportunity for learning and experience sharing.

Trial governance

As informed earlier the trial was registered prospectively on clinicaltrials.gov (NCT03762421). The governance mechanisms put in place to provide oversight to the programme included an Expert Advisory Committee comprising of experts in the fields of public administration, mental health research, trial statistics, and bioethics. The independent chair was Dr Asad Tamiz Uddin Nizami, Professor of Psychiatry at Rawalpindi Medical University. The Committee was consulted occasionally via e-mail and Skype. A Trial Steering Committee (TSC) was also constituted which provided oversight for the conduct of the trial following its protocol and the relevant procedures. The TSC met regularly on Skype was chaired by the research supervisor (AR). It consisted of the researcher, CSA Director Programmes and trainers, and facilitators involved in the intervention delivery process.

Outcome measures

The outcome measures were evaluated at three time points i.e., prior to the delivery of the intervention, immediately post intervention (7 weeks after intervention delivery) and then at 3 months' post intervention delivery. The following matrix gives an overview of the outcome measures in terms of when they were assessed and what concepts they assessed. The outcomes measures were conducted in English as all participants were educated and well versed in English.

Box 3

Concept	***Pre-assessment measures***	***Post-treatment and 3months follow-up assessment measures***
Psychological distress	PHQ-9	PHQ-9
Coping strategies	Brief-COPE	Brief-COPE
Anxiety	GAD-7	GAD-7
Well-being	WHO-5 well-being index	WHO-5 well-being index
Psychological capital	Psychological Capital Questionnaire	Psychological Capital Questionnaire
Contamination possibility		Tailor Made Questionnaire (Only at 3 months)

Data was also collected on a number of socioeconomic and demographic factors including age, gender, educational background/earlier exposure to co-education (mixed gender schools/colleges), previous job experience, marital status, socio-economic status of the family (based upon monthly income) province of domicile, and occupational groups.

Detail of each outcome measure, divided into primary and secondary outcomes, is given below.

Primary Outcomes

Patient Health Questionnaire (PHQ-9):

The first primary outcome is change in the prevalence of psychological distress 3 months post intervention which was recorded using the 9-item Patient Health Questionnaire (PHQ-9), an instrument that incorporates DSM-IV depression diagnostic criteria with other key major depressive symptoms (Kroenke, Spitzer, & Williams, 2001). Participants rated their responses on a 4-point Likert scale ranging from not at all to nearly every day. The PHQ-9 total severity score ranges from 0 to 27.

Brief-COPE:

The Brief-COPE (Carver, 1997) was the second primary outcome which was used to assess state coping (the way people cope with a specific stressful situation) and trait coping (the usual way people cope with stress in everyday life). It consists of 14 subscales i.e. active coping, planning, positive reframing, acceptance, humour, religion, use of emotional support, use of instrumental support, self-distraction, denial, venting, substance use, behavioural disengagement, and self-blame, with two items per subscale. Cronbach's alphas for the Brief-COPE sub-scales range from 0.50 to 0.90 (Meyer, 2001).

Traditionally, coping has been defined as a special category of adaptation elicited in normal individuals by unusually taxing circumstances (Costa Jr et al., 1996). Lazarus & Folkman (1984) categorised coping behaviours as either problem-focused or emotion-focused. Behaviours, such as planned problem-solving, can be labelled as problem-focused coping while other behaviours such as distancing, self-controlling, accepting responsibility, escape/avoidance, and positive reappraisal can be categorised as emotion-focused. While the first category undertakes actions in order to eliminate the stress factor or reduce its impact, the second one alludes to actions aimed at preventing, minimizing, or reducing the emotional anguish caused by the stressful situation (Lazarus & Folkman, 1984). Endler & Parker (1990) suggested adding a third set of strategies called avoidant strategies, which focus on avoiding stressful situations by seeking the company of others or by engaging in different activities (Endler & Parker, 1990).

Secondary Outcomes

Psychological Capital Questionnaire (PCQ):

Psychological capital (PsyCap) is defined as a measurable high order construct, comprising four state-like psychological resources: self-efficacy, hope, optimism, and resilience (Harms & Luthans, 2012). Psychological Capital (PsyCap) was measured with the Psychological Capital Questionnaire (PCQ) 12 items version (Luthans et al., 2007). The PCQ consists of four dimensions: self-efficacy, hope, resilience, and optimism. Each of the four dimensions comprises six items, rated from 1 (strongly disagree) to 6 (strongly agree). Higher values indicate higher levels of experienced Psychological Capital.

Generalised Anxiety Disorder -7 scale (GAD-7):

Symptoms of anxiety were measured by GAD-7 (Spitzer et al, 2006). GAD-7 is based on the Diagnostic and Statistical Manual of Mental Disorders Version IV (DSM IV) diagnostic criteria for generalised anxiety disorder, and has 7 items. Each item is scored on a Likert scale from 0 to 3, generating a maximum score of 21. GAD-7 has been validated for Pakistani population (Ahmad et al., 2017).

WHO-5 well-being index (WHO-5):

Wellbeing will be measured by WHO-5 Well-being index (Topp et al., 2015). It is a short and generic self-reporting global rating scale measuring well-being. Respondents themselves rate how well each of the 5 statements applies to them in the last two weeks. Each of the 5 items is scored from 5 (all of the time) to 0 (none of the time). The raw score ranges from 0 (absence of well-being) to 25 (maximal well-being). Scores are then converted to a percentage scale from 0 (absent) to 100 (maximal).

The intervention

The intervention consists of 5 weekly face-to-face group sessions (workshops) lasting about 1.5 hours each. It is loosely based upon WHO's PM+ programme but was adapted through an elaborate process for the target group as explained in Chapter 4. Session 1 covers orientation about adversity and stress and provides training in slow breathing to manage stress. Session 2 introduces a problem management tool to address problems identified by participants themselves. Sessions 3 introduces behavioural activation encourages individuals to engage in routine tasks for improving their well-being. Session 4 introduces strategies to strengthen social support networks, when required. In the final Session, the strategies learnt during the workshops are reviewed.

The adapted intervention was integrated into the routine induction sessions and delivered in 5 workshops at Civil Services Academy (CSA). The workshops were separated by a week to allow for reflective learning. The Core contents of the 5 sessions of Psychosocial Skills Development Workshops are as follows

Workshop 1 Stress management:

Stress management (Deep Breathing) helps participants better manage stress related to problems in work and personal life. It can help the person to calm down at moments of stress.

Workshop 2 Problem solving:

This workshop introduces strategies for addressing practical problems being faced by participants (e.g., examination failure, career difficulties conflict in the family and so on).

Workshop 3 Behavioural activation or 'keep doing get going:'

This workshop teaches how-to carry-on social activities or necessary tasks or jobs in stressful circumstances). It also encourages a positive mindset to avoid the vicious problems/adversity cycle.

Workshop 4 Strengthening support network:

This workshop aims at strengthening a participant's social support (e.g., with trusted friends, family, co-workers or mentors) promotes wellbeing.

Workshop 5 Self-care:

This workshop revises the strategies learned and introduces the triangle of peace and calm, and the need for personal care.

Sample size calculations

Sample size calculations are based on Chi square test comparing outcome rates in intervention and control groups. I based the calculations on earlier studies especially that of entrepreneurs in Pakistan (a similar population). The primary end point in that study was also the prevalence of psychological distress at 3 months post-intervention. In the earlier study, 35% of participants scored 5 or above on the PHQ-9 (Rahman, Hamdani, et al., 2016). I assumed a similar prevalence of psychological distress (scores>=5 on PHQ 9) in the trainee civil servant population. It is still much more conservative than estimates in the general population which range from 35-65% (Mirza & Jenkins, 2004). In line with the preliminary results

from the study on Business Professionals in Pakistan, I hypothesize a reduction in prevalence from 35% to 15% in intervention arm as compared to 35% to 25% in the control arm at 3 months follow-up ((Saraf, 2019).

Since, the current sample was not derived from a clinically-referred population, I hypothesised a 20% decrease in occurrence of psychological distress in the intervention arm compared to control arm. Power calculations suggested a minimum sample size of 84 participants per group (power = 0.90; $\alpha = .05$, 2-sided). To account for a 25% attrition at 3 months' follow-up, I aimed to include a total of 240 participants, randomised into intervention (n=120) And control arms (n=120).

Data analysis

Primary Outcome Analysis

Findings are being reported according to the CONSORT guidelines for randomised control trials (CONSORT, 2010). The primary focus of analyses was on intent-to-treat analyses consisting of all the participants. Subsequent analyses considered per-protocol populations.

The primary analysis compared the prevalence of psychological distress and coping skills score before and after the intervention in the two groups, using Fisher's exact test. In the primary analyses, non-parametric tests will be used but parametric models like linear and logistic regression will be used for sensitivity analyses in order to control for baseline values of the participants' characteristics. Generalised estimating equations (GEE) were run using all time points together to investigate whether changes in psychological distress differ across the two groups and whether the changes in psychological distress differ from pre-intervention to post intervention (one week after completion of treatment) and from post intervention to follow-up (at 3 months).For the secondary continuous outcomes, a linear mixed model to assess intervention effects were conducted which allows the number of observations to vary between participants and effectively handles the missing data.

The mixed model used a longitudinal data structure that included both fixed and random effects. Intervention, time, and interaction between intervention and time were included as fixed effects in the mixed models and participants as random effect. Differences in the least squares means (intervention effects) at each time point with 95% confidence intervals were derived. A 2-sided $p < .05$ was used to define statistical significance. Covariate-adjusted mixed model was also performed by adding pre-

specified covariates at baseline into the above model. Subgroup analyses were performed on the pre-specified covariates.

To estimate the treatment effect for the primary outcome [presence of depressive symptoms as measured by PHQ-9 (cut-off score off ≥ 5)] at 3 months' post intervention, a generalised linear mixed model was used with treatment, visit, interaction between treatment and visit as fixed effects, baseline measurement of PHQ-9 as covariate, and participant as random effect. Odds ratios with their 95% confidence intervals at each visit (7 weeks and 3 months) were derived from the generalised linear mixed model analysis of a primary outcome.

Subgroup analysis

Assessment of the homogeneity of treatment effect of primary endpoint by a subgroup variable will be conducted by a generalised mixed model with the treatment, visit, subgroup var variable, and their interaction term as predictors, baseline measurement of PHQ-9 as covariate, and participant as a random effect. The odds ratio of the primary endpoint and the P-value for the interaction term will be presented. Subgroup variables will be the same as the covariates used in the covariate-adjusted analysis: baseline severity of the PHQ-9, coping skills, severity of the anxiety outcome (anxiety symptoms), personal well-being, age, previous job experience and socioeconomic status. For a continuous subgroup variable, it will be dichotomised at median in its subgroup analysis.

Socioeconomic and demographic profile of trainee civil servants

While the participants of the group participants of the study were similar in age and work experience, there was a great diversity in their social and demographic background. Out of 240 total participants, 57.9% of the participants were male (139/240), 42.1% were female. The average age of the group was 26.71 years. Average number of the year's education of the whole group was 17.84 years. There was a variety of educational background of the participants. 27% of them had a background in Business Studies whereas 24.2 percent had a background in Social Studies. 19.2% had studied in Engineering whereas 6.7% had studied in Law. There was a variety of other subjects which were studied by the participants which including Aero Sciences, MBBS, Thermodynamics, Transportation, Water Sciences, Policy and Management, Veterinary Sciences, etc. These miscellaneous educational backgrounds comprised 22.9% number of the total participants.

In response of the question whether they had experiences of co-education, all of the participants replied yes. This question seems to be not properly phrased. It seems that there were while answering the question on experience with co-education, the participants were not thinking of just their previous education but also of the CTP where obviously they were all studying in a co-educational atmosphere.

19.2% of the total participants were currently married whereas 80% of the participants had never married only 0.8% of the participants had separated from their spouses.

About 30% of the participants had no previous job experience whereas 70% of the participants had some sort of prior job experience. Out of the ones that had job experience 35% had worked in the government sector whereas 34% had an experience in the private sector. Only 1.3% of the total participants had worked in the business sector. Among those who had job experience, a vast majority had a job experience of less than year (53%) whereas 15.8% had a work experience of 1 to 2 years. About 30% of the total participants had a work experience of more than 2 years.

Data was also collected on the participant's provincial origins. This was not significant because the allocations are made on pre-determined regional quota with a small number of participants selected on merit (10%). However, it is important to note for a randomisation point of view that the intervention and control group both contains nearly similar proportions of people belonging to various provinces.

Data was also collected on the average annual family income of the participants, in order to have some idea of their socio-economic class.

Table below shows the distribution of participants across two groups on the characteristics of gender, age, education, previous subject study, experience with co-education, marital status occupational group, previous job experience, province of domicile and household income.

Table 21: Demographic characteristics of participants across both groups (N=240)

Variables	Intervention group (n=120) *f* (%)	Control group (n=120) M(SD) *f* (%)	Total *f* (%)	*p*
Age (M[SD])	26.81 (2.12)	26.62 (2.37)	26.71 (2.25)	0.18
Gender				
Males	64 (53.3%)	75(62.5%)	139 (57.9%)	0.09
Female	56 (46.7%)	45(37.5%)	101 (42.1%)	
Education (M[SD])	17.88 (2.49)	17.88 (2.39)	17.84 (2.44)	0.69
Subject				
Business studies	32 (26.7)	33 (27.5)	65 (27.1)	0.03
Social Sciences	32 (26.7)	26 (21.7)	58 (24.2)	
Engineering	14 (11.7)	32 (26.7)	46 (19.2)	
Law	9 (7.5)	7 (5.8)	16 (6.7)	
Others	33 (27.5)	22 (18.3)	55 (22.9)	
Co-education				
Yes	120 (100%)	120 (100%)	240	
Marital status				
Currently married	23 (19.2%)	23 (19.2%)	46 (19.2%)	1
Never married	96 (80%)	96 (80%)	192 (80%)	
Separated	1 (0.8%)	1 (0.8%)	2 (0.8%)	

Service group				
Audit and accounts	4 (3.3)	7 (5.8)	11 (4.6)	0.70
Foreign Services of Pakistan	9 (7.5)	12 (10)	21 (8.8)	
Pakistan Administrative Services	20 (16.7)	16 (13.3)	36 (15)	
Office Management Group	20 (16.7)	20 (16.7)	40 (16.7)	
Customs	19 (15.8)	13 (10.8)	32 (13.3)	
Others	48 (40)	52 (43.3)	100 (41.7)	
Job experience				
No	39 (32.5%)	35 (29.2%)	74 (30.8%)	0.33
Yes	81 (67.5%)	85 (70.8%)	166 (69.2%)	
Previous job experience				
Govt.	46 (38.3)	40 (33.3)	86 (35.8)	
Private	35 (29.2)	47 (39.2)	82 (34.2)	
Business	2 (1.7)	1 (0.8)	3 (1.3)	
Not applicable	37 (30.8)	32 (26.7)	69 (28.8)	
Years of experience				

Less than 1 year	65 (54.2)	63 (52.5)	128 (53.3)	0.55
1-2 years	16 (13.3)	22 (18.3)	28 (15.8)	
More than 2 years	39 (32.5)	35 (29.2)	74 (30.8)	
Province				
Punjab	77 (64.2)	70 (58.3)	147 (61.3)	0.45
Sindh	13 (10.8)	15 (12.5)	28 (11.7)	
KPK	11 (9.2)	19 (15.3)	30 (12.5)	
AJK	4 (3.3)	2 (1.7)	6 (2.5)	
Gilgit Baltistan	7 (5.6)	10 (8.3)	17 (7.1)	
Baluchistan	4 (3.3)	1 (0.8)	5 (2.1)	
Others	4 (3.3)	3 (2.5)	7 (2.9)	
Family income in PKR (M[SD])	310400.03 (544318.26)	324617.52 (495112.59)	317508.78 (519256.67)	0.89

Notes: Subject -others= Aero Sciences, MBBS, Thermodynamics, Transportation, Water Sciences, Policy and Management, Veterinary Sciences, Wireless Communication; Service group-others=Information Group, Inland Revenue Services, International Relations, Police Services of Pakistan, Railways Commercial and Transportation Group, Military Lands and Cantonments; Province-jobs= Islamabad, FATA,

As can be seen from the data in the above table, there were no significant differences between the intervention and control groups in terms of demographic characteristics of the participants thus proving the success of randomisation.

Conclusion

In line with the aim of this study to evaluate the effectiveness of an especially adapted intervention for improving psychological well-being among a group of newly inducted civil servants in Pakistan,

Chapter 4 described the development of a feasible and culturally appropriate intervention for the target group.

In this Chapter, the methodology used to evaluate its effectiveness was covered. While talking about the methodology used to evaluate the intervention, I discussed the research design, the study settings and populations, ethical considerations of the study, and outcomes. The following Chapter will describe the findings of the randomised controlled trial to test the hypotheses.

Chapter 6

Findings

The world breaks everyone and afterward many are strong at the broken places

Ernst Hemingway

Chapter 6: Findings and analysis

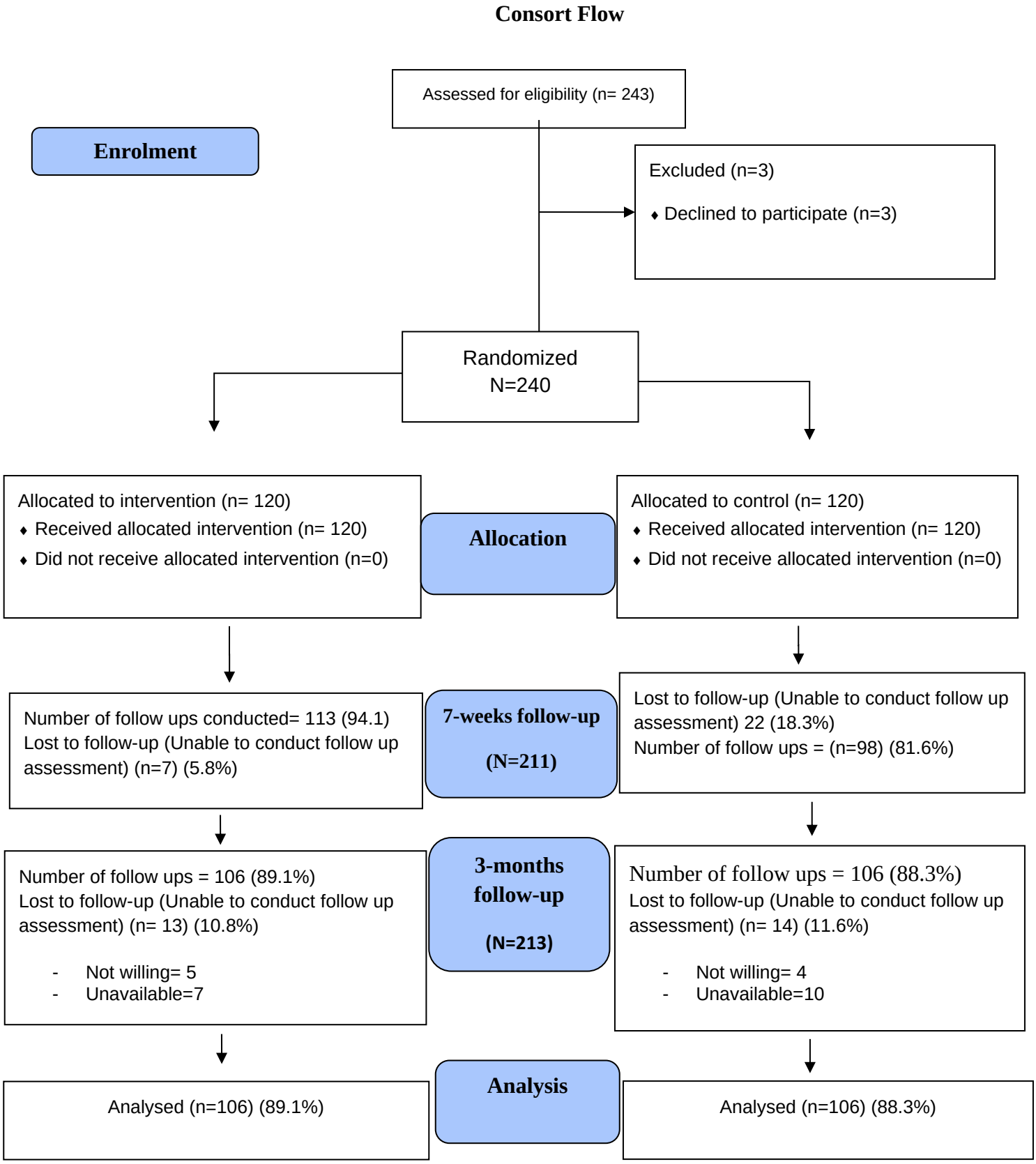
Before I describe the findings of the study, it would be pertinent to review its aims, objectives and hypotheses. The aim of this study was to evaluate the effectiveness of a culturally adapted intervention for improving psychological well-being among a group of newly inducted civil servants in Pakistan. Its primary hypothesis was that prevalence of psychological distress will be reduced and coping skills enhanced in the group receiving the intervention with usual training at Civil Services Academy (CSA) as compared to the group receiving the usual training only. The secondary hypotheses are that in the intervention group, there will be an improvement in anxiety symptoms, psychological well-being, coping skills and psychological capital in comparison with the control group.

The previous Chapter described the methodology used to evaluate the effectiveness of the intervention. In this Chapter, I will describe the findings of the randomised controlled Study.

Participants Flow Chart

In the previous Chapter based upon previous studies in Pakistan I found that a minimum sample size of 84 participants per group (power = 0.90; α = .05, 2-sided) to be required for the Randomised Controlled Trial. To account for a 25% attrition at 3 months' follow-up, we aimed to include a total of 240 participants, randomised into intervention (n=120) and control arms (n=1207). I hypothesised a reduction in prevalence from 35% to 15% in intervention arm as compared to 35% to 25% in the control arm at 3 months follow-up (Hamdani et al, 2021). I anticipated less than 5% refusal/non-responsiveness rate out of total 243 participants at CSA.

Figure 3: The following flow chart gives an overview of the number of participants of the study.



***Findings*:**

A total of 240 participants were recruited and randomised by an independent researcher into an intervention and control group after the baseline assessment on a 1:1 allocation ratio using a computer software. About 88% (211/240) and 88.75% (213/240) of the participants completed the post assessment at 7 weeks and 3 months' post intervention respectively. T-test and chi-square analyses were computed to compare the difference between two groups on socio-demographic variables at baseline.

Data was collected on the impact of the intervention delivery (at 7 weeks' post intervention) and 3 months' post intervention via online questionnaires.

In order to compare the occurrence of the outcomes across two groups, I calculated odds ratio by using generalised mixed model analysis and adjusted the imbalances of age, baseline severity of depressive symptoms (PHQ-9 scores), coping skills, anxiety symptoms (GAD-7 scores), personal well-being (WHO-5 scores) and psychological capital across two arms. Findings are being reported according to the CONSORT guidelines for randomised control trials (CONSORT, 2010).

The analysis of the present study was 'Intention to Treat'(ITT)-which means that once all the participants are randomised into intervention and control arm, all of them are analysed regardless of if they complete endpoint or not (Gupta, 2011). ITT analysis includes every subject who is randomised according to randomised treatment assignment and ignores noncompliance, protocol deviations, withdrawal, and anything that happens after randomisation. Subsequent analyses considered per-protocol populations.

The primary analysis involved comparing pre to post changes in the prevalence of psychological distress of the participants randomly assigned to the arms, using Fisher's exact test. Primary analyses used non-parametric tests; however, sensitivity analyses used parametric models such as linear and logistic regression to control for baseline values of the participants' characteristics. Generalised estimating equations (GEE) were run using all time points together to investigate whether changes in psychological distress differ across the two groups and whether the changes in psychological distress differ from pre-intervention to post intervention (one week after completion of treatment) and from post intervention to follow-up (at 3 months).

For the secondary continuous outcomes, a linear mixed model to assess intervention effects was conducted which allows the number of observations to vary between participants and effectively handle the missing data.

The mixed model used a longitudinal data structure that included both fixed and random effects. Intervention, time, and interaction between intervention and time were included as fixed effects in the mixed models and participants as random effect. Differences in the least squares means (intervention effects) at each time point with 95% confidence intervals were derived. A 2-sided $p < .05$ was used to define statistical significance. Covariate-adjusted mixed model was also performed by adding pre-specified covariates at baseline into the above model. Subgroup analyses were performed on the pre-specified covariates.

The findings of ITT analysis follow.

Impact of intervention on primary outcome (depressive symptoms)

The primary objective of the study was to evaluate the impact of the intervention delivered along with usual training at Civil Services Academy to reduce the occurrence of depressive symptoms at 3 months' post intervention and enhance coping skills. It compared the results of self-reported PHQ-9 on the intervention arm which received the intervention and the usual training with those in the control arm which received the usual training only. It evaluated which of these groups will report greater decrease in the occurrence of depression at 3 months' post intervention delivery.

The items of PHQ-9 measure self-reported symptoms like little interest or pleasure in doing things, feeling down, trouble falling or staying asleep, feeling tired or having little energy, trouble concentrating on things, being so fidgety or restless. A high score on PHQ-9 indicates that the respondent is experiencing these symptoms more than 3 days during last two 2 weeks. The following table shows the differences in the mean scores on PHQ-9 across the intervention as well as control group at the three time points.

Table 22: Difference of mean scores on PHQ-9 across both groups at baseline, 7 week and 3 months (N=240)

Scales	**N**	**Intervention group** *M(SD)*	**N**	**Control group** *M(SD)*	***t***	***95%CI*** *UL-LL*	***p***
PHQ-9							
Pre-treatment	120	4.14 (3.54)	120	3.80 (3.29)	0.75	-0.53-1.20	0.36
Post-treatment	113	2.61 (2.98)	98	3.64 (4.72)	-1.86	-2.09-0.02	0.002
3-months follow-up	106	2.70 (3.66)	106	3.13 (3.73)	-0.83	-1.42-0.57	0.89

Cases of depression across two groups

The participants, who scored greater than 5 on PHQ-9 scale were considered as depressed cases (Case). The case of depression on PHQ-9 is defined as someone who experiences symptoms of little interest or pleasure in doing things, feeling down, trouble falling or staying asleep, feeling tired or having little energy, trouble concentrating on things, being so fidgety or restless on at least 3 days during the last two weeks.

At the baseline, the cases in the intervention group were 51 i.e., 42.5 % as compared to 43 (35.8%) in the control group. In post intervention follow up these numbers decreased to 22 (19.5%) and 28 (28.6%) respectively. In the 3 month follow up the cases in the intervention group remained almost the same whereas those in the control group showed a slight increase (from 28 to 30). The percentage of non-cases significantly increase in the post intervention follow up in the intervention group compared to the baseline figure [91 (80.5%) VS 69 (57.5%)].

The percentage of non-cases remained at 80.2% at the 3 month follow up in the intervention group. On the other hand, there was a smaller increase in the non-cases in the control group while comparing the baseline and post intervention follow up figures [77 (64.2%) VS 70 (71.4%)]. The percentage remained the same in the 3 months follow up. It is to be noted that the actual figures of non-cases in the 3 months

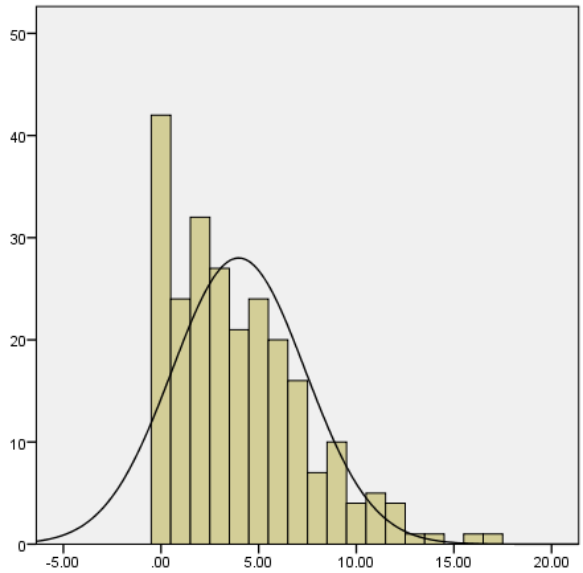
follow up were slightly different because of the total number of respondents varying in the various follow ups.

Table 23: Categories of Patient Health Questionnaire (PHQ-9) at baseline, 7- weeks and 3 months across both groups (N=240)

Time points	2 categories of PHQ-9	Intervention Group f (%)	Control Group f (%)	Total f (%)	$\chi 2$	*p*
Baseline	Non-Case (0-4)	69 (57.5)	77 (64.2)	146 (60.8)	0.635	0.17
	Case (5 &greater)	51 (42.5)	43 (35.8)	94 (39.2)		
Post-intervention follow-up	Non-Case (0-4)	91 (80.5)	70 (71.4)	161 (76.3)	2.40	0.08
	Case (5 & greater)	22 (19.5)	28 (28.6)	50(23.7)		
3-months follow-up	Non-Case (0-4)	85 (80.2)	76 (71.7)	161 (75.9)	2.09	0.09
	Case (5 & greater	21 (19.8)	30 (28.3)	51 (24.1)		

p>0.001

Figure 4: Distribution curve for PHQ-9 scores (N=240)



Odds Ratio Results

Adjusted results

Primary analysis showed that *one week* after baseline, there was inverse association between intervention sessions and prevalence of PHQ-9 and GAD-7 cases, odds ratio (95% CI) for PHQ-9 and GAD-7cases were 0.41(0.19-0.89) and 0.31(0.12-0.78) respectively. Adjustments for potential mediating factors (covariate analysis) like baseline outcome data, age, gender, years of education, marital status, service group, years of previous job experience, and monthly family income led to a minimal attenuation [OR 0.37(0.16-0.83) and 0.25(0.09-0.70) respectively]. It was also observed that *three months* after baseline there was also an inverse association between intervention sessions and prevalence of PHQ-9, odds ratio (95% CI) for PHQ-9 cases were 0.41(0.19-0.87).

Sub group analysis

Results indicate that *one week* after baseline, there was inverse association between intervention sessions and prevalence of PHQ-9 cases for sub group >=1 year of job experience and <150000 monthly income, odds ratio (95% CI) for PHQ-9 were 0.24(0.09-0.63) and 0.14(0.04-0.45) respectively. It was also observed that *three months* after baseline there was also an inverse association between intervention sessions and prevalence of PHQ-9 cases for sub group males, >=26 years of age, >=1 year of job

experience, odds ratio (95% CI) for PHQ-9 cases were 0.34(0.12-0.98), 0.39(0.15-1.01), and 0.26(0.10-0.68), respectively.

Unadjusted results

Covariate analysis showed that *one week* after baseline, there was inverse association between intervention sessions and prevalence of PHQ-9 and GAD-7cases, odds ratio (95% CI) for PHQ-9 and GAD-7cases were 0.37(0.16-0.83) and 0.25(0.09-0.70) respectively. It was also observed that *three months* after baseline there was also an inverse association between intervention sessions and prevalence of PHQ-9, odds ratio (95% CI) for PHQ-9 cases were 0.37(0.17-0.83).

Sub group analysis

Results indicate that *one week* after baseline, there was inverse association between intervention sessions and prevalence of PHQ-9 cases for sub group >=26 years of age and <150000 monthly income, odds ratio (95% CI) for PHQ-9 were 0.28(0.11-0.74) and 0.29(0.10-0.85) respectively.

Generalised Mixed Model Analysis

Primary analysis showed that one *week* after baseline, the intervention arm had significantly lower scores on **PHQ-9** (mean [SD], 2.61 [2.98] vs 3.64 [4.72]; mean difference [MD], -1.02; 95% CI, -2.01 to -0.03) and **Transformed WHO-5**(mean [SD], 78.05 [15.05] vs 73.02 [17.76]; MD, 4.66; 95% CI, 0.01 to 9.31).

Covariate analysis showed that one *week* after baseline, the intervention arm had significantly lower scores on **Brief COPE** (mean [SD], 24.09 [8.78] vs 23.39 [9.28]; MD, 2.07; 95% CI, 0.14 to 4.01) and **GAD-7(**mean [SD], 1.75 [2.80] vs 2.23 [3.86]; MD, -0.70; 95% CI, -1.38 to -0.02). Covariate analysis showed that three *months after* baseline, the intervention arm had significantly lower scores on **COPE** (mean [SD], 23.42 [8.68] vs 21.92 [8.55]; MD, 2.11; 95% CI, 0.19 to 4.04).

Imputation analysis showed that *three months after* baseline, the intervention arm had significantly lower scores on **Transformed WHO-5**(mean [SD], 77.55 [18.62] vs 74.72 [19.39]; MD, 3.64; 95% CI, -0.09 to 7.37).

The following tables summarise the findings.

Table 24: Summary statistics and results from mixed-model analysis of primary and secondary outcomes (Unadjusted results, primary analysis)

Primary and secondary outcomes	**Visit**	**Intervention Arm**		**Control Arm**		**Primary analysis**	**p-value**
		N	**M (SD)**	**N**	**M (SD)**	**Mean Difference (95% CI)**	
PHQ-9	Baseline	120	4.14(3.54)	120	3.81(3.29)	0.33(-0.60,1.26)	0.481
	1 week	113	2.61(2.98)	98	3.64(4.72)	-1.02(-2.01, -0.03)	0.043
	3 months	106	2.71(3.67)	106	3.13(3.74)	-0.37(-1.35,0.62)	0.465
Brief-COPE	Baseline	120	22.63(7.72)	120	23.70(7.64)	-1.08(-3.21,1.06)	0.322
	1 week	113	24.09(8.78)	98	23.39(9.28)	0.98(-1.28,3.23)	0.394
	3 months	106	23.42(8.68)	106	21.92(8.55)	1.45(-0.79,3.69)	0.205
PCQ	Baseline	120	83.53(7.24)	120	83.67(8.08)	-0.14(-2.90,2.62)	0.920
	1 week	113	83.22(11.27)	98	82.96(13.31)	0.27(-2.67,3.21)	0.856
	3 months	106	82.21(11.52)	106	82.38(13.24)	-0.11(-3.03,2.82)	0.943
GAD	Baseline	120	2.40(2.60)	120	2.08(2.92)	0.32(-0.47,1.10)	0.426
	1 week	113	1.75(2.80)	98	2.23(3.86)	-0.45(-1.28,0.37)	0.281
	3 months	106	1.65(2.98)	106	1.92(3.31)	-0.21(-1.04,0.61)	0.608
Transformed WHO-5	Baseline	120	68.37(17.68)	120	69.93(15.30)	-1.57(-5.96,2.83)	0.484
	1 week	113	78.05(15.05)	98	73.02(17.76)	4.66(0.01,9.31)	0.049
	3 months	106	77.55(18.62)	106	74.72(19.39)	2.90(-1.73,7.52)	0.220

Table 25: Summary statistics and results from mixed-model analysis of primary and secondary outcomes (Unadjusted results, Covariant analysis)

Primary and secondary outcomes	**Visit**	**Intervention Arm**		**Control Arm**		**Covariate analysis**	**p-value**
		N	**M (SD)**	**N**	**M (SD)**	**Mean Difference (95% CI)**	
PHQ-9	Baseline	120	4.14(3.54)	120	3.81(3.29)	0.24(-0.56,1.04)	0.558
	1 week	113	2.61(2.98)	98	3.64(4.72)	-1.08(-1.94, -0.23)	0.013
	3 months	106	2.71(3.67)	106	3.13(3.74)	-0.46(-1.32,0.39)	0.285
Brief-COPE	Baseline	120	22.63(7.72)	120	23.70(7.64)	-0.25(-2.07,1.56)	0.783
	1 week	113	24.09(8.78)	98	23.39(9.28)	2.07(0.14,4.01)	0.036
	3 months	106	23.42(8.68)	106	21.92(8.55)	2.11(0.19,4.04)	0.032
PCQ	Baseline	120	83.53(7.24)	120	83.67(8.08)	0.26(-2.36,2.89)	0.844
	1 week	113	83.22(11.27)	98	82.96(13.31)	0.72(-2.08,3.52)	0.614
	3 months	106	82.21(11.52)	106	82.38(13.24)	0.30(-2.50,3.09)	0.834
GAD	Baseline	120	2.40(2.60)	120	2.08(2.92)	0.08(-0.56,0.72)	0.799
	1 week	113	1.75(2.80)	98	2.23(3.86)	-0.70(-1.38, -0.02)	0.044
	3 months	106	1.65(2.98)	106	1.92(3.31)	-0.43(-1.11,0.25)	0.210
Transformed WHO-5	Baseline	120	68.37(17.68)	120	69.93(15.30)	-1.25(-5.03,2.52)	0.515
	1 week	113	78.05(15.05)	98	73.02(17.76)	4.68(0.66,8.71)	0.023
	3 months	106	77.55(18.62)	106	74.72(19.39)	2.83(-1.18,6.85)	0.166

Table 26: Summary statistics and results from mixed-model analysis of primary and secondary outcomes (Unadjusted results, imputation analysis)

Primary and Secondary outcomes	**Visit**	**Intervention Arm**		**Control Arm**		**Imputation analysis**	**p-value**
		N	**M (SD)**	**N**	**M (SD)**	**Mean Difference (95% CI)**	
PHQ-9	Baseline	120	4.14(3.54)	120	3.81(3.29)	0.26(-0.53,1.05)	0.519
	1 week	113	2.61(2.98)	98	3.64(4.72)	-1.01(-1.80, -0.22)	0.013
	3 months	106	2.71(3.67)	106	3.13(3.74)	-0.28(-1.07,0.51)	0.483
Brief-COPE	Baseline	120	22.63(7.72)	120	23.70(7.64)	-0.19(-1.97,1.60)	0.837
	1 week	113	24.09(8.78)	98	23.39(9.28)	2.26(0.48,4.05)	0.013
	3 months	106	23.42(8.68)	106	21.92(8.55)	2.43(0.65,4.21)	0.008
PCQ	Baseline	120	83.53(7.24)	120	83.67(8.08)	0.23(-2.34,2.79)	0.863
	1 week	113	83.22(11.27)	98	82.96(13.31)	0.49(-2.07,3.06)	0.706
	3 months	106	82.21(11.52)	106	82.38(13.24)	0.56(-2.01,3.13)	0.669
GAD	Baseline	120	2.40(2.60)	120	2.08(2.92)	0.09(-0.54,0.72)	0.777
	1 week	113	1.75(2.80)	98	2.23(3.86)	-0.63(-1.25,0.00)	0.050
	3 months	106	1.65(2.98)	106	1.92(3.31)	-0.34(-0.97,0.28)	0.283
Transformed WHO-5	Baseline	120	68.37(17.68)	120	69.93(15.30)	-1.29(-5.02,2.44)	0.497
	1 week	113	78.05(15.05)	98	73.02(17.76)	4.41(0.68,8.14)	0.021
	3 months	106	77.55(18.62)	106	74.72(19.39)	3.64(-0.09,7.37)	0.056

Adjusted results

Primary analysis showed that *one week* after baseline, the intervention arm had significantly lower scores on **PHQ-9** (mean [SD], 2.61 [2.98] vs 3.64 [4.72]; adjusted mean difference [AMD], -1.19; 95%

CI, -2.04 to -0.34), **COPE** (mean [SD], 24.09 [8.78] vs 23.39 [9.28]; AMD, 1.95; 95% CI, 0.06 to 3.84), **GAD-7**(mean [SD], 1.75 [2.80] vs 2.23 [3.86]; AMD, -0.68; 95% CI, -1.35 to -0.00) and **Transformed WHO-5**(mean [SD], 78.05 [15.05] vs 73.02 [17.76]; AMD, 5.27; 95% CI, 1.27 to 9.28). Primary analysis showed that three *months after* baseline, the intervention arm had significantly lower scores on **COPE** (mean [SD], 23.42 [8.68] vs 21.92 [8.55]; AMD, 1.96; 95% CI, 0.08 to 3.84)

Imputation analysis showed that *three months* after baseline, the intervention arm had significantly lower scores on **Transformed WHO-5**(mean [SD], 77.55 [18.62] vs 74.72 [19.39]; AMD, 3.64; 95% CI, -0.09 to 7.37).

The tables below summarize the findings

Table 27: Summary statistics and results from mixed-model analysis of primary and secondary outcomes (Adjusted results, primary analysis)

Primary and secondary outcomes	**Visit**	**Intervention Arm**		**Control Arm**		**Covariate analysis**	**p-value**
		N	**M (SD)**	**N**	**M (SD)**	**Mean Difference (95% CI)**	
PHQ-9	Baseline	120	4.14(3.54)	120	3.81(3.29)	0.24(-0.56,1.04)	0.558
	1 week	113	2.61(2.98)	98	3.64(4.72)	-1.08(-1.94, -0.23)	0.013
	3 months	106	2.71(3.67)	106	3.13(3.74)	-0.46(-1.32,0.39)	0.285
Brief-COPE	Baseline	120	22.63(7.72)	120	23.70(7.64)	-0.25(-2.07,1.56)	0.783
	1 week	113	24.09(8.78)	98	23.39(9.28)	2.07(0.14,4.01)	0.036
	3 months	106	23.42(8.68)	106	21.92(8.55)	2.11(0.19,4.04)	0.032
PCQ	Baseline	120	83.53(7.24)	120	83.67(8.08)	0.26(-2.36,2.89)	0.844
	1 week	113	83.22(11.27)	98	82.96(13.31)	0.72(-2.08,3.52)	0.614
	3 months	106	82.21(11.52)	106	82.38(13.24)	0.30(-2.50,3.09)	0.834

GAD	Baseline	120	2.40(2.60)	120	2.08(2.92)	0.08(-0.56,0.72)	0.799
	1 week	113	1.75(2.80)	98	2.23(3.86)	-0.70(-1.38, -0.02)	0.044
	3 months	106	1.65(2.98)	106	1.92(3.31)	-0.43(-1.11,0.25)	0.210
Transformed WHO-5	Baseline	120	68.37(17.68)	120	69.93(15.30)	-1.25(-5.03,2.52)	0.515
	1 week	113	78.05(15.05)	98	73.02(17.76)	4.68(0.66,8.71)	0.023
	3 months	106	77.55(18.62)	106	74.72(19.39)	2.83(-1.18,6.85)	0.166

Table 28: Summary statistics and results from mixed-model analysis of primary and secondary outcomes (Adjusted results, covariant analysis)

Outcomes	**Visit**	**Intervention Arm**		**Control Arm**		**Imputation analysis**	**p-value**
		N	**M (SD)**	**N**	**M (SD)**	**Mean Difference (95% CI)**	
PHQ-9	Baseline	120	4.14(3.54)	120	3.81(3.29)	0.26(-0.53,1.05)	0.519
	1 week	113	2.61(2.98)	98	3.64(4.72)	-1.01(-1.80, -0.22)	0.013
	3 months	106	2.71(3.67)	106	3.13(3.74)	-0.28(-1.07,0.51)	0.483
Brief-COPE	Baseline	120	22.63(7.72)	120	23.70(7.64)	-0.19(-1.97,1.60)	0.837
	1 week	113	24.09(8.78)	98	23.39(9.28)	2.26(0.48,4.05)	0.013
	3 months	106	23.42(8.68)	106	21.92(8.55)	2.43(0.65,4.21)	0.008
PCQ	Baseline	120	83.53(7.24)	120	83.67(8.08)	0.23(-2.34,2.79)	0.863

	1 week	113	83.22(11.27)	98	82.96(13.31)	0.49(-2.07,3.06)	0.706
	3 months	106	82.21(11.52)	106	82.38(13.24)	0.56(-2.01,3.13)	0.669
GAD	Baseline	120	2.40(2.60)	120	2.08(2.92)	0.09(-0.54,0.72)	0.777
	1 week	113	1.75(2.80)	98	2.23(3.86)	-0.63(-1.25,0.00)	0.050
	3 months	106	1.65(2.98)	106	1.92(3.31)	-0.34(-0.97,0.28)	0.283
Transformed WHO-5	Baseline	120	68.37(17.68)	120	69.93(15.30)	-1.29(-5.02,2.44)	0.497
	1 week	113	78.05(15.05)	98	73.02(17.76)	4.41(0.68,8.14)	0.021
	3 months	106	77.55(18.62)	106	74.72(19.39)	3.64(-0.09,7.37)	0.056

Table 29: Summary statistics and results from mixed-model analysis of primary and secondary outcomes (Adjusted results, imputation analysis)

Outcomes	**Visit**	**Intervention Arm**		**Control Arm**		**Primary analysis**	**p-value**
		N	**M (SD)**	**N**	**M (SD)**	**Mean Difference (95% CI)**	
PHQ-9	Baseline	120	4.14(3.54)	120	3.81(3.29)	0.15(-0.65,0.95)	0.712
	1 week	113	2.61(2.98)	98	3.64(4.72)	-1.19(-2.04, -0.34)	0.006
	3 months	106	2.71(3.67)	106	3.13(3.74)	-0.60(-1.45,0.25)	0.166
Brief-COPE	Baseline	120	22.63(7.72)	120	23.70(7.64)	-0.41(-2.18,1.36)	0.648
	1 week	113	24.09(8.78)	98	23.39(9.28)	1.95(0.06,3.84)	0.044
	3 months	106	23.42(8.68)	106	21.92(8.55)	1.96(0.08,3.84)	0.041

PCQ	Baseline	120	83.53(7.24)	120	83.67(8.08)	-0.08(-2.69,2.53)	0.954
	1 week	113	83.22(11.27)	98	82.96(13.31)	0.33(-2.46,3.12)	0.818
	3 months	106	82.21(11.52)	106	82.38(13.24)	0.02(-2.76,2.79)	0.989
GAD	Baseline	120	2.40(2.60)	120	2.08(2.92)	0.11(-0.52,0.74)	0.739
	1 week	113	1.75(2.80)	98	2.23(3.86)	-0.68(-1.35, -0.00)	0.049
	3 months	106	1.65(2.98)	106	1.92(3.31)	-0.44(-1.11,0.23)	0.195
Transformed WHO-5	Baseline	120	68.37(17.68)	120	69.93(15.30)	-0.71(-4.46,3.04)	0.711
	1 week	113	78.05(15.05)	98	73.02(17.76)	5.27(1.27,9.28)	0.010
	3 months	106	77.55(18.62)	106	74.72(19.39)	3.57(-0.42,7.55)	0.079

Impact of intervention on Coping skills of trainee civil servants

Brief-COPE was used to assess coping skills of the trainee civil servants. The coping skills of trainee civil servants were assessed on the 7 domains of Brief-COPE; 1) Active coping, 2) Positive reframing, 3) Acceptance, 4) Planning, 5) Religion 6) Emotional Support and 7) Instrumental support. These coping skills are related to the personal goal completion and progress of the trainee civil servants. The following table shows the scores for Brief-COPE as well as its sub domains for both the intervention and control group.

Table 30: Difference of mean scores on Brief-COPE across both groups at baseline, 7 weeks and 3 months (N=240)

***Brief-COPE Scale**							
Active coping							
Pre-treatment	120	4.18 (1.47)	120	4.18 (1.43)	0.00	-0.37-0.37	0.73
Post-treatment	113	4.12 (1.75)	98	3.98 (1.74)	0.55	-0.34-0.61	0.71
3-months follow-up	106	3.97 (1.74)	106	3.78 (1.63)	0.81	-0.26-0.64	0.94
Instrumental support							
Pre-treatment	120	3.10 (1.67)	120	3.34 (1.78)	-1.04	-0.67-0.20	0.18
Post-treatment	113	3.73 (1.60)	98	3.68 (1.89)	0.21	-0.42-0.52	0.05
3-months follow-up	106	3.73 (1.60)	106	3.48 (1.73)	1.11	-0.19-0.70	0.28
Emotional support							
Pre-treatment	120	3.40 (1.70)	120	3.50 (1.75)	-0.44	-0.53-0.33	0.65
Post-treatment	113	3.86 (1.71)	98	3.55 (1.87)	1.27	-0.17-0.80	0.14
3-months follow-up	106	3.68 (1.70)	106	3.63 (1.73)	0.57	-0.40-0.52	0.57
Positive reframing							

Pre-treatment	120	3.98 (1.60)	120	4.53 (1.68)	-2.59	-0.96- - 0.13	0.22
Post-treatment	113	4.28 (1.60)	98	4.17 (1.73)	0.47	-0.34- 0.56	0.45
3-months follow-up	106	4.03 (1.63)	106	3.74 (1.65)	1.29	-0.15 – 0.73	0.78
Acceptance							
Pre-treatment	120	3.90 (1.56)	120	4 (1.65)	-0.48	-0.50-0.30	0.94
Post-treatment	113	4.15 (1.51)	98	4.04 (1.68)	0.53	-0.31-0.55	0.59
3-months follow-up	106	4.04 (1.59)	106	3.67 (1.75)	1.59	-0.08-0.82	0.06
Planning							
Pre-treatment	120	4.04 (1.49)	120	4.13 (1.58)	-0.46	-0.48-0.30	0.29
Post-treatment	113	3.92 (1.63)	98	3.94 (1.63)	-0.12	-0.47-0.41	0.70
3-months follow-up	106	4.16 (1.58)	106	3.86 (1.60)	1.33	-0.13-0.72	0.79
Religion							
Pre-treatment	120	3.81 (1.76)	120	3.41 (2.03)	1.62	-0.08-0.88	0.00
Post-treatment	113	3.90 (1.70)	98	3.59 (1.92)	1.24	-0.18-0.80	0.04
3-months follow-up	106	3.82 (1.70)	106	3.47 (1.86)	1.42	-0.13-0.83	0.08

$p<0.001$; $p<0.05$; $p>0.05$

The above table shows that the score of all the sub scales of the Brief-COPE questionnaire was nearly equal across both groups at baseline 7 weeks and 3 months. The following table shows a comparison of the Brief COPE sub scales in both groups at 3 months.

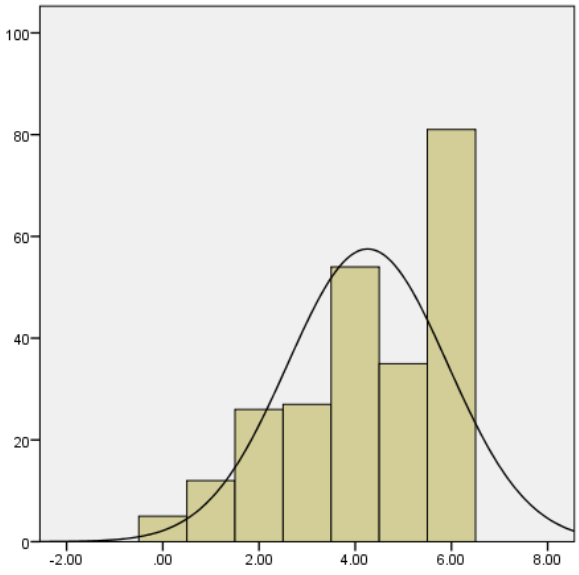
Table 31: The descriptive statistics of Brief-COPE across both groups at 3 months

Scales	**N**	**Intervention group** ***M(SD)***	**N**	**Control group** ***M(SD)***	***t***	***95%CI*** ***UL-LL***	***p***
Active coping	106	3.97 (1.74)	106	3.78 (1.63)	0.81	-0.26-0.64	0.94
Instrumental support	106	3.73 (1.60)	106	3.48 (1.73)	1.11	-0.19-0.70	0.28
Emotional support	106	3.68 (1.70)	106	3.63 (1.73)	0.57	-0.40-0.52	0.57
Positive reframing	106	4.03 (1.63)	106	3.74 (1.65)	1.29	-0.15 – 0.73	0.78
Acceptance	106	4.04 (1.59)	106	3.67 (1.75)	1.59	-0.08-0.82	0.06
Planning	106	4.16 (1.58)	106	3.86 (1.60)	1.33	-0.13-0.72	0.79
Religion	106	3.82 (1.70)	106	3.47 (1.86)	1.42	-0.13-0.83	0.08

*Note: *P-values in the above table indicated that the difference between two groups on the composite scores and on all domains of Brief-COPE scale (i.e., emotional support, instrumental support, positive reframing, acceptance, planning, and religion) was statistically insignificant.*

The data on coping skills of Trainee Civil Servant indicated consistently high mean scores on 3 domains; Positive reframing, Acceptance and Planning in both groups (intervention and control) which indicates that trainee civil servants use these coping skills more often. However, the scores are relatively

low on Active coping, Religion, Emotional Support and Instrumental support in both groups, indicating trainee civil servants use less of these coping skills to manage their problems.



Secondary outcomes

The secondary hypotheses are that in the group receiving the intervention along with usual training, there will be an improvement in psychological well-being, and psychological capital compared to the group undergoing usual training only. In line with we defined the secondary outcomes as Brief Cope to measure coping skills, Psychological Capital Questionnaire to measure Psychological Capital, GAD-7 to measure anxiety symptoms and WHO-5 to measure well-being.

Impact of intervention on psychological capital of trainee civil servants

Psychological capital (PsyCap) is defined as a measurable high order construct, comprising four state-like psychological resources: self-efficacy, hope, optimism, and resilience (P. D. Harms & Luthans, 2012). In our study Psychological Capital (PsyCap) was measured with the Psychological Capital Questionnaire (PCQ) 12 items version (Luthans et al., 2007). The PCQ consists of four dimensions: self-efficacy, hope, resilience, and optimism. Each of the four dimensions comprises six items, rated from 1 (strongly disagree) to 6 (strongly agree). Higher values indicate higher levels of experienced Psychological Capital.

Scores on the psychological capital questionnaire in our study were consistently high at all three time points, both in control and intervention groups. This means that trainee civil servants are high in

PsyCap, and are found to be self-aware, more empowered; who can pursue their goals and perform better than those low in PsyCap. This was true of all four sub-scales of psychological capital, hope, optimism, self-efficacy and resilience. For scores, please see table below.

Table 32: Difference of mean scores on PCQ across both groups at baseline, 7 week and 3 months (N=240)

Sub Scales	**N**	**Intervention group** ***M(SD)***	**N**	**Control group** ***M(SD)***	***t***	***95%CI*** ***UL-LL***	***P***
Self-Efficacy							
Pre-treatment	120	21.25 (2.94)	120	20.67 (3.03)	1.49	0.38-1.33	0.48
Post-treatment	113	21.15 (4.66)	98	20.69 (4.38)	0.74	-0.76-1.70	0.79
3-months follow-up	106	20.310	106	20.81 (4.22)	-0.78	-1.76-0.76	0.24
Hope							
Pre-treatment	120	17.62 (2.69)	120	18.30 (3.07)	-1.83	-1.41-0.05	0.43
Post-treatment	113	17.23 (3.83)	98	18.04 (4.29)	-1.43	-1.91-0.29	0.46
3 months follow up	106	17.41 (4.79)	106	17.72 (3.83)	-0.52	-1.48-0.86	0.14
Resiliency							
Pre-treatment	120	23.19 (3.05)	120	23.18 (2.79	0.02	-0.73-0.75	0.23

Post-treatment	113	23.30 (3.38)	98	22.73 (3.94)	1.11	-0.42-1.56	0.54
3-months follow-up	106	22.93 (3.59)	106	22.77 (4.50)	0.28	-0.94-1.26	0.50
Optimism							
Pre-treatment	120	21.45 (1.67)	120	21.50 (2.12)	-0.16	-0.52-0.44	0.45
Post-treatment	113	21.53 (2.58)	98	21.48 (2.80)	0.11	-0.69-0.77	0.52
3-months follow-up	106	21.54 (1.99)	106	21.06 (2.88)	1.41	-0.19-1.15	0.19

**Note: ***P-values in the above-mentioned table indicated that the difference between two groups on the composite scores and on all domains scores of Psychological Capital Questionnaire (PCQ) (i.e., self-efficacy, hope, resilience, optimism) at baseline, 7 weeks and 3 months' post intervention was statistically insignificant.

Figure 5: Distribution curve for 'self-efficacy' sub-scale scores of psychological capital questionnaire (N=240)

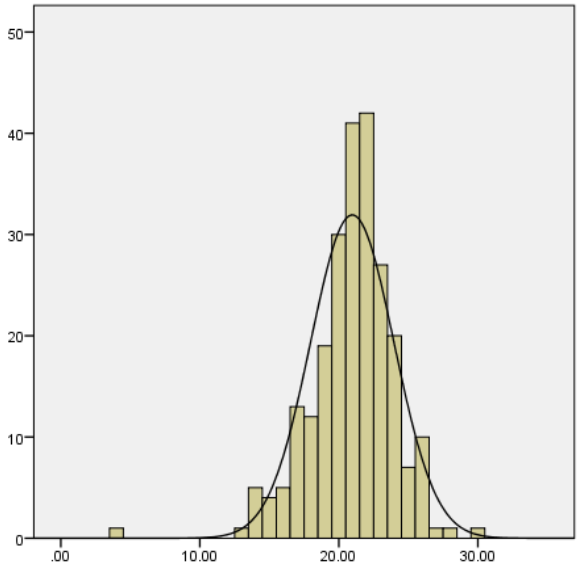


Figure 6: Distribution curve for ‘hope’ sub-scale scores of psychological capital questionnaire (N=240)

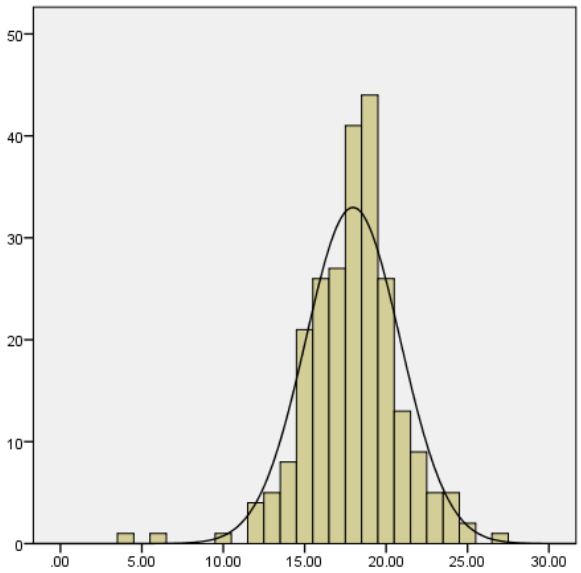


Figure 7: Distribution curve for ‘resiliency’ sub-scale scores of psychological capital questionnaire(N=240)

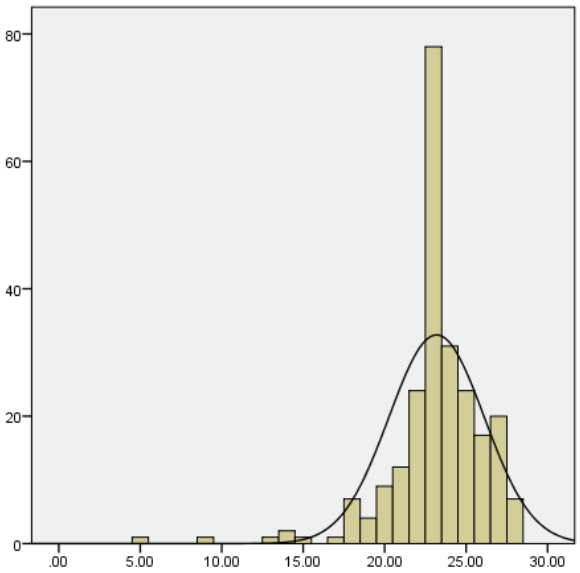
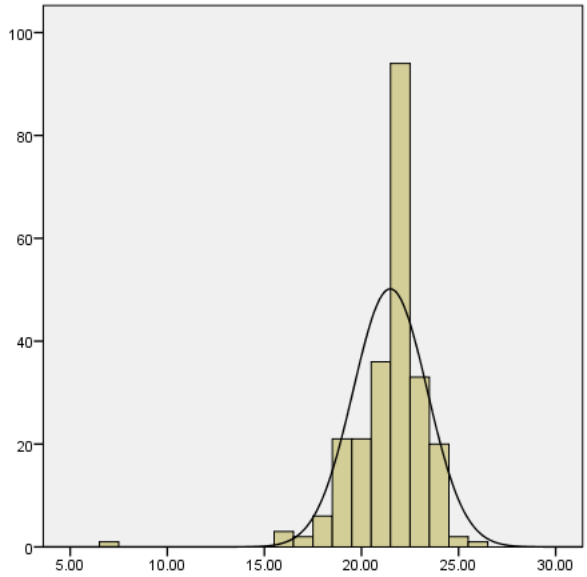


Figure 8: Distribution curve for 'optimism' sub-scale scores of psychological capital questionnaire (N=240)



Impact of intervention on GAD-7 (Anxiety symptoms) in trainee civil servants

GAD-7 was used to evaluate the impact of intervention on occurrence of anxiety symptoms, The items of GAD-7 measure symptoms of anxiousness/nervousness, worry, trouble relaxing, restlessness, irritability, and apprehensiveness. The high score on GAD-7 (≥ 5) indicates that a person is experiencing these symptoms more than 3 days during last two 2 weeks. Individuals scoring more than 5 are termed cases. A case of anxiety symptoms means experiencing the symptoms of anxiousness/nervousness, worry, trouble relaxing, restlessness, irritability, and apprehensiveness on more than 3 days during last two 2 weeks.

Cases of anxiety across two groups

The table below shows the cases and non-cases of Generalised Anxiety Disorder (GAD-7at baseline 7 weeks and 3 months across both rooms). The cut-off mark is 5. This means that anyone scoring more than five in the questionnaire is considered to be a case whereas anyone scoring less than five is considered to be not suffering from Generalised Anxiety Disorder.

Table 33: Categories of Generalised Anxiety Disorder (GAD) at baseline, 7 week and 3 months across both groups (N=240)

Time points	2 categories of GAD	Intervention Group *f*(%)	Control Group *f*(%)	Total *f*(%)	χ^2	*p*
Baseline	Non-Case (0-4)	95 (79.2)	102 (85)	197 (82.1)	1.38	0.15
	Case (5 &greater)	25 (20.8)	18 (15)	43 (17.9)		
Post-intervention follow-up	Non-Case (0-4)	99 (87.6)	79 (80.6)	178 (84.4)	1.94	0.11
	Case (5 & greater)	14 (12.4)	19 (19.4)	33 (15.6)		
3-months follow-up	Non-Case (0-4)	87 (82.1)	89 (84)	176 (83)	0.13	0.42
	Case (5 & greater	19 (17.9)	17 (16)	36 (17)		

p>0.001

Note: P-values *in the above table indicated that the difference between two groups on the level of anxiety symptoms at baseline, 7 weeks and 3 months' post intervention was statistically insignificant.*

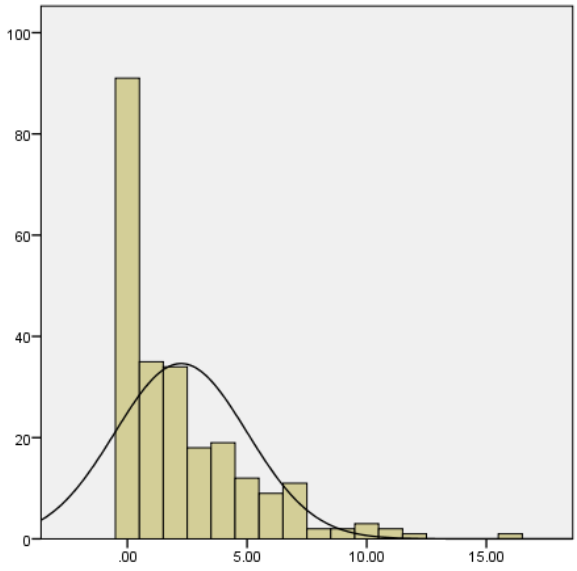
Table 34: Difference of mean scores on GAD-7across both groups at baseline, 7 week and 3 months (N=240)

Scales	**N**	**Intervention group** ***M(SD)***	**N**	**Control group** ***M(SD)***	***t***	***95%CI*** ***UL-LL***	***p***
GAD							
Pre-treatment	120	2.40 (2.59)	120	2.08 (2.92)	0.88	-0.38-1.01	0.60
Post-treatment	113	1.75 (2.80)	98	2.23 (3.85)	-1.04	-1.38-0.42	0.03
3-months follow-up	106	1.65 (2.97)	106	1.92 (3.30)	-0.63	-1.12-0.57	0.66

$p<0.001$; $p<0.05$; $p>0.05$

The table above shows the difference of the mean score of GADS across the intervention as well as in the control group at base line, 7 weeks and 3 months. This table shows that the average GAD-7score in the intervention group decreased from 2.4 to 1.75 in the post intervention period and further decreased to 1.65 in the 3 months follow up. The average GAD-7score increased from 2.08 at the baseline to 2.23 at the 7 weeks post intervention follow up in the control group. These figures later on went down in the control group at the 3 months follow up also which can be justified by the adjustment of the trainee civil servants to the CSA atmosphere and CTP. However, these findings can only be considered general trends as they are not statistically significant. A larger study in the future might be helpful in confirming a relationship.

Figure 9: Distribution curve for GAD-7scores (N=240)



Impact of intervention on personal wellbeing of trainee civil servants (WHO-5 Scale)

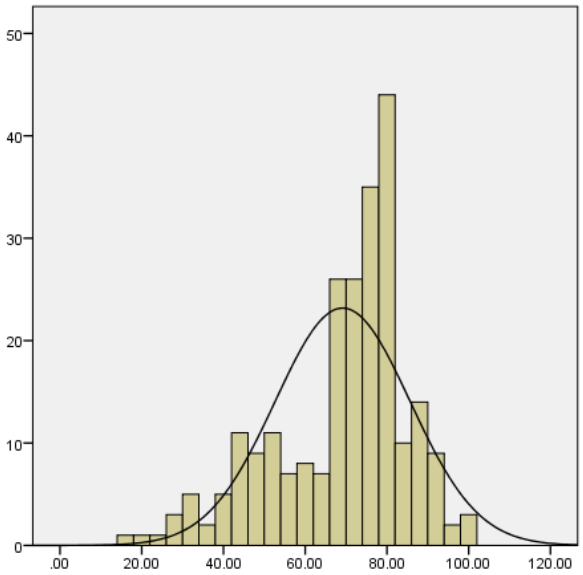
The WHO wellbeing scale of 5 items was used to measure impact of intervention on psychological wellbeing, The WHO-5 measures the psychological wellbeing in terms of feeling cheerful, relaxed, and active and having pleasurable activities in one's life. The table below shows the difference of the mean scores on WHO-5 across intervention and control groups at baseline, 7 week and 3 months. According to this table the WHO-5 which measures well-being of the participants of the study is high across both groups and remains high throughout the study although the number increases slightly more in intervention group at 7 weeks and 3 months as compared to the control group. Therefore, the intervention seems to have had some effects on the well-being of the participants. However, a certain increase can be seen in the wellbeing irrespective of the intervention in the control group as well.

Table 35: Difference of mean scores on WHO-5, across both groups at baseline, 7 week and 3 months (N=240)

Scales	**N**	**Intervention group** ***M(SD)***	**N**	**Control group** ***M(SD)***	***t***	***95%CI*** ***UL-LL***	***P***
Pre-treatment	120	68.36 (17.68)	120	69.93 (15.30)	-0.73	-5.77-2.63	0.16
Post-treatment	113	78.05 (15.05)	98	73.02 (17.76)	2.22	0.57-9.48	0.06
3-months follow-up	106	77.54 (18.61)	106	74.71 (19.38)	1.08	-2.31-7.97	0.94

p<0.001; p<0.05; p>0.05

Figure 12: Distribution curve for WHO-5 scores (N=240)



End of workshop questionnaire for assessing contamination

In Chapter 5, while choosing to do an individual randomised controlled trial to evaluate the intervention, I had pointed at the dangers of contamination of data. In order to assess the contamination of the data a short custom-made questionnaire was asked from both the intervention group as well as the control group at the end of the session a. This was important because the trainee civil servants were all living in hostels together and they had the opportunity to share the content of the workshops.

The following table shows the frequency and percentages of responses to this questionnaire across both homes. This questionnaire was asked immediately after the intervention and a total of 201 out of 240 participants answered the question. We can see that the vast majority of questions were answered correctly by the intervention group as compared to the control group. For example, Question No. 1, 70 of the participants (61.9%) and answered correctly as compared to 51 (52.6%) participants of the control group. Similarly, 76 of the participants which was an overwhelming majority of 67% answered Question No. 2 correctly in the intervention group whereas only 33% of the participants in control group answered correctly. The figures for question no. 3, 4, 5, 6 were similar as can be seen from the table below.

Table 36: Responses to end of workshop questionnaire across both arms (N=240)

Q1: Which one of these statements is true?

Responses	**Intervention group** ***f*(%)**	**Control group** ***f*(%)**	***χ2***	***P***
Breathing exercise is the only way of managing stress	8 (7.1)	6 (6.2)	4.08	0.25
Breathing exercise is just one way of managing stress	70 (61.9)	51 (52.6)		
In addition to breathing exercise, meditation and mindfulness were also tried	33 (29.2)	34 (35.1)		

I don’t know	2 (1.8)	6 (6.2)

p>0.05

Q2: Three components of the problem tree are?

Responses	**Intervention group *f*(%)**	**Control group *f*(%)**	***χ2***	***P***
Focal problems, result and causes	19 (16.8)	16 (16.5)	35.08	0.00
Focal problem, objectives and effects	17 (15)	34 (35)		
Effects, focal problem and causes	76 (67.3)	32 (33)		
I don't know	1 (0.9)	15 (15.5)		

p<0.001

Q3: The three elements of the objective tree are?

Responses	**Intervention group *f*(%)**	**Control group *f*(%)**	***χ2***	***P***
Objectives, purposes and results	25 (22.1)	30 (30.9)	17.55	0.00
Objectives, components, and results	23 (20.4)	30 (30.9)		
Objectives, effects and causes	60 (53.1)	25 (25.8)		
I don’t know	5 (4.4)	12 (12.4)		

p<0.001

Q4: The three steps of problem solving are?

Responses	**Intervention group** ***f*(%)**	**Control group** ***f*(%)**	***χ2***	***P***
Analysis, discussion & intervention	39 (34.5)	43 (44.3)	6.77	0.07
Division, discussion & intervention	10 (8.8)	10 (10.3)		
Observation, interpretation & intervention	62 (54.9)	38 (39.2)		
I don't know	2 (1.8)	6 (6.2)		

p>0.05

Preliminary_Q5: The two categories of problem are?

Responses	**Intervention group** ***f*(%)**	**Control group** ***f*(%)**	***χ2***	***P***
Major and minor	4 (3.5)	29 (29.9)	75.55	0.00
Solvable and unsolvable	103 (91.2)	33 (34)		
Personal and professional	6 (5.3)	27 (27.8)		
I don't know	-	8 (8.2)		

p<0.001

Q6: How many scenarios are possible while managing problem? (N=210)

Responses	**Intervention group** ***f*(%)**	**Control group** ***f*(%)**	***χ2***	***P***
3	54 (47.8)	37 (38.1)	8.96	0.03

4	40 (35)	27 (27.8)
I don’t know	19 (16.8)	33 (34)

p<0.05

This data shows that there was some understanding of the main elements of the intervention across the groups but this did not necessarily originate from contamination. The understanding across the group could be on account of prior education or awareness. The participants were by and large a well-educated and well-read group who had studied across various disciplines in order to qualify in the nationwide competitive examination and had some understanding of the strategies being used even if they did not attend the workshops. It is also possible that the participants in the intervention group discussed some elements of the intervention with their colleagues in the control group. However, they did not provide the exact concepts and therefore there was not much of contamination.

Conclusion

The findings of individual randomised controlled trial are consistent with the primary hypothesis that the adapted intervention coupled with usual training is more effective in reducing depressive symptoms, the most common manifestation of psychosocial distress and enhancing coping skills. At 3-months post-intervention, the mixed-model analysis showed that intervention arm participants reported significantly higher scores on Brief-COPE, compared to control arm participants (m[SD], 23.42[8.86] vs. 21.92[8.55]; mean difference, 95%CI, 2.11 [0.19 to 4.04]; $p<0.05$). Similarly, lower scores on PHQ-9 at one-week post intervention was reported by intervention arm participant compared to control arm participants (m[SD], 2.61[2.98] vs. 3.64[4.72]; mean difference, 95%CI, -1.01[-1.80 to -0.22]; $p<0.05$). Statistically significant difference on secondary outcomes at one-week and 3-months post-intervention was also observed.

In the next Chapter, I will discuss the significance of these findings as well as the key features, limitations and impact of this study.

Chapter 7: Discussion

You will learn by reading,

But you will understand with LOVE.

Rumi

The first chapter sells the book; the last chapter sells the next book.

Mickey Spillane

Chapter 7: Discussion

Mental health, saddling across the disciplines of health, management, economics, and development, is a priority of the Sustainable Development Goals (SDGs) (Marquez & Saxena, 2016). There has been considerable research on mental health in the public sector in developed countries. But for all the talk about the anecdotal prevalence of mental health issues and workplace stress among the civil service of Pakistan, I could not find any study addressing these issues among civil servants in Pakistan. This study attempts to bridge this gap. It developed and evaluated a culturally appropriate intervention for the psychological well-being of trainee civil servants in Civil Services Academy, Lahore, Pakistan.

In line with the aim to evaluate the effectiveness of an intervention for improving psychological well-being in a group of newly inducted civil servants at Civil Service Academy, Lahore, the twin objectives of the study were to develop an intervention for the target population and evaluate its effectiveness in this population.

The scoping review of psychosocial interventions used to address mental health issues at workplace formed the basis of discussions on the possible components of such an intervention for civil servants of Pakistan, its theoretical underpinning, delivery agents, dosage, duration and format. This was followed by discussions with a broad array of stakeholders. Eventually, an intervention was developed which consisted of five face-to-face group sessions (workshops) of one and a half hour each delivered on a weekly basis by non-specialists. It is loosely based upon WHO's Problem Management Plus (PM+) programme but was adapted through an elaborate process for the target group as described in Chapter 4.

The primary hypothesis of the study was that prevalence of psychological distress will be reduced and coping skills enhanced in the group receiving the intervention with usual training at Civil Services Academy as compared to the group receiving the usual training only. The secondary hypotheses are that in the group receiving the intervention along with usual training, there will be an improvement in anxiety symptoms, psychological well-being, coping skills and psychological capital in comparison with the control group undergoing usual training only.

A two-arm single blind, randomised controlled trial evaluated the effectiveness of the adapted intervention to reduce symptoms of psychological distress in trainee civil servants in Pakistan. The trial arm received the adapted group intervention as well as induction sessions (called Common Training Programme or CTP) while the control arm received the induction sessions only. The “induction sessions”

consisted of series of lectures on public sector management, research methodology, basic information technology, government rules and regulations, economics, and public finance.

The findings of the individual randomised controlled trial as described in Chapter 6 are consistent with the hypothesis that the adapted intervention coupled with usual training is more effective in reducing depressive symptoms, the most common manifestation of psychosocial distress and enhancing coping skills. At 3-months post-intervention, the mixed-model analysis showed that intervention arm participants reported significantly higher scores on Brief-COPE, compared to control arm participants (m[SD], 23.42[8.86] vs. 21.92[8.55]; mean difference, 95%CI, 2.11 [0.19 to 4.04]; $p<0.05$). Similarly, lower scores on PHQ-9 at one-week post intervention was reported by intervention arm participant compared to control arm participants (m[SD], 2.61[2.98] vs. 3.64[4.72]; mean difference, 95%CI, -1.01[-1.80 to -0.22]; $p<0.05$). Statistically significant difference on secondary outcomes at one-week and 3-months post-intervention was also observed.

The conclusion of the RCT is that the adapted PM+ intervention, combined with adaptive leadership framework has resulted in improving coping skills and reducing psychological distress in trainee civil servants. In this Chapter, I will discuss the significance of these findings and the key features, limitations and impact of this study.

Unique setting

A key strength of the study was its being successfully conducted in a real-life setting. The PM+ intervention has been previously adapted for a variety of populations ranging from entrepreneurs to health workers in developing countries including Pakistan (Dawson et al., 2015; (Saraf, 2019) but never before on civil servants in a training setting.

The study was conducted at Civil Service Academy (CSA), Lahore, a residential training institution which provides 6 months long induction training called the Common Training Programme (CTP) to newly selected civil servants of the Central Superior Services (CSS) of Pakistan. During their stay at the academy, trainees acquire knowledge and competencies necessary for meeting the challenges of their future careers. Since the trainees have diverse educational and regional backgrounds, the CTP serves as a foundation course for officers of all the twelve occupational groups. It is a turning point for the civil servants as it builds a foundation for their future career which is reflected by the fact that they

continue to identify themselves with their CTP number throughout their career and it remains an important social and professional connection.

The induction course, Common Training Programme or CTP, itself was quite stressful because of its wide covering syllabus including disciplines which many of the participants had not studied before. The setting also puts them in close touch with people of different classes and regions to which they were, at times, not exposed before. Moreover, they were under pressure because of the immense significance of their performance in the CTP for their future careers.

Earlier studies to address work-related stress identified through a scoping review in Chapter 2 included employees working in specific fields like telecommunications, municipal services, pharmaceuticals, technology, police and fire departments and hospital stuff. None of them dealt with middle level management civil servants exclusively. The population of this study, on the other hand, comprised of civil servants who were well educated and were entering at the middle management level. They also belonged to various occupational groups with diverse job specifications.

In the course of the study, I identified the key challenges facing the civil service which have affected its character and mental health over the years. I discovered an increasingly less cohesive bureaucracy still retaining a bloated sense of elitism. Despite being salaried employees, civil servants in Pakistan are similar to entrepreneurs as they typically strongly identify with their job and they tend to not differentiate between their work and family or social lives. Role ambiguity, role conflict, workload- all of which are considered as job stressors are all seen as pervasive among Pakistani civil servants. Civil servants also operate in competitive environments where the risks are high and circumstances uncertain. The uncertainties in the external environment (perceived by trainee civil servants as outside their locus of control) can create stress.

Insider-Outsider perspective

While carrying out this research I was deeply conscious of my own position as an insider outsider. I have a long experience as a professional civil servant as well as a trainer in civil service training institutions. My own experiences allowed me an insight into the psychosocial challenges being faced by the participants.

On the other hand, I was mindful of the need to disassociate myself from the research and not allow my own personal views perspectives and experiences to cloud the results of the research study. I was also conscious of the fact that the new generation of civil servants had characteristics and challenges of their own which may or may not be similar to those of my generation.

Development of Intervention

Although PM+ has been earlier adapted for various target populations around the world including a group of entrepreneurs in KPK Province, Pakistan ((Saraf, 2019), the specific cultural, socio-political and professional context of the population of the current study was markedly different from the populations who had earlier received it. Also, as the population was not clinically pre-diagnosed with any psychological illness, the main purpose of the intervention was preventive.

A four-step adaptation, based upon (Barrera Jr & Castro, 2006), was used. This comprised of information gathering, revision of material, extensive consultations with stakeholder and external evaluation following the dimensions of the Bernal Framework. While not as elaborate as some other adaptation methodologies like the DIME model, it was a top-down as well as bottom-up participatory process.

The simple systematic adaptation process developed and used in this study can guide future researchers and academics as well as trainers. The process was iterative in nature allowing for the incorporation of evolving social and cultural constructs and understanding. It could be used for future adaptation of this or other interventions for other groups of civil servants. Developing this resource for future scholars and researchers is an important outcome of this study.

The resulting intervention was loosely based upon Problem Management plus (PM+), one of the psychological interventions developed by WHO as part of its Mental Health Gap Action Programme (mhGAP) (Dawson et al., 2015). PM+ had many features which made it suitable for a study involving civil servants in Pakistan. For one, it is short, low-intensity and trans-diagnostic psychological intervention for adults to help alleviate a range of psychological and practical problems that participants identify as relevant to their lives, including common mental health problems (Dawson et al., 2015; WHO, 2016a). The name “Problem Management Plus” is intended to reflect the aims of the intervention to improve one’s management over practical and associated common mental health problems. The “plus” refers to addition

of evidence-based behavioural strategies to enhance the capacity to adaptively manage emotional problems. (Dawson et al., 2015).

PM+ is also one of the relatively few psychological interventions, which have been developed and tested in Low and Middle-Income Countries (LMICs) and across various geographical and socio-cultural contexts (Dawson et al., 2015; Keus Van De Poll et al., 2020;; Rahman et al., 2016; Thilina & Yadurshini, 2020). Socio-cultural adaptations of PM+ have been carried out in a number of LMICs and their effectiveness has been established. The intervention has also been evaluated in primary care population in Pakistan showing significant improvement in depressive symptoms and anxiety (Rahman et al., 2016).

In the KP province of Pakistan, both the individual and group versions of PM+ were shown to be effective in reducing symptoms of anxiety, depression and post-traumatic stress in both men and women (Hamdani et al., 2017b). Another study showed that the group-based PM+ module, delivered by lay-helpers with no prior mental health specialization, resulted in significant improvements in depression, anxiety, general psychological profile and functioning among women with common mental disorders (Khan et al., 2019). A randomised control study showed it to be cost effective in dealing with mood and anxiety disorders among adults in a post-conflict area of Pakistan (Hamdani et al., 2020).

While a variety of interventions have been delivered to address work related mental health issue, the two major theories forming the basis of the interventions covered in the scoping review in Chapter 2 are Mindfulness and Cognitive Behavioural Therapy. Though mindfulness is an increasingly popular concept in psychological interventions, CBT is a more established psychological paradigm with greater research backing. Also, mindfulness by its nature requires a certain degree of prior commitment by participants which would make it difficult to deliver in this setting. Mindfulness-based interventions primarily concern themselves with addressing stress in workplace. On the other hand, interventions based upon CBT more often than not include problem-solving and interpersonal skills. For example, the ‘Stress inoculation training program’ (SIT), based upon CBT, also includes psychoeducation, relaxation techniques and stress management (Kawaharada et al., 2009). Its purpose is to help individuals in developing coping skills and learning different strategies like cognitive restructuring, self-monitoring, problem resolution and relaxation. It also has group discussions to help cross learning among individuals. Similarly, ‘Psychosocial interventions’ (PSI) (Ewers et al., 2002) includes psychoeducation on stress, engagement skills, ABC model, guided discovery, and intervention strategies for different psychological conditions. Any intervention which does not include skills which the civil servants consider important for

their career advancement might not be acceptable by trainees. A focus on problem-solving skills and interpersonal skills would fit into the academic setting of CSA whose main purpose was to prepare the participants for their future careers.

Both problem-solving and behavioural treatment techniques has been integrated in the intervention developed in this study resulting in flexibility to allow low-intensity delivery while seeking to preserve a strong evidence base (Bennett-Levy et al., 2010). It also incorporates a psychoeducation component where participants learn about common reactions to adversity (Dawson et al., 2015; WHO, 2016b).

The five workshops are designed to be delivered in a group format by non-specialist providers in usual training settings. The training curriculum was developed by incorporating the principles of PM+ and the adaptive leadership framework (Heifetz et al., 2009). Earlier adaptations for entrepreneurs provided a useful basis for this study as this was a non-clinical population interested in career advancement and leadership. The core strategies of the intervention following the structure of PM+ which are: (1) stress management; (2) problems management; (3) get going, keep doing (improving levels of activity); and (4) strengthening social support.

It was important to present the intervention as a tool for enhancing productivity and performance in the careers of civil servants rather than an intervention for mental health issues to enhance its acceptability. It was also important to make it clear that the intervention does not assume the presence of any existing problems but rather provides tools to participants to prepare them for future stressful situations. The stigma attached to stress and psychological and mental health issues meant that it might not be acceptable if it was presented as a mental health intervention. Therefore, I decided to present the intervention as a series of psychosocial skills development workshops, calling the therapy sessions, training workshops and the delivery agents, trainers and facilitators.

The adaptations included re-branding the intervention as psychosocial skills development workshops rather than a psychological intervention. By this change of terminology, the intervention was made more acceptable to the participants and the faculty. The overall objectives of workshops were reflected by renaming the programme to Psychosocial Skills development workshops. This highlighted the non-clinical state of participants and created an image of a training for development of useful skills rather than therapeutic sessions. This enhanced acceptability of the intervention by making it relevant to the future careers of the trial participants. The fact that the researcher was an experienced civil servant

himself, helped in the acceptance of the intervention by participants and gave him access to other senior civil servants with experience of teaching at CSA who supported the adaptation process.

It was important to avoid using mental health terminology in the conducting of this study because of the stigma attached to mental health particularly in the civil servants. On the other hand, it was unavoidable to use some of the terms like stress, psychosocial development etc. during the conduct of the workshops. However, for the purposes of our adapted intervention, these concepts were framed more in the context of improving the performance of the civil servants rather than their mental health.

While I could not share the data with CSA because of ethical concerns and because I did not want it to influence the answers to the questionnaires, I was able to assure the participants of the practical utility of these workshops through the presence of civil servants as trainers/facilitators. Prior to the workshops I conducted a session with the whole CTP on in which the civil servants were made aware of the importance of these workshops, the concepts of workplace stress and how it affects the careers of civil servants. During the process of intervention delivery, references to these goals were repeatedly made with a focus on how each strategy applied to case-studies from the lives, and careers of civil servants.

Most of the participants were aware of mental health issues facing civil servants and realised the importance of having an intervention to address such issue. Most of them also knew someone in the civil services who had shown signs of stress. I also found that the civil servants linked their stress mostly to their work and its impact on others aspects of their life. They saw political pressures, financial pressures and the difficulties in maintaining a work-life balance as major sources of stress. They were also conscious of the social pressures on civil servants.

I also found major complaints against the training environment in the Civil Services Academy for creating stress generally based upon their annoyance with the academy still treating them as students rather than officers. However, in the discussions, we found that the reasons for supporting intervention for the mental health of civil servants were mostly related to their job performance and career prospects The value of the intervention was mostly acknowledged as a measure to address future issues and to create awareness of psychosocial issues.

As the participants were selected thought nation-wide competitive exam, they had a high self-image of being the “intellectual elite” of the country. Therefore, they considered such basic concepts like deep breathing too simplistic. Many of the participants were familiar with other stress management

techniques and would suggest more complex methodologies. Trainers acknowledged that the simplest and easiest to use stress management technique was selected and explained this. was intentionally done to ensure tits easy availability for all members of the group irrespective of their prior experience or understanding of stress management tools. The purpose was to demonstrate that the actual success of the process depends upon how effectively these tools are practiced on a daily basis not their complexity.

Ease of use and the simple nature of the tools will leave no excuse for not using the tools regularly. More complicated and complex tools for stress management, may also require more training and time and might not be suitable for everybody. However, trainers were asked to emphasize that in real life any suitable method can be used.

As this was an educated non-clinical population, the concepts and the evidence-based research behind PM+ was presented in the first workshop and the information note attached as Appendix 1 was circulated to gain the respect of the stakeholders. The workshops were presented as the first step towards a major overhaul of the civil service training by focusing on the hitherto neglected psychosocial aspects. -Contributing to improvement in training of civil servants was a major motivation for trainers and participants alike.

Another important choice to make was the delivery format. Most interventions at workplace have been delivered in the group format. These include interventions based upon CBT as well as mindfulness. (Crain et al., 2017; Duchemin et al., 2015; Kawaharada et al., 2009; Kemeny et al., 2012; Kersemaekers et al., 2018; Mache et al., 2017; Ojala et al., 2019; Page & Vella-Brodrick, 2013; Shapiro et al., 2005; Slatyer et al., 2018; Vuori et al., 2012; Yung et al., 2004). Only one study (Bartlett et al., 2017) was reported to have used using both individual as well as group formats for of intervention delivery.

I developed the intervention on the basis of the group format of PM +as well which uses the same strategies as the individual version but also has the benefits of peer interaction and provides the possibility for group members to act as therapeutic agents for each other (Yalom, 2005). A meta-analysis suggests that group psychotherapeutic interventions based upon cognitive behavioural approaches are as effective as individual interventions at 6-month follow-up (Cuijpers et al., 2008). In fact, the ability to reach a larger number of people, the group format offers a potentially scalable and cost-effective approach.

A group format was more appropriate in the CSA setting on account of its ability to allow free discussions between the participants themselves and avoid any notion of differential treatment in view of

the widespread stigma associated with mental health issues. It also protected privacy. There were certain participants who felt that this group therapy intervention would not be of any use and those who need psychosocial skills development should be provided with individual help. However, most of the participants agreed that a group-based workshop is helpful in order to develop an awareness of these issues and to encourage those who are having problems to attend individual therapeutic sessions by removing their inhibitions.

A larger size of the group than tradition PM+ was considered to be more appropriate in the study for psychoeducation through PowerPoint presentations in the first and third segments while smaller groups were formed for discussions and activities in the second segment of each workshop. This allowed greater interaction among the participants and gave them room to have more fruitful discussions with diverse perspectives in larger groups. On the other hand, the facilitators of the discussions had to make sure that every participant in the activities' session gets an equal chance and participants do not shy from expressing themselves or sharing their problems.

The duration of the intervention was another key consideration. The literature review showed that earlier interventions have been shortened in duration for use in workplace settings. (Bartlett et al., 2017; Kersemaekers et al., 2018; Lilly et al., 2019; Slatyer et al., 2018). The average number of sessions in the interventions studied in the scoping review was seven with the average duration of each session being 92 minutes. The total average program the duration was eight weeks. PM + with five sessions was originally presented as a brief manageable intervention. (Dawson et al., 2015). I further shortened the durations of the individual workshop sessions by doing away with the introductions, games and videos etc. This was important because the workshops are being conducted in the academic setting and using videos etc. would create the impression that the presenters have not been presenting original work and rather lazily using videos etc. A fast-paced short session also helped in maintaining the attention of the participants for non-graded workshops who already had a full plate being in full-time training which will significantly impact their future careers.

Delivery of the intervention

The scoping review also highlighted the variety of delivery agents used to deliver interventions to address mental health issues at workplace. Majority of the interventions in previous studies were delivered by the developers of the intervention with 9 to 35 years of experience (Bartlett et al., 2017; Crain et al.,

2017; Duchemin et al., 2015; Elder et al., 2014; Kawaharada et al., 2009; Kersemaekers et al., 2018). Other interventions were delivered by professional psychologists (Kawaharada et al., 2009; Shapiro et al., 2005; Slatyer et al., 2018) or researchers (Ewers et al., 2002; Page & Vella-Brodrick, 2013; Vuori et al., 2012; Martin et al., 2009).

Most of these professionals had extensive training in the interventions as well as its theoretical basis. In this set up using professionals might not be as valuable on account of the limited professionals available as well as the potential reaction of the civil servants to the presence of mental health professionals. This would give an impression of delivering a therapeutic intervention rather than one for prevention of psychosocial issues and career development.

A key feature of the PM+ which makes it suitable for the study is task shifting which means that a task normally performed by a specialist is transferred to a person with a different or lower level of education and training, or just specifically trained to perform a limited task, without having a formal health education (Hoeft et al., 2018). Aspects of CBT are modified and simplified in the PM+ modules to make it simpler to implement, and feasible in communities that may not have many specialists who can deliver more complex psychological interventions (Dawson et al., 2015).

Task sharing interventions in low- and middle-income countries found an increase of the number of adults recovering from depression or anxiety as compared to usual care (Van Ginneken et al., 2013). Task sharing opens up the possibilities of increasing access to care despite the limited human resources (Chiumento et al., 2021). Delivery of the intervention with a short training to non-specialised healthcare professionals is a great comparative advantage in developing countries like Pakistan with low per capita healthcare support (Hamdani et al., 2020; WHO, 2007)

Evaluations of peer support workers embedded within mental health services identify the benefits of shared life experiences, can contribute to an understanding of the recovery journey (McLean et al., 2009). A study of refugees in Turkey demonstrated that interventions were more effective when trainees and trainers are part of the same community and have experienced similar situations like traumas (Akbay-Safi et al., 2021). Researchers have also reported a positive effect of the intervention on the trainers or deliverers themselves (Basil et al., 2021).

A unique aspect of the workshops of the study was their conduct by a mix of psychologists, senior civil servants, and members of the Civil Services Academy faculty. This provided us with a group of

trainers which was able to relate to the issues and aspirations of the junior civil servants and enrich the intervention development process. The faculty of the academy consists of civil servants on deputation as well as faculty members permanently based in the academy with an academic background. Out of the three delivering the main presentations in the first sessions; one was a permanent faculty member, while the other two were visiting faculty members conducting various sessions. Supervision was provided by more experienced professionals. This task sharing model can cater for the shortage of professionals as wells as avoid the stigma attached to seeking help for psychosocial difficulties.

The trainers being civil servants were able to draw upon their personal experiences during their careers to help illustrate the importance of the workshop and the skills being developed. The presence of senior civil servants among the trainers also focused the discussions and discouraged venting out of negativity as the trainers were able to normalize the trainee's feelings of stress. The shared experiences allowed for genuine empathy and acknowledgment of difficulties and contributed to the trainee-trainer relationship. Examples from the civil service were consciously used to illustrate real life psychosocial issues and their possible solutions. The civil servants among trainers narrated their own stories and the stories of their colleagues who have suffered stress and how it had affected their lives and jobs. This was important to ensure effective participation by the trainee civil servants who were all geared up to take up their new positions. The delivery by trainers well familiar with the contextual factors was critical for the intervention's success. These trainers were able to develop rapport with participants allowing them to open up and brainstorm solutions.

The results of the trial showed that lay workers can be successfully trained and supervised to effectively deliver the psychological intervention and demonstrate the feasibility of the task-shifting approach. The findings are consistent with earlier findings in relation to task shifting in mental health care mainly by non-specialists like community health workers, in low-income countries. (Bolton et al., 2003;; Rahman et al., 2016).

In the post COVID scenario, there is a renewed focus on developing digital solutions to provide personalised support to employees with employee well-being becoming a strategic focus for business organizations (Carolan et al., 2017). Such digital solutions provide a flexibility of research and could lead to improvements in the mental-health of employees and their job productivity (Carolan et al., 2017). It was concluded that online projects for those with depressive symptoms had an advantage over other programs as they reportedly felt more comfortable in online programs, as compared to face-to-face

programs (Kawai et al., 2010). It was also felt that such interventions are more acceptable to those who wanted to deal with emotional issues on their own to avoid stigma attached to these problems (Martin et al., 2009). PM+ has also been delivered through telephone counselling in a shorter version. Although difficulties have been reported in delivering the intervention without physical presence as without body language, the delivery agents had to learn to express their empathy through words rather than gestures and a “kind look”. However, it was useful during the COVID-19 crisis as it allowed maintaining of an effective response by developing a culturally and contextually knowledgeable team (Sabry et al., 2021).

Previous studies at the workplace reported successful e-based interventions. Such interventions were the Physical Activity Loyalty Scheme (PAL) intervention, the Web-based mindfulness intervention, Mindfulness Program, Mental Health Guru (MH-Guru), Workplace Wellness intervention, and Computerised cognitive behavioural therapy at work (Beating the blues) (Blake et al., 2013; Griffiths et al., 2016; Grime, 2004; Kerr et al., 2019).

'The Physical Activity Loyalty Scheme (PAL) intervention’ (Hunter et al., 2016) used emails for motivation and continuation of the practice and sharing of resources at workplace. In this intervention I used WhatsApp as well as the dashboard of the Civil Services Academy for communicating resources and reminders etc. However, it was not considered advisable to have a WhatsApp group among the participants as this would result in unnecessary distraction and participants would not be comfortable in sharing their personal information with other participants who were also their competitors.

While we did not consider the use of E-based interventions advisable in this population at this stage because of difficulties in ensuring fidelity and compliance, this mode of delivery could be explored in further studies.

Major changes were made in the delivery of the intervention. The workshops were conducted in a three-session format. The first session or the plenary session consisted of presentations made to a group of about fifty trainee civil servants. These presentations were developed to contain all the adapted material needed by trainers and are an integral part of the manual in Appendix H. For the second session, smaller groups of 10 to 12 participants sat in a round table getting with no presentations being made but guidelines for discussions displayed to keep the participants focused. The participants were allowed to choose different examples of problems themselves in the activity's session. The trainee civil servants were then

brought back into the larger setting and asked to present the gist of their discussions with their colleagues for further discussions.

Another innovation is the effective use of cascade model of training and supervision, which is a quick and effective mechanism of delivering training. It was useful as the trainers and facilitators of the workshops had other jobs too and therefore, limited time for training. Instead of having a four-day training session it was decided to conduct a two-day training session with simulation exercises and role plays followed by pre and post workshop sessions and discussions on WhatsApp. This allowed a reiteration of the lesions and did not put too much demand on the schedule of the trainers. It also provided an opportunity to discuss adaptations and identifying the challenges being faced by the participants, their perceptions of psychosocial skills and any successful or unsuccessful methods of dealing with stress being adopted by them in the past.

Two types of the trainers were prepared as a result of the training of training workshops and the related process; the trainers or presenters to conduct the knowledge-based sessions of the workshops and the facilitators who were not yet able to conduct standalone presentations; but did lead the activities and discussions in the smaller groups. These facilitators can later become trainers after some practice resulting in a pool of potential trainers.

Another noteworthy feature of PM+ which is also reflected in the intervention was a trans-diagnostic approach which applies “the same underlying principles across mental disorders, without tailoring the protocol to specific diagnoses” (McEvoy et al., 2009). PM plus has even been used to address issues related to alcohol misuse among conflict affected populations (Fuhr et al., 2021).

This approach can be valuable because it allows to address multiple problems at one time in people with comorbidity (Wilamowska et al., 2010). One more advantage is that it reduces the need for and challenge of making differential diagnoses and learning multiple treatment manuals for different disorders in LMICs (Murray et al., 2014). This was a factor in the context of the study as prior diagnosis would lead to stigmatisation and defeat its purpose. There were some interesting counter intuitive adaptations done.

Firstly, all the presentations in the first session of each workshop were made in English instead of in the local language as the trainee civil servants were all educated and well versed in English. In fact, there is a certain “snob value” attached to English language in the Pakistani society particularly in this

elitist subset. However, the activities held in the second session of each workshop were conducted in a fluid bilingual format, allowing the participants to hold free discussions.

Another interesting point was that although Pakistani culture is gender sensitive, trainers and trainees of both genders were kept mixed to enhance the acceptability of the intervention in the co-educational atmosphere of the academy and not to give the female participants a feeling of being considered unequal. Similarly, while forming the sub-groups, I followed the CSA practice of not segregating them on the basis of gender, regional background or occupational groups. The fact that the civil servants among the trainers also belonged to different occupational groups also helped in building a rapport between the trainers and participants. Service culture seemed to dominate regional and class affiliations as well as gender.

Addressing the stigma attached to mental illness is important. This stigma is based upon traditional notions of mental health issues as well as their possible impact on their assessment during the CTP and on the future career of participants. The importance of CTP for the future careers of trainee civil servants is an important limiting factor. Their rank in their respective occupational groups and batch depends upon their performance in the examination CSS as well as in the CSA and their specialised occupational training centres where they would go after the CTP. Therefore, data obtained during the intervention were not shared with civil service faculty. Participants were reassured that they freely and frankly share their opinions. Special attempts were also made to ensure that the participants do not consider symptoms of stress to be unusual and do not consider the expression of feeling of stress to be a sign of weakness “as an officer”. For this purpose, the trainer civil servants narrated their own life stories and those of their colleagues who had suffered stress and how it had affected their careers.

Participants were also assured that the answers given during the workshop would not reflect on their performance within the Common Training Programme. This training workshop was not meant for their assessment but primarily to give them tools for addressing psychosocial problems during their lives and careers. This was important for ethical considerations as well as for making the group comfortable in sharing their feelings among the group and trainers/facilitators.

Another significant innovation was ICT based online data collection strategy which asked participants to answer the questionnaires online. The data was stored directly on a web server outside the Civil Service Academy to ensure confidentiality and safe storage. The answers were not shared with the

Academy. This was important for ethical considerations as well enhancing acceptability of the intervention among the target group.

The trial

The evaluation of the intervention was done through a randomised controlled trial which is considered the gold standard for this purpose. I had carried out randomisation based upon appropriate software with the help of an independent researcher in order to have proper randomisation and avoid selection bias. Carrying out all the questionnaires in an online format took care of the possibility of a recall bias because of which the events can be remembered or quoted differently by participants. The online format also allowed participants to answer the questions at their leisure within a 24 hours window so that they did not feel any undue pressure to answer the questions.

A total of 240 participants were recruited and randomised into intervention and control group on a 1:1 allocation ratio. The evaluation was done initially before the intervention, immediately post intervention (7 weeks after intervention delivery) and then at 3 months' post intervention delivery. The primary outcome was the PHQ-9 which measures self-reported depressive symptoms on at least 3 days during last 2 weeks and score on Brief Cope for coping skills. Other outcomes include GAD-7(anxiety), WHO-5(wellbeing) and Psychological Capital.

At 3-months post-intervention, the mixed-model analysis showed that intervention arm participants reported significantly higher scores on Brief-COPE, compared to control arm participants (m[SD], 23.42[8.86] vs. 21.92[8.55]; mean difference, 95%CI, 2.11 [0.19 to 4.04]; $p<0.05$). Similarly, lower scores on PHQ-9 at one-week post intervention was reported by intervention arm participant compared to control arm participants (m[SD], 2.61[2.98] vs. 3.64[4.72]; mean difference, 95%CI, -1.01[-1.80 to -0.22]; $p<0.05$). Statistically significant difference on secondary outcomes at one-week and 3-months post-intervention was also observed.

The adapted PM+ intervention, combined with adaptive leadership framework has resulted in improving coping skills and reducing psychological distress in trainee civil servants and therefore has the potential to be integrated into the curricula of Civil Service Academy (CSA) to equip civil servant trainees with necessary skills to cope with the forthcoming challenges at job.

Challenges in conducting the study

There were considerable difficulties in conducting the study. Firstly, motivating the trainee civil servants to take this intervention seriously was not easy. The elitist nature of the civil service of Pakistan made these trainee civil servants think that the faculty and the psychologists who had not passed through the rigorous process of the competitive exam were not in a position to teach them anything new. This was not totally without reason. In the nationwide competitive exam, the trainee civil servants had studied many subjects which they had not studied before and had more or less taught themselves these subjects without any formal teaching. Therefore, they had high level of self-study skills and had at times picked up many of the Stress management and problem management skills which were offered as a part of the intervention.

A question that was raised many times regarding the stress management and problem management tools introduced in the intervention was how these tools were selected. A number of participants proposed more sophisticated tools like mindfulness and the fishbone decision-making system in connection of stress and problem management respectively. I had to address these concerns by saying that the purpose of the workshops was to introduce them to these simplest tools to demonstrate that even if the basic tools are practiced regularly there can be a positive impact.

The trainee civil servants at this stage of their career were focused on learning tools and subjects to make their future careers easy and productive. Task shifting through a peer group of trainers helped to present the intervention as a series of training workshops to provide them with necessary psychosocial skills for their future life and career. However, the questions asked in the outcomes would inevitably reveal the nature of the research to a certain extent.

Many participants question the trans-diagnostic nature of the intervention and did not see any reason for having a group intervention for people who did not show any symptoms of stress psychological distress. They proposed to carry out individual therapy after a proper diagnosis identifying participants with underlying psychological issues. They also felt that such an intervention should be individual in nature and include medication. It took a considerable energy to explain the reasons for selecting a trans-diagnostic intervention and applying it to people with no symptoms. The line taken was that the stigma attached to psychological distress and mental health issues made it difficult to carry out screening and labelling participants with mental health issues might actually be counterproductive.

The civil servants also expressed reservations on the utility of the tools introduced through the workshops to address serious psychological illnesses like suicidal thoughts or severe depression. I had to clarify that these workshops are meant for sub clinical populations and to address relatively mild forms of stress. The purpose was to give coping tools to the trainee civil servants as pre-emptive measures and not as a therapy. A referral pathway was set up for those in whom serious psychological issues were uncovered as a result of the workshops.

The group therapy was also questioned on the grounds that individual reactions towards stress differed based upon their chemical and genetic makeup. This concern was addressed by replying that purpose of the group therapy was to allow those who had such tendencies as well as those who were successful in dealing with stress to share their ideas and experiences. I also highlighted that the group interventions have the advantage of creating awareness and providing certain tools without naming or exposing any individual for his or her tendency to not effectively cope with stress. This was important as the inability to cope with stress was considered to be "an un-officer like" behaviour and a stigma in the Civil Service. Participants were more likely to brush aside such issues because of their perceived negative effects on their career prospects.

As the intervention was held in a training atmosphere, there was a danger that all the participants would consider this to be part of their assessment and would be careful not to give the “wrong answer”. Therefore, I stressed time and again during the delivery of the intervention that there were no wrong answers and the most important thing was to give truthful replies to the questionnaires. There was also a risk that the participants would fall under-pressure to answer the questions - a violation of ethical principle of free consent. Therefore, during the delivery of the intervention and prior to each data collection round, I emphasised again and again that the faculty will not be aware of the score of the questionnaire and there was no obligation on the participants to answer the questionnaires. They were also told that their answers would not be used for their psychological evaluation or their assessment in the Common Training Programme. Free informed consent was confirmed at each time point.

On the other hand, it was challenging to convince the participants to take this intervention seriously while it did not count towards their performance at Common Training Programme. I compensated for this by emphasising the importance of dealing with workplace stress and improving psychosocial wellbeing of civil servants for their lives and careers.

Carrying out the workshops at CSA was a convenient logistic arrangement. However, there were a number of difficulties in this set up. CSA is primarily an institution geared towards making officers out of the new entrants. The faculty wanted to bring the participants into a "training mode" so they can learn the competencies required for their future careers. On the other hand, the intervention required the trainee civil servants to open up and share their feelings with their colleagues and faculty freely. The opening up process was also difficult because of the competitive environment of CSA which also has the important purpose of grading newly inducted civil servants and assessing their suitability for their future careers. In the beginning, they also wanted the study to do some sort of psychological assessment of trainee civil servants which I refused to do. I also made it clear that the data collected will not be shared with the CSA in accordance with ethical commitments of the research. Moreover, the academic setting of CSA required a degree of social distance between the faculty and the participants which runs counter to the purposes of the intervention.

Limitations

A major limitation in most of the earlier studies identified in the scoping review was the cost of conducting the intervention and the lack of engagement by the study population. This can be improved by fine tuning and redefining the objectives of the intervention in terms of developing skills necessary for the careers of the civil servants.

The adaptation process included stakeholders who had some interest or involvement in the mental health of civil servants. The diversity of the stakeholders made sure that a variety of views were incorporated. The researcher took notes of the discussions and organized them according to the various themes discussed. However, there was no rigorous qualitative or participatory methodological approach applied which was weakness of the adaptation process.

This was a major challenge of conducting a research study in real life settings particularly in a training and evaluation setup. Applying rigorous qualitative methodology would not be possible within the scope of this PhD study and the complete process of development of an intervention and its evaluation through a randomized control trial could not have been completed. The completion of the process was important in order to gain the support of the stakeholders particularly the administration and faculty of the Civil Service Academy. They only supported the whole study as a part of the study these workshops were being run in the Civil Service Academy.

CSA is geared towards preparing these participants for their future careers by filling in the gaps in their earlier education as they have diverse educational backgrounds. It also aims to evaluate the trainees and assess their capabilities in performing their jobs. The evaluative atmosphere was a challenge as respondents to outcome questionnaires might be tempted to give a response which could supposedly be more favourably viewed by the academy.

Although PM+ provides a framework to guide specific sessions, it leaves key questions entirely on the implementation of the intervention and his exploration of the local context (Goloktionova & Mukerjee, 2021). While this can make it suitable for a variety of environments, it can be a limitation too (Goloktionova & Mukerjee, 2021).

The limitations need to be kept in mind while interpreting the study's results as well as designing future studies. Firstly, there was a degree of attrition of responses to the questionnaires at 7-week post treatment and 3 months follow-up. This illustrates the ethical and logistic challenges of undertaking research in real life settings. However, the risk of bias due to this limitation is likely to be small as there were similar rates of attrition across both groups of the trial; and mixed models' analysis was used using the random-effects model adjusts for bias induced by missing values.

Secondly, there was also an improvement in the control group receiving the usual training. While this could be attributed to regression to the mean, possible contamination of the control group with elements of intervention cannot be entirely ruled out as both intervention and control groups were interacting freely. Individual randomised controlled trials are not ideal in community settings due to the risk of contamination. This would result in an under-estimation of the intervention effect. The danger of contamination was further expounded by the fact that CTP is a residential program.

A cluster randomised trial would have made the study less susceptible to contamination (Keogh-Brown et al., 2007). However, it would warrant a pilot study to explore problems and strategies to overcome them and a bigger sample to demonstrate the effect of the intervention on the outcomes, making the study expensive, lengthy and complex and hence impractical within the context of a PhD.

To address this issue, a tailor-made questionnaire was conducted at the end of the study which showed that while there was some understanding of the main elements of the intervention across the groups, there was not much contamination. While the control group was aware of the general aims and objectives of the intervention, they were oblivious to the details of the intervention.

Thirdly, the duration of sustained benefit or mechanisms for PM+ is yet to be determined (Rahman et al., 2016). I carried out this study at a three-month endpoint after the intervention. This was an arbitrary timeline based upon practical considerations. After the end of the CTP, the trainee civil servants would spread out to the training institutions of their respective occupational groups and would not be in the same conditions as before. Future studies are required to explore which component mediates effect, how long this effect lasts, and the feasibility and effect of booster sessions (Dimler & Natsuaki, 2015). Future research could also collect follow-up data for a longer period.

Fourthly, the Bernal and Sáez-Santiago framework primarily used for cultural adaptation carries its own limitations. The framework was developed over 20 years ago in North America in relation to trans-cultural issues of working with Latino communities. It was originally informed by a theory-driven and anecdotal approach instead of community-based exploration e. Its concepts are rather abstract and can sometimes overlap. I used an adapted bottom-up process of adaptation based upon (Barrera Jr & Castro, 2006) to avoid these pitfalls. But I used the Bernal Framework to structure the adaptations. Also, I did not have an opportunity to test whether the adapted version was more effective than a non-adapted version of PM+. The consultations with stakeholders did not include any trainee civil servant exactly in the same situation of the target group. Although I did include psychologists of the same age group and recently graduated training civil servants from CSA in the consultations, there is a possibility of differences in their experiences could lead to an imperfect adaptation. Moreover, in a training environment, the possibility of trainee civil servants as well as the faculty involved in conducting of the workshops not being completely honest in expressing their views during the adaptation process cannot be totally excluded. With the importance of CTP for their careers at the back of their mind, it was quite possible that the participants would hide their true feelings and emotions and try to "group-think" or make us hear what we wait to hear.

The absence of a rigorous qualitative methodology was a major limitation of the study. The hypotheses were not formulated into open-ended questions and a proper Focus Group Discussion guide was not developed. This was on account of the challenges of conducting a research study in real life settings.

These limitations could be addressed in future studies. A more rigorous qualitative research methodology with careful coding and labelling would allow future researchers to capture a more complete understanding of the topic. However, as explained above, the study benefitted from the insider-outsider position of the researcher. On the other hand, there was an attenuated need for enhanced researcher

reflexivity to avoid the unwanted influence of personal judgments, practices, and belief systems during the data collection process by identifying any personal beliefs that may have incidentally affected the research. Such biases can have an impact on the choice of the methodology of data collection as well as its analysis and reporting. At the same time, an overemphasis on reflexivity could lead to an over complication of the analysis. The same dilemmas applied to the trainers and members of the CSA faculty who were themselves civil service trainers or civil servants.

The objective of cultural adaptation of psychological interventions is to balance fit and fidelity. This means that the psychological interventions are adapted in a manner that they are supported by evidence while also being responsive to the culture and context of the target population. During the adaptation process of PM+ for trainee civil servants as well as its conduct, the emphasis seemed to be had been on fit rather than fidelity. The trainers seemed to be taking the PM+ intervention as a lose framework within which they could incorporate their requirements. All workshops were audio recorded to ensure quality and fidelity of intervention delivery. Throughout the delivery of intervention, trainers had pre and post workshop sessions with the master trainer to discuss progress and challenges in intervention delivery. However, more rigorous fidelity assessment by trained independent assessors was not done owing to the challenges of conducting the intervention in real life setting with trainers who were otherwise experienced and the time limitations within the context of a PhD study.

Moreover, the lack of experience in conducting workshop style interventions meant that the trainers and facilitators at Civil Service Academy lacked empathy with the trainees and were reluctant to allow them to be "frank" with them. Ideally, we should have had trainers who were not been involved in the rest of the training programme. However, such trainers would not be easy to find as I did not want to have professional psychologists dominating the sessions and working civil servants were rarely able to devote such extensive time for conducting a thankless training at the CSA.

It was also likely that the trainers and facilitators as well as the trainees could have introduced their subjective bias while formulating examples to be used during the workshops. This could be addressed in the future by offering the templates developed as a result of this adaptation process in the training manual. These templates portray real life concerns, emotions and understanding of trainee civil servants.

There is a flooring effect seen in case of PHQ9 which is primarily an outcome to measure symptoms of depression. Future studies could also use different outcomes to measure the effectiveness of

this intervention on civil servants in Pakistan. On reflection, I would think that future studies can focus on other outcomes which measure the distress or work performance of civil servants. Such outcomes could include:

- The Kessler Psychological Distress Scale (K10), (Kessler, 2003) a simple measure of psychological distress. The K10 scale involves 10 questions about emotional states each with a five-level response scale. The measure can be used as a brief screen to identify levels of distress.
- The Work and Social Adjustment Scale ("WSAS"), a simple and reliable measure for impairment in functioning (Mundt, et al., 2002). The WSAS assesses the impact of a person's mental health difficulties on their ability to function in terms of work, home management, social leisure, private leisure and personal or family relationships. This instrument is 5 questions long, and is a sensitive and useful outcome measure with correlations to severity of depression and some anxiety symptoms.
- The Individual Work Performance Questionnaire (IWPQ), based on a four-dimensional conceptual framework, in which individual work performance consisted of task performance, contextual performance, adaptive performance, and counterproductive work behavior (Koopmans, et al., 2013).
- The Mental Health Literacy Scale (MHLS), a 35-item questionnaire looking at the respondents understanding of mental health. The first 15 items are scored on a 1-4 scale with items 10, 12 & 15 being reversed scored. Items 16-35 are scored on a 1-5 scale with items 20-28 being reverse scored (O'Connor & Casey, 2015).
- The 28-item Stigma Scale, which has a three-factor structure measuring discrimination, disclosure and potential positive aspects of mental illness (King, et al., 2007).

Impact on Practice and Policy

A number of factors make this study stand out. Firstly, the studies were conducted in training settings where interventions for common mental disorders are practically non-existent. Secondly, the participants in this trial were not pre-diagnosed for emotional distress. Also, the intervention, while simple to deliver, is based on empirically supported principles and meticulously adapted to the needs of the target group. Finally, the trainers were recruited from the local population, which means that they could relate well to their clients, though they were supervised by more experienced clinicians to ensure fidelity.

The study contributes to the existing body of literature in various ways. Theoretically, it showed improvement in many covariates, thus reaffirming the trans-diagnostic nature of the intervention. It also devised a tool to study contamination in such trials. It was also significant that the intervention was held in a non-clinical population particularly important for the society.

A measure of success was the integration of the intervention in future Common Training Programmes for newly induced civil servants at the Civil Services Academy.

The results of the RCT demonstrated the effectiveness of the adapted psychological intervention in reducing distress in newly inducted trainee civil servants. The Academy also carried out its own assessment of the effectiveness of the intervention based upon feedback from the participants and faculty and decided to continue with it in their future training programs.

After conducting a randomised evaluation of the intervention in the period October 2018 to March 2019, the next batch of Civil Service of Pakistan also underwent a similar training, this time mostly conducted by the regular staff at the CSA and a peer group of working civil servants. The study successfully introduced basic practices for stress management, problem management and other tools to young civil servants. It also created awareness among the civil servants of the importance of dealing with their own behavioural and psychological issues as well as those of their colleagues and subordinates. As a by-product, it also acquainted the Academy with different methods of training unlike the mostly lecture based used course. The use of information technology for conducting these surveys was also an innovation. The collection of the data through online questionnaires avoided many possible biases like the recall bias or concerns over lack of confidentiality and the absence of free informed consent.

Task shifting by using the services of mid-career civil servants for delivering this intervention as opposed to psychologists or non-civil service trainers also helped. Moreover, the presence of senior civil servants among trainers gave the participants an impression of normalcy of psychosocial challenges. They could share real-life stressful experiences from civil service work environment and therefore relate to the participants. PM+ has also shown to be successful in easing protracted isolation and fostering trust in those delivering (Goloktionova & Mukerjee, 2021). The impact of this intervention on trainer civil servants needs to be explored in future studies.

Future implementation could also address the heterogeneity of the population, and incorporate appropriate evaluation measures, including tools to measure long-term productivity. I believe that greater

funds should be allocated for implementation and research in this area. An investment in public policy programs and donor resources in these countries will increase the capacities of civil service for public service delivery.

Further research could also be carried out on the dilution of effects and regression to mean by carrying out a study for a long period and the possibility of delivering the intervention through ICT like mobile apps etc.

While the scoping literature review was a pioneering exercise and allowed me to map the available literature and identify the knowledge gaps, a future systematic review could build upon the findings of the scooping review and gather evidence from studies pertaining to the focused research question as well as undertake a more in-depth qualitative appraisal of the studies identified.

Conducting workshops on psychological well-being at the Civil Service Academy turned out to be a uniquely rewarding personal experience of peeping into the minds of a younger group of civil servants, the challenges they face and their views on the future of development and governance in Pakistan. It also gave me an insight into the loopholes within the civil service training programmes which catered for development of a variety of professional skills but did not pay much attention to the psychosocial skills development of the participants.

The CSA continues to host these workshops. Following my doctorate, I plan to upscale the workshops to other groups of civil servants of Pakistan, aiming to create a greater awareness of these issues and hopefully providing some tools to understand and address them. This would be a modest contribution to enhancing the performance of the civil service and hence, the development of my country.

The intervention developed in this study could be a candidate for upscaling. However, we would have to address the challenges to scaling up from systemic barriers. For this, options like system innovation ideas, on cycles of deepening (learning by doing), broadening (repeating and linking) and scaling up (embedding) offer possibilities of introducing new interventions to new groups could be explored (Woodward et al., 2021).

Conclusion

The aim of this study was to evaluate the effectiveness of an intervention for improving psychological well-being among a group of newly inducted civil servants in Pakistan. To the best of my

knowledge, there is no evidence based manualised intervention targeting the needs of this population. This study developed a culturally appropriate intervention for trainee civil servants at Civil Service Academy, Lahore and evaluated its effectiveness through a randomised controlled trial. The adapted intervention, implemented in non-mental health settings and tested with non-clinical population- trainee civil servants showed promising results.

What started out as a PhD thesis seems to have turned into a rewarding experience of contributing to the well-being of an important segment of the Pakistani society. The integration of the intervention into civil service training programmes carries the promise of a more psychologically balanced and productive bureaucracy which is vital for the future of Pakistan.

References

Adams, G., Gulliford, M., Ukoumunne, O., Eldridge, S., Chinn, S., & Campbell, M. (2004). Patterns of intra-cluster correlation from primary care research to inform study design and analysis. *Journal of clinical epidemiology, 57*(8), 785-794.

Afza, T., Mujtaba, B. G., Habib, N. J. I. J. o. B., & Science, S. (2011). Stress perceptions of working adult Pakistanis and Americans. *2*(5), 32-40.

Ahmad, S., Hussain, S., Shah, F. S., & Akhtar, F. J. J. P. M. A. (2017). Urdu translation and validation of GAD-7: A screening and rating tool for anxiety symptoms in primary health care. *67*(10), 1536-1540.

Aikens, K. A., Astin, J., Pelletier, K. R., Levanovich, K., Baase, C. M., Park, Y. Y., & Bodnar, C. M. (2014). Mindfulness goes to work: impact of an online workplace intervention. *Journal of Occupational Environmental Medicine. 56*(7), 721-731.

Akbar, Z. S. (2005). The Political Economy of Decentralisation in Pakistan ', Decentralisation and Social Movements Working Paper No. 1. *Sustainable Development Policy Institute, Islamabad and Department of Geography, University of Zurich Irchel Switzerland*.

Akbay-Safi, S., Tabba, A., & Mahmoud, L. R. (2021). Training Survivors of Gender-Based Violence in the Problem Management Plus Programme in Turkey. *19*(2), 180-186. Available at doi:10.4103/intv.intv_21_21

Alavi, H. (1972). The state in post-colonial societies Pakistan and Bangladesh. *New left review.*(74), 59.

Aly, J. H. (2007). Planning demise of civil service. *Daily Down*. Retrieved from https://www.dawn.com/news/1070595

Anderson, S., Allen, P., Peckham, S., & Goodwin, N. (2008). Asking the right questions: scoping studies in the commissioning of research on the organisation and delivery of health services. *New left review. 6*(1), 1-12.

Andersson, G., & Cuijpers, P. (2008). Pros and cons of online cognitive–behavioural therapy. *The British Journal of Psychiatry, 193*(4), 270-271.

Andrea, H., Bültmann, U., van Amelsvoort, L. G., & Kant, Y. (2009). The incidence of anxiety and depression among employees—the role of psychosocial work characteristics. *Depression anxiety. 26*(11), 1040-1048.

Applied Mental Health Research Group. (2013). Design, implementation, monitoring, and evaluation of mental health and psychosocial assistance programs for trauma survivors in low resource countries; a user's manual for researchers and program implementers. *United States: Johns Hopkins University Bloomberg School of Public Health*.

Arends, I. (2015). Fit Mind, Fit Job: From Evidence to Practice in Mental Health and Work. In *Fit Mind, Fit Job: From Evidence to Practice in Mental Health and Work*: OECD/ODCE.

Arksey, H., & O'Malley, L. (2005). Scoping studies: towards a methodological framework. *International journal of social research methodology. 8*(1), 19-32.

Armstrong, D., Gosling, A., Weinman, J., & Marteau, T. (1997). The place of inter-rater reliability in qualitative research: An empirical study. Sociology, 31, 597–606. https://doi.org/10.1177/0038038597031003015

Armstrong R, Hall BJ, Doyle J, Waters E. Cochrane Update. 'Scoping the scope' of a cochrane review. J Public Health (Oxf) 2011;33(1):147–150.

Bakker, A. B., Demerouti, E., & Verbeke, W. (2004). Using the job demands-resources model to predict burnout and performance. *Human Resource Management: Published in Cooperation with the School of Business Administration, The University of Michigan in alliance with the Society of Human Resources Management. 43*(1), 83-104.

Baldwin, J. R., & Lindsley, S. L. (1994). *Conceptualizations of culture*: Urban Studies Center, College of Public Programs, Arizona State University.

Bao, Y., & Zhong, W. (2019). How stress hinders health among Chinese public sector employees: The mediating role of emotional exhaustion and the moderating role of perceived organizational support. *International journal of environmental research public health. 16*(22), 4408.

Barnes, T., Pashby, I., & Gibbons, A. (2002). Effective university–industry interaction:: A multi-case evaluation of collaborative r&d projects. *European Management Journal. 20*(3), 272-285.

Barona, A., & Santos de Barona, M. (2003). Recommendations for the psychological treatment of Latino/Hispanics populations. *Council of National Psychological Associations for the advancement of ethnic minority interests Psychological treatment of ethnic minority populations.* 19-23.

Barrera Jr, M., & Castro, F. G. (2006). A heuristic framework for the cultural adaptation of interventions.

Barrera Jr, M., Castro, F. G., Strycker, L. A., & Toobert, D. J. (2013). Cultural adaptations of behavioral health interventions: a progress report. *Journal of consulting clinical psychology. 81*(2), 196.

Bartlett, L., Lovell, P., Otahal, P., & Sanderson, K. (2017). Acceptability, feasibility, and efficacy of a workplace mindfulness program for public sector employees: a pilot randomized controlled trial with informant reports. *Mindfulness. 8*(3), 639-654.

Basil, M., Youssef, M., Al-Khatib, L., Shebrek, A., Akili, S., & Zakrian, M. (2021). Personal Reflections on Problem Management Plus: Written by Syrian Helpers at Stichting Nieuw Thuis, Rotterdam, The Netherlands. *19*(1), 118-120. doi:10.4103/intv.Intv_32_20

Baxter, A. J., PaOon, G., ScoO, K. M., Degenhardt, L., & Whiteford, H. A. (2013). Global epidemiology of mental disorders: what are we missing. PLoS One, 8(6), e65514

Beck, A. T., Emery, G., & Greenberg, R. L. (2005). *Anxiety disorders and phobias: A cognitive perspective*: basic Books.

Bemme, D., & D'Souza, N. A. (2014). Global mental health and its discontents: An inquiry into the making of global and local scale. Transcultural Psychiatry, 51(6), 850-874

Benish, S. G., Quintana, S., & Wampold, B. E. J. J. o. C. P. (2011). Culturally adapted psychotherapy and the legitimacy of myth: a direct-comparison meta-analysis. *58*(3), 279.

Bennett-Levy, J., Farrand, P., Christensen, H., & Griffiths, K. (2010). *Oxford guide to low intensity CBT interventions*: Oxford University Press.

Bernal, G., Bonilla, J., & Bellido, C. (1995). Ecological validity and cultural sensitivity for outcome research: Issues for the cultural adaptation and development of psychosocial treatments with Hispanics. *Journal of abnormal child psychology. 23*(1), 67-82.

Bernal, G., Jiménez-Chafey, M. I., & Domenech Rodríguez, M. M. (2009). Cultural adaptation of treatments: A resource for considering culture in evidence-based practice. *Professional Psychology: Research Practice. 40*(4), 361.

Bernal, G., & Sáez-Santiago, E. (2006). Culturally centered psychosocial interventions. *Journal of Community Psychology. 34*(`2), 121-132.

Birnbaum, H. G., Wilder, R. C., Kelley, D., Ben-Hamadi, R., Joish, V. N., & Greenberg, P. E. (2010). Employer burden of mild, moderate, and severe major depressive disorder: mental health services utilization and costs, and work performance. *Depression anxiety. 27*(1), 78-89.

Blake, H., Zhou, D., & Batt, M. E. (2013). Five-year workplace wellness intervention in the NHS. *Perspectives in public health. 133*(5), 262-271.

Bloom, D. E., Cafiero, E., Jané-Llopis, E., Abrahams-Gessel, S., Bloom, L. R., Fathima, S., ... & Weiss, J. (2012). *The global economic burden of noncommunicable diseases* (No. 8712). Program on the Global Demography of Aging.

Bogg, J., & Cooper, C. (1995). Job satisfaction, mental health, and occupational stress among senior civil servants. *Human relations. 48*(3), 327-341.

Bolton, P., Bass, J., Neugebauer, R., Verdeli, H., Clougherty, K. F., Wickramaratne, P., . . . Weissman, M. (2003). Group interpersonal psychotherapy for depression in rural Uganda: a randomized controlled trial. *Jama. 289*(23), 3117-3124.

Bradley, D. E., & Roberts, J. A. (2004). Self-employment and job satisfaction: investigating the role of self-efficacy, depression, and seniority. *Journal of small business management. 42*(1), 37-58.

Braibanti, R. (1966). *Research on the Bureaucracy of Pakistan: A Critique of Sources and Issues*. Durham, N.C: Duke University Press.

Brohan, E., Henderson, C., Wheat, K., Malcolm, E., Clement, S., Barley, E. A., . . . Thornicroft, G. (2012). Systematic review of beliefs, behaviours and influencing factors associated with disclosure of a mental health problem in the workplace. *BMC psychiatry. 12*(1), 1-14.

Bulak, A. (2018). *Stress, coping and well-being in Irish civil servants* (Doctoral dissertation, Dublin Business School).

Cabassa, L. J., & Baumann, A. A. (2013). A two-way street: bridging implementation science and cultural adaptations of mental health treatments. *Implementation science, 8*(1), 1-14.

Carolan, S., Harris, P. R., & Cavanagh, K. (2017). Improving employee well-being and effectiveness: systematic review and meta-analysis of web-based psychological interventions delivered in the workplace. *Journal of medical Internet research, 19*(7), e271.

Carver, C. S. (1997). You want to measure coping but your protocol'too long: Consider the brief cope. *International journal of behavioral medicine. 4*(1), 92-100.

Cheema, G. S. (2005). *Building democratic institutions: governance reform in developing countries*: Kumarian Press.

Chen. (2005). Mental health of the civil servants. *4*, 71-73.

Chiesa, A., & Serretti, A. (2009). Mindfulness-based stress reduction for stress management in healthy people: a review and meta-analysis. *The journal of alternative complementary medicine, 15*(5), 593-600.

Chiumento, A., Billows, L., Mackinnon, A., McCluskey, R., White, R., Khan, N., . . . Dowrick, C. (2021). Task-Sharing Psychosocial Support with Refugees and Asylum Seekers: Reflections and Recommendations for Practice from the PROSPER Study. *Intervention, Journal of Mental Health Psychosocial Support in Conflict Affected Areas. 19*(1).

Chiumento, A., Rahman, A., Frith, L., Snider, L., & Tol, W. A. (2017). Ethical standards for mental health and psychosocial support research in emergencies: review of literature and current debates. *Globalization health. 13*(1), 1-19.

Chowdhary, N., Jotheeswaran, A., Nadkarni, A., Hollon, S., King, M., Jordans, M., . . . Patel, V. (2014). The methods and outcomes of cultural adaptations of psychological treatments for depressive disorders: a systematic review. *Psychological medicine, 44*(6), 1131-1146.

Clark, D. (2011). Implementing NICE guidelines for the psychological treatment of depression and anxiety disorders: the IAPT experience. *23*(4), 318-327.

Clark, C., Pike, C., McManus, S., Harris, J., Bebbington, P., Brugha, T., ... & Stansfeld, S. (2012). The contribution of work and non-work stressors to common mental disorders in the 2007 Adult Psychiatric Morbidity Survey. *Psychological medicine, 42*(4), 829-842.

Colom, F. (2011). Keeping therapies simple: psychoeducation in the prevention of relapse in affective disorders. *The British Journal of Psychiatry, 198*(5), 338-340.

Costa Jr, P. T., Somerfield, M. R., & McCrae, R. R. (1996). Personality and coping: A reconceptualization.

Cox, T., Griffiths, A., & Rial-Gonzalez, E. (2000). Work-related stress. *Office for Official Publications of the European Communities, Luxembourg*

Crain, T. L., Schonert-Reichl, K. A., & Roeser, R. W. (2017). Cultivating teacher mindfulness: Effects of a randomized controlled trial on work, home, and sleep outcomes. *Journal of occupational health psychology. 22*(2), 138.

Cuijpers, P., Cristea, I. A., Karyotaki, E., Reijnders, M., & Huibers, M. J. (2016). How effective are cognitive behavior therapies for major depression and anxiety disorders? A meta-analytic update of the evidence. *World Psychiatry. 15*(3), 245-258.

Cuijpers, P., Van Straten, A., Warmerdam, L., & Smits, N. (2008). Characteristics of effective psychological treatments of depression: a metaregression analysis. *Psychotherapy Research, 18*(2), 225-236.

Czabała, C., Charzyńska, K., & Mroziak, B. (2011). Psychosocial interventions in workplace mental health promotion: an overview. *Health promotion international. 26*(suppl_1), i70-i84.

Daudt, H. M., van Mossel, C., & Scott, S. J. (2013). Enhancing the scoping study methodology: a large, inter-professional team's experience with Arksey and O'Malley's framework. *BMC medical research methodology, 13*(1), 1-9.

Davis, K., Drey, N., & Gould, D. (2009). What are scoping studies? A review of the nursing literature. *International journal of nursing studies, 46*(10), 1386-1400.

Dawson, K. S., Bryant, R. A., Harper, M., Tay, A. K., Rahman, A., Schafer, A., & Van Ommeren, M. (2015). Problem Management Plus (PM+): a WHO transdiagnostic psychological intervention for common mental health problems. *World Psychiatry, 14*(3), 354.

De Barona, M. S., & Barona, A. J. P. S. C. (2006). School counselors and school psychologists: Collaborating to ensure minority students receive appropriate consideration for special educational programs. *10*(1_suppl), 2156759X0601001S2156702.

Demyttenaere K, Bruffaerts R, Posada-Villa J, et al. (2004). Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization World Mental Health Surveys. JAMA, 291: 2581–2590.

Dewa, C. S., Lesage, A., Goering, P., & Craveen, M. (2004). Nature and prevalence of mental illness in the workplace. *Healthc Pap, 5*(2), 12-25.

Dewa, C. S., Thompson, A. H., & Jacobs, P. (2011). The association of treatment of depressive episodes and work productivity. *The Canadian Journal of Psychiatry, 56*(12), 743-750.

Dickson-Swift, V., James, E. L., Kippen, S., & Liamputtong, P. (2007). Doing sensitive research: what challenges do qualitative researchers face? *Qualitative research, 7*(3), 327-353.

Dimler, L. M., & Natsuaki, M. N. (2015). The effects of pubertal timing on externalizing behaviors in adolescence and early adulthood: A meta-analytic review. *Journal of Adolescence, 45*, 160-170.

Dobie, A., Tucker, A., Ferrari, M., & Rogers, J. M. (2016). Preliminary evaluation of a brief mindfulness-based stress reduction intervention for mental health professionals. *Australasian Psychiatry, 24*(1), 42-45.

Dollard, M. F., & Winefield, A. H. (2002). Mental health: overemployment, underemployment, unemployment and healthy jobs. *Australian e-Journal for the Advancement of Mental Health, 1*(3), 170-195.

Duchemin, A.-M., Steinberg, B. A., Marks, D. R., Vanover, K., & Klatt, M. (2015). A small randomized pilot study of a workplace mindfulness-based intervention for surgical intensive care unit personnel: effects on salivary α-amylase levels. *Journal of occupational environmental medicine/American College of Occupational Environmental Medicine. 57*(4), 393.

Echeverry, J. J. (1997). Treatment barriers accessing and accepting professional help.

Elder, C., Nidich, S., Moriarty, F., & Nidich, R. (2014). Effect of transcendental meditation on employee stress, depression, and burnout: a randomized controlled study. *The Permanente Journal. 18*(1), 19.

Endler, N. S., & Parker, J. D. (1990). State and trait anxiety, depression and coping styles. *Australian Journal of Psychology, 42*(2), 207-220.

Ewers, P., Bradshaw, T., McGovern, J., & Ewers, B. (2002). Does training in psychosocial interventions reduce burnout rates in forensic nurses? *Journal of advanced nursing, 37*(5), 470-476.

Ewing, D. L., Monsen, J. J., Thompson, E. J., Cartwright-Hatton, S., & Field, A. (2015). A meta-analysis of transdiagnostic cognitive behavioural therapy in the treatment of child and young person anxiety disorders. *Behavioural cognitive psychotherapy, 43*(5), 562-577.

Faisal, F., Noor, N., & Khair, A. (2019). Causes and Consequences of Workplace Stress among Pakistan University Teachers. *Bulletin of Education Research, 41*(3), 45-60.

Falicov, C. J. (2009). Religion and spiritual traditions in immigrant families: Significance for Latino health and mental health.

Fernando, S. (2004). *Cultural diversity, mental health and psychiatry: The struggle against racism*: Routledge.

Fernando, S., & Weerackody, C. (2009). Challenges in developing community mental health services in Sri Lanka. *Journal of Health Management, 11*(1), 195-208.

Finance Division, Government of Pakistan (2021). *Economic Survey of Pakistan, 2020/21*. Retrieved from Pakistan: https://www.finance.gov.pk/survey_2021.html

Fiske, A. P. (2002). Using individualism and collectivism to compare cultures--a critique of the validity and measurement of the constructs: comment on Oyserman et al.(2002).

Fleischmann, M., Xue, B., & Head, J. (2020). Mental health before and after retirement—Assessing the relevance of psychosocial working conditions: The Whitehall II prospective study of British civil servants. *The Journals of Gerontology: Series B, 75*(2), 403-413.

Fox, S., Spector, P. E., & Miles, D. (2001). Counterproductive work behavior (CWB) in response to job stressors and organizational justice: Some mediator and moderator tests for autonomy and emotions. *Journalof vocational behavior, 59*(3), 291-309.

Fuhr, D. C., Bogdanov, S., Tol, W. A., Nadkarni, A., & Roberts, B. (2021). Problem Management Plus and Alcohol (PM+ A): A New Intervention to Address Alcohol Misuse and Psychological Distress Among Conflict-Affected Populations. *Intervention, 19*(1), 141.

Gadit, A., Vahidy, A., & Shafique, F. J. J. C. P. S. P. (1998). Mental Health Morbidity: An experience in a community psychiatric clinic. *8*(6), 262-264.

Gaskell, G. (2000). Individual and group interviewing. In M. W. Bauer & G. Gaskell (Eds.), Qualitative Researching with Text, Image and Sound: A Practical Handbook (pp. 38–56). Sage.

Goetzel, R. Z., Ozminkowski, R. J., Sederer, L. I., & Mark, T. L. (2002). The business case for quality mental health services: why employers should care about the mental health and well-being of their employees. *Journal of occupational. 44*(4), 320-330.

Goetzel, R. Z., Roemer, E. C., Holingue, C., Fallin, M. D., McCleary, K., Eaton, W., . . . Bartlett, J. (2018). Mental health in the workplace: A call to action proceedings from the mental health in the workplace: Public health summit. *Journal of occupational environmental medicine. 60*(4), 322.

Goloktionova, A. E., & Mukerjee, M. (2021). Bringing Problem Management Plus to Ukraine: Reflections on the Past and Ways Forward. *Intervention. 19*(1), 131.

Goodspeed, R. B., & DeLucia, A. G. (1990). Stress reduction at the worksite: An evaluation of two methods. *American Journal of Health Promotion, 4*(5), 333-337.

Greene MC, Jordans MJD, Kohrt BA, Ventevogel P, Kirmayer LJ, Hassan G, Chiumento A, van Ommeren M, Tol WA. Addressing culture and context in humanitarian response: preparing desk reviews to inform mental health and psychosocial support. Confl Heal. 2017;11:21.

Greenwood, K., & Krol, N. (2020). ways managers can support employees' mental health. *Harvard Business Review* retrieved from*https://hbr. org//08/8-ways-managers-can-support-employees-mental-health*.

Griffiths, K. M., Bennett, K., Walker, J., Goldsmid, S., & Bennett, A. (2016). Effectiveness of MH-Guru, a brief online mental health program for the workplace: A randomised controlled trial. *Internet interventions. 6*, 29-39.

Grime, P. R. (2004). Computerized cognitive behavioural therapy at work: a randomized controlled trial in employees with recent stress-related absenteeism. *Occupational Medicine. 54*(5), 353-359.

Grimshaw, J. (2010). A guide to knowledge synthesis: a knowledge synthesis chapter. *Ottawa: Canadian Institutes of Health Research*.

Grosse, S. D., Lollar, D. J., Campbell, V. A., & Chamie, M. (2009). Disability and disability-adjusted life years: not the same. *Public Health Reports, 124*(2), 197-202.

Griner, D., & Smith, T. B. (2006). Culturally adapted mental health intervention: A meta-analytic review. *Psychotherapy: Theory, research, practice, training. 43*(4), 531.

Gründemann, R., Nijboer, I., & Schellart, A. (1991). The work-relatedness of drop-out from work for medical reasons. *Ministry of Social Affairs Employment, Den Haag*.

Guan, S., Xiaerfuding, X., Ning, L., Lian, Y., Jiang, Y., Liu, J., & Ng, T. B. (2017). Effect of job strain on job burnout, mental fatigue and chronic diseases among civil servants in the Xinjiang Uygur Autonomous Region of China. *International journal of environmental research public health. 14*(8), 872.

Gupta, S. K. (2011). Intention-to-treat concept: A review. *Perspectives in clinical research, 2*(3), 109-112. doi:10.4103/2229-3485.83221

Hamdani, S. U., Ahmed, Z., Sijbrandij, M., Nazir, H., Masood, A., Akhtar, P., . . . van Ommeren, M. (2017a). Problem Management Plus (PM+) in the management of common mental disorders in a specialized mental healthcare facility in Pakistan; study protocol for a randomized controlled trial. *International journal of mental health systems. 11*(1), 1-9.

Hamdani, S. U., Ahmed, Z., Sijbrandij, M., Nazir, H., Masood, A., Akhtar, P., . . . van Ommeren, M. J. I. j. o. m. h. s. (2017b). Problem Management Plus (PM+) in the management of common mental disorders in a specialized mental healthcare facility in Pakistan; study protocol for a randomized controlled trial. *11*(1), 1-9.

Hamdani, S. U., Rahman, A., Wang, D., Chen, T., van Ommeren, M., Chisholm, D., & Farooq, S. (2020). Cost-effectiveness of WHO problem management plus for adults with mood and anxiety disorders in a post-conflict area of Pakistan: randomised controlled trial. *The British Journal of Psychiatry. 217*(5), 623-629.

Hamdani, S. U., Huma, Z. E., Masood, A., Zhou, K., Ahmed, Z., Nazir, H., Amin, H., Akhtar, P., Bryant, R. A., Dawson, K., van Ommeren, M., Wang, D., Rahman, A., & Minhas, F. A. (2021). Effect of adding a psychological intervention to routine care of common mental disorders in a specialized mental healthcare facility in Pakistan: a randomized controlled trial. International journal of mental health systems, 15(1), 11. https://doi.org/10.1186/s13033-020-00434-y

Hampson, E., & Jacob, A. (2020). Mental health and employers: Refreshing the case for investment. *Deloitte*.

Hao, S., Hong, W., Xu, H., Zhou, L., & Xie, Z. (2015). Relationship between resilience, stress and burnout among civil servants in Beijing, China: Mediating and moderating effect analysis. *Personality Individual Differences. 83*, 65-71.

Harms, Credé, M., Tynan, M., Leon, M., & Jeung, W. (2017). Leadership and stress: A meta-analytic review. *The leadership quarterly. 28*(1), 178-194.

Harms, P. D., & Luthans, F (2012). Measuring implicit psychological constructs in organizational behavior: An example using psychological capital. *33*(4), 589-594.

Harnois, G., & Gabriel, P. (2000). Mental health and work: Impact, issues and good practices, World Health Organization, Geneva.

Heifetz, R. A., Heifetz, R., Grashow, A., & Linsky, M. (2009). *The practice of adaptive leadership: Tools and tactics for changing your organization and the world*: Harvard Business Press.

Henderson, C., Williams, P., Little, K., & Thornicroft, G. (2013). Mental health problems in the workplace: changes in employers' knowledge, attitudes and practices in England 2006-2010. *The British Journal of Psychiatry. 202*(s55), s70-s76.

Hesselink, J. K., & Jain, A. (2014). *Interventions to prevent and manage psychosocial risks and work-related stress*. Hoofddorp: TN retrieved from https://oshwiki.eu/wiki/Interventions_to_prevent_and_manage_psychosocial_risks_and_work-related_stress

Hoeft, T. J., Fortney, J. C., Patel, V., & Unützer, J. (2018). Task sharing approaches to improve mental health care in rural and other low resource settings: a systematic review. *The Journal of rural health. 34*(1), 48-62.

Hunter, Gough, A., Murray, J. M., Tang, J., Brennan, S. F., Chrzanowski-Smith, O. J., . . . Hutchinson, G. (2019). Results from the mediation analyses. In *A loyalty scheme to encourage physical activity in office workers: a cluster RCT*: NIHR Journals Library.

Hunter, R. F., Brennan, S. F., Tang, J., Smith, O. J., Murray, J., Tully, M. A., . . . Prior, L. (2016). Effectiveness and cost-effectiveness of a physical activity loyalty scheme for behaviour change maintenance: a cluster randomised controlled trial. *BMC Public Health. 16*(1), 1-12.

Hunter, R. F., Murray, J. M., Gough, A., Tang, J., Patterson, C. C., French, D. P., . . . Kee, F. (2018). Effectiveness and cost-effectiveness of a loyalty scheme for physical activity behaviour change maintenance: results from a cluster randomised controlled trial. *Int J Behav Nutr Phys Act, 15*(1), 127. doi:10.1186/s12966-018-0758-1

Husain, N., Creed, F., & Tomenson, B. (2000). Depression and social stress in Pakistan. *Psychological medicine. 30*(2), 395-402.

ILO, I. (2016). Workplace stress: A collective challenge. *Labour Administration, Labour Inspection Occupational Safety Health*

Jenkins, R., Harvey, S., Butler, T., & Lloyd Thomas, R. (1996). Minor Psychiatric Morbidity, Its Prevalence and Outcome in a Cohort of Civil Servants—A Seven-year Follow-up Study. *Occupational medicine. 46*(3), 209-215.

Jones, G. N. (1997). Pakistan: A civil service in an obsolescing imperial tradition. *Asian journal of public Administration. 19*(2), 321-364.

Jooma, R., Minhas, F., & Saxena, S. (2009). WHO-AIMS report on mental health institutes in Pakistan. *World Health Organisation Office, Islamabad, Pakistan.*.

Karasek Jr, R. A. (1979). Job demands, job decision latitude, and mental strain: Implications for job redesign. *Administrative science quarterly.* 285-308.

Kawaharada, M., Yoshioka, E., Saijo, Y., Fukui, T., Ueno, T., & Kishi, R. (2009). The effects of a stress inoculation training program for civil servants in Japan: a pilot study of a non-randomized controlled trial. *Industrial Health. 47*(2), 173-182.

Kawai, K., Yamazaki, Y., & Nakayama, K. (2010). Process evaluation of a web-based stress management program to promote psychological well-being in a sample of white-collar workers in Japan. *Industrial health. 48*(3), 265-274.

Kelly, S. (1995). The impact of the relationship and family stresses in the workplace. *Psychological health in the workplace.* 21-29.

Kemeny, M. E., Foltz, C., Cavanagh, J. F., Cullen, M., Giese-Davis, J., Jennings, P., . . . Wallace, B. A. (2012). Contemplative/emotion training reduces negative emotional behavior and promotes prosocial responses. *Emotion, 12*(2), 338.

Kendall, E., Murphy, P., O'Neill, V., & Bursnall, S. (2000). Occupational stress: Factors that contribute to its occurrence and effective management.iIn: Western Australia:, Grriffth University .

Kennedy, C. H. (1987). *Bureaucracy in Pakistan*: Karachi; New York: Oxford University Press.

Keogh-Brown, M., Bachmann, M., Shepstone, L., Hewitt, C., Howe, A., Ramsay, C. R., . . . Miles, S. (2007). Contamination in trials of educational interventions.

Kerr, D. C., Ornelas, I. J., Lilly, M. M., Calhoun, R., & Meischke, H. (2019). Participant engagement in and perspectives on a web-based mindfulness intervention for 9-1-1 telecommunicators: Multimethod study. *Journal of medical Internet research, 21*(6), e13449.

Kersemaekers, W., Rupprecht, S., Wittmann, M., Tamdjidi, C., Falke, P., Donders, R., . . . Kohls, N. (2018). A workplace mindfulness intervention may be associated with improved psychological well-being and productivity. A preliminary field study in a company setting. *Frontiers in psychology, 9*, 195.

Kessler RC, Barker PR, Colpe LJ, Epstein JF, Gfroerer JC, Hiripi E, et al. Screening for serious mental illness in the general population. Arch Gen Psychiatry. 2003 Feb;60(2):184-9.

Keus Van De Poll, M., Bergström, G., Jensen, I., Nybergh, L., Kwak, L., Lornudd, C., & Lohela-Karlsson, M. (2020). Cost-effectiveness of a problem-solving intervention aimed to prevent sickness absence among employees with common mental disorders or occupational stress. *International journal of environmental research public health, 17*(14), 5234.

Khan, Hamdani, S., Chiumento, A., Dawson, K., Bryant, R., Sijbrandij, M., . . . Wang, D. (2019). Evaluating feasibility and acceptability of a group WHO trans-diagnostic intervention for women with common mental disorders in rural Pakistan: a cluster randomised controlled feasibility trial. *Epidemiology Psychiatric Sciences, 28*(1), 77-87.

Khan, A. (1961). Critical conditions for the formation of infinite networks. *49*(152), 283-286.

Khoury, B., Sharma, M., Rush, S. E., & Fournier, C. (2015). Mindfulness-based stress reduction for healthy individuals: A meta-analysis. *Journal of psychosomatic research. 78*(6), 519-528.

Kinard, E. M. (1996). Conducting research on child maltreatment: effects on researchers. *Violence Vict, 11*(1), 65-69.

King, M., Dinos, S., Shaw, J., Watson, R., Stevens, S., Passetti, F., . . . Serfaty, M. (2007). The Stigma Scale: Development of a standardised measure of the stigma of mental illness. British Journal of Psychiatry, 190(3), 248-254. doi:10.1192/bjp.bp.106.024638.

Kohrt, Brandon & Hruschka, Daniel. (2010). Nepali Concepts of Psychological Trauma: The Role of Idioms of Distress, Ethnopsychology and Ethnophysiology in Alleviating Suffering and Preventing Stigma. Culture, medicine and psychiatry. 34. 322-52. 10.1007/s11013-010-9170-2.

Koopmans, L., Bernaards, C., Hildebrandt, V., van Buuren, S., van der Beek, A.J. and de Vet, H.C.W. (2013), "Development of an individual work performance questionnaire", International Journal of Productivity and Performance Management, Vol. 62 No. 1, pp. 6-28. https://doi.org/10.1108/17410401311285273.

Kortum, E., & Leka, S. (2014). Tackling psychosocial risks and work-related stress in developing countries: The need for a multilevel intervention framework. *International Journal of Stress Management. 21*(1), 7.

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: validity of a brief depression severity measure. *Journal of general internal medicine. 16*(9), 606-613.

Kupriyanov, R., & Zhdanov, R. (2014). The eustress concept: problems and outlooks. *World Journal of Medical Sciences. 11*(2), 179-185.

Lasalvia, A., Zoppei, S., Van Bortel, T., Bonetto, C., Cristofalo, D., Wahlbeck, K., . . . Reneses, B. (2013). Global pattern of experienced and anticipated discrimination reported by people with major depressive disorder: a cross-sectional survey. *The Lancet. 381*(9860), 55-62.

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*: Springer publishing company.

Leka, S., & Jain, A. (2010). Health impact of psychosocial hazards at work: an overview, World Health Organization.

Lelliott, Paul, Boardman, Jed, Harvey, Sam, Henderson, Max, Knapp, Martin and Tulloch, Simon (2008) *Mental health and work.* . Royal College of Psychiatrists, London, UK.

Levac, D., Colquhoun, H., & O'Brien, K. K. (2010). Scoping studies: advancing the methodology. *Implementation science. 5*(1), 1-9.

Lilly, M., Calhoun, R., Painter, I., Beaton, R., Stangenes, S., Revere, D., . . . medicine, e. (2019). Destress 9-1-1—an online mindfulness-based intervention in reducing stress among emergency medical dispatchers: a randomised controlled trial. *Occupational environmental medicine. 76*(10), 705-711.

Liu, B., Yang, K., & Yu, W. (2015). Work-related stressors and health-related outcomes in public service: Examining the role of public service motivation. *The American Review of Public Administration. 45*(6), 653-673.

Luthans, F., Avolio, B. J., Avey, J. B., & Norman, S. M. (2007). Positive psychological capital: Measurement and relationship with performance and satisfaction. *Personnel psychology. 60*(3), 541-572.

Mache, S., Baresi, L., Bernburg, M., Vitzthum, K., & Groneberg, D. (2017). Being prepared to work in gynecology medicine: evaluation of an intervention to promote junior gynecologists professionalism, mental health and job satisfaction. *Archives of gynecology obstetrics. 295*(1), 153-162.

Majid, D. A., Ali, S., Awan, F. A., & Kousar, S. (2020). Kashmir: The Major Source of Conflict between Pakistan and India. *South Asian Studies. 34*(2).

Malgady, R. G., Rogler, L. H., & Costantino, G. (1990). Culturally sensitive psychotherapy for Puerto Rican children and adolescents: A program of treatment outcome research. *Journal of Consulting Clinical Psychology. 58*(6), 704.

Manun'Ebo, M., Cousens, S., Haggerty, P., Kalengaie, M., Ashworth, A., & Kirkwood, B. (1997). Measuring hygiene practices: a comparison of questionnaires with direct observations in rural Zaire. *Tropical medicine international health. 2*(11), 1015-1021.

Marmot, Davey Smith, G., Stansfeld, S., Patel, C., North, F., Head, J., . . . Feeney, A. (1991). Inequalities in health twenty years on: the Whitehall II study of British Civil Servants. *Lancet. 337*, 1387-1394.

Marmot, Rose, G., Shipley, M., & Hamilton, P. (1978). Employment grade and coronary heart disease in British civil servants. *Journal of Epidemiology Community Health, 32*(4), 244-249.

Marquez, P. V., & Saxena, S. (2016). Making Mental Health a Global Priority. *Cerebrum : the Dana forum on brain science, 2016*, cer-10-16.

Martin, A., Sanderson, K., & Cocker, F. (2009). Meta-analysis of the effects of health promotion intervention in the workplace on depression and anxiety symptoms. *Scandinavian journal of work, environment*, 7-18.

Martinez-Devesa, P., Waddell, A., Perera, R., & Theodoulou, M. (2007). Cognitive behavioural therapy for tinnitus. *Cochrane database of systematic reviews*, (1).

Masiero, M., Mazzocco, K., Harnois, C., Cropley, M., & Pravettoni. (2020). From individual to social trauma: sources of everyday trauma in Italy, the US and UK during the COVID-19 pandemic. *21*(5), 513-519.

McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of traumatic stress, 3*(1), 131-149.

McEvoy, P. M., Nathan, P., & Norton, P. (2009). Efficacy of transdiagnostic treatments: A review of published outcome studies and future research directions. *23*(1), 20-33.

McHugh, M. L. (2012). Interrater reliability: the kappa statistic. *Biochemia medica. 22*(3), 276-282.

McLean, E., Cogswell, M., Egli, I., Wojdyla, D., & De Benoist, B. J. P. h. n. (2009). Worldwide prevalence of anaemia, WHO vitamin and mineral nutrition information system, 1993–2005. *12*(4), 444-454.

Meichenbaum, D. H., & Deffenbacher, J. L. (1988). Stress inoculation training. *The Counseling Psychologist. 16*(1), 69-90.

Meyer, B. (2001). Coping with Severe Mental Illness: Relations of the Brief COPE with Symptoms, Functioning, and Well-Being. *Journal of Psychopathology and Behavioral Assessment, 23*(4), 265-277. doi:10.1023/A:1012731520781

Miedziun, P., & Czabała, J. C. (2015). Stress management techniques. *Arch Psychiatry Psychother. 17*(4), 23-31.

Mills, C. J. D., & Change. (2018). From 'invisible problem'to global priority: The inclusion of mental health in the sustainable development goals. *49*(3), 843-866.

Mirza, I., & Jenkins, R. (2004). Risk factors, prevalence, and treatment of anxiety and depressive disorders in Pakistan: systematic review. *Bmj. 328*(7443), 794.

Muhammad Gadit, A. A., & Mugford, G. (2007). Prevalence of depression among households in three capital cities of Pakistan: need to revise the mental health policy. *2*(2), e209.

Mumford, D. B., Minhas, F. A., Akhtar, I., Akhter, S., & Mubbashar, M. H. (2000). Stress and psychiatric disorder in urban Rawalpindi. Community survey. *Br J Psychiatry, 177*, 557-562. doi:10.1192/bjp.177.6.557

Mumford, D. B., Saeed, K., Ahmad, I., Latif, S., & Mubbashar, M. H. (1997). Stress and psychiatric disorder in rural Punjab: a community survey. *The British Journal of Psychiatry. 170*(5), 473-478.

Munn, Z., Peters, M. D., Stern, C., Tufanaru, C., McArthur, A., & Aromataris, E. (2018). Systematic review or scoping review? Guidance for authors when choosing between a systematic or scoping review approach. *BMC medical research methodology. 18*(1), 1-7.

Mundt, J. C., I. M. Marks, et al. (2002). "The Work and Social Adjustment Scale: A simple measure of impairment in functioning." Br. J. Psychiatry 180: 461-4.

Muñoz, R. (1982). The Spanish-speaking consumer and the community mental health center. 362-398.

Murphy, L. (1996). Stress management in work settings: A critical review of the health effects. *11*(2), 112-135.

Murray, Barber, R. M., Foreman, K. J., Ozgoren, A. A., Abd-Allah, F., Abera, S. F., . . . Abu-Raddad, L. J. (2015). Global, regional, and national disability-adjusted life years (DALYs) for 306 diseases and injuries and healthy life expectancy (HALE) for 188 countries, 1990–2013: quantifying the epidemiological transition. *The Lancet. 386*(10009), 2145-2191.

Murray, L. K., Dorsey, S., Bolton, P., Jordans, M. J., Rahman, A., Bass, J., & Verdeli, H. (2011). Building capacity in mental health interventions in low resource countries: an apprenticeship model for training local providers. *International Journal of Mental Health Systems. 5*(1), 1-12.

Murray, L. K., Dorsey, S., Haroz, E., Lee, C., Alsiary, M. M., Haydary, A., . . . Bolton, P. (2014). A common elements treatment approach for adult mental health problems in low-and middle-income countries. *Cognitive behavioral practice. 21*(2), 111-123.

National Collaborating Centre for Mental, Health (2011). National Institute for Health and Clinical Excellence: Guidance. In *Common Mental Health Disorders: Identification and Pathways to Care*. Leicester (UK): British Psychological Society.

National Institute of Population Studies (NIPS) [Pakistan] and ICF. 2019. Pakistan Demographic and Health Survey 2017-18. Islamabad, Pakistan, and Rockville, Maryland, USA: NIPS and ICF.

Nehra, D. K., Sharma, N., Kumar, P., & Nehra, S. (2013). Mindfulness Based Stress Reduction (MBSR) Program: An Overview. *Mental Health: Risks Resources*

Newman, M. G., Cho, S., & Kim, H. (2017). Worry and generalized anxiety disorder: a review. Newman, MG, Cho, S., & Kim, H.(2017). Worry and Generalized Anxiety Disorder: A Review. Reference Module *in Neuroscience and Biobehavioral Psychology*. doi, 10.

Nichter, Mark (1981) Idioms of Distress: Alternatives in the Expression of Psychosocial Distress: A Case Study from South India. Culture, Medicine and Psychiatry 5: 379–408

North, F. M., Syme, S. L., Feeney, A., Shipley, M., & Marmot, M. (1996). Psychosocial work environment and sickness absence among British civil servants: the Whitehall II study. *American journal of public health. 86*(3), 332-340.

O'Brien, Kelly & Colquhoun, Heather & Levac, Danielle & Baxter, Larry & Tricco, Andrea & Straus, Sharon & Wickerson, Lisa & Nayar, Ayesha & Moher, David & O'Malley, Lisa. (2016). Advancing scoping study methodology: A web-based survey and consultation of perceptions on terminology, definition and methodological steps. BMC Health Services Research. 16. 10.1186/s12913-016-1579-z.

O'Connor, M., & Casey, L. (2015). The Mental Health Literacy Scale (MHLS): A new scale-based measure of mental health literacy. Psychiatry Research, 229(1-2), 511-516. doi:10.1016/j.psychres.2015.05.064.

OECD, & Union. (2018). *OECD Science, Technology and Innovation Outlook 2018*: OECD Publishing Paris.

Oei, T. P., & Dingle, G. (2008). The effectiveness of group cognitive behaviour therapy for unipolar depressive disorders. *Journal of Affective Disorders. 107*(1-3), 5-21.

Ohiorhenuan, J. F. (1978). Unequal Development: An Essay on the Social Formations of Peripheral Capitalism. In: JSTOR.

Ojala, B., Nygård, C.-H., Huhtala, H., Bohle, P., & Nikkari, S. T. (2019). A cognitive behavioural intervention programme to improve psychological well-being. *International journal of environmental research public health. 16*(1), 80.

Olatunji, B. O., Williams, N. L., Tolin, D. F., Abramowitz, J. S., Sawchuk, C. N., Lohr, J. M., & Elwood, L. S. (2007). The Disgust Scale: item analysis, factor structure, and suggestions for refinement. *Psychological assessment. 19*(3), 281.

Page, McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., . . . Brennan, S. E. (2021). The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *Bmj. 372*.

Page, K. M., & Vella-Brodrick, D. A. (2013). The working for wellness program: RCT of an employee well-being intervention. *Journal of Happiness Studies. 14*(3), 1007-1031.

Palazzo, L. d. S., Carlotto, M. S., & Aerts, D. R. G. d. C. (2012). Burnout Syndrome: population-based study on public servants. *Revista de saude publica. 46*, 1066-1073.

Parasuraman, S., & Simmers, C. A. (2001). Type of employment, work–family conflict and well-being: a comparative study. *Journal of Organizational Behavior: The International Journal of Industrial, Occupational Organizational Psychology Behavior. 22*(5), 551-568.

Patel, V., Kirkwood, B. R., Pednekar, S., Araya, R., King, M., Chisholm, D., . . . Weiss, H. (2008). Improving the outcomes of primary care attenders with common mental disorders in developing countries: a cluster randomized controlled trial of a collaborative stepped care intervention in Goa, India. *Trials. 9*(1), 1-11.

Patel V. (2014) Why mental health matters to global health? Transcultural Psychiatry, 51, 777-789

Patel, V., Saxena, S., Lund, C., Thornicroft, G., Baingana, F., Bolton, P., . . . Eaton, J. (2018). The Lancet Commission on global mental health and sustainable development. *The lancet, 392*(10157), 1553-1598.

Pendersen, M., & Hensen, P. (2003). Effects of high pH on the growth and survival of six marine heterotrophic protests. *Mar. Ecol. Prog. Ser. 260*, 33-41.

Peters, M. D., Godfrey, C., McInerney, P., Baldini Soares, C., Khalil, H., Parker, D., & Munn, Z. (2017). Chapter 11: scoping reviews. *Joanna Briggs Institute Reviewer's Manual. The Joanna Briggs Institute*

Peters, M. D., Godfrey, C. M., Khalil, H., McInerney, P., Parker, D., & Soares, C. B. (2015a). Guidance for conducting systematic scoping reviews. *JBI Evidence Implementation. 13*(3), 141-146.

Peters, M. D., Godfrey, C. M., Khalil, H., McInerney, P., Parker, D., & Soares, C. B.. (2015b). Guidance for conducting systematic scoping reviews. *13*(3), 141-146.

Peters, M. D., Marnie, C., Tricco, A. C., Pollock, D., Munn, Z., Alexander, L., . . . Khalil, H. (2020). Updated methodological guidance for the conduct of scoping reviews. *JBI evidence synthesis. 18*(10), 2119-2126.

Pham, M., Rajić, A., Greig, J., Sargeant, J., Papadopoulos, A., & McEwen, S. (2014). A scoping review of scoping reviews: advancing the approach and enhancing the consistency. Res Synth Methods 5 (4): 371–385. In.

Piccinelli, M., Gomez Homen, F., Initiative, W. N. f. M. H., & Organization, W. H. (1997). *Gender differences in the epidemiology of affective disorders and schizophrenia*. Retrieved from

Preece, R., Williams, S., Jones, S., Peel, P., & Roughton, M. (2012). Measuring implementation of evidence-based guidance on promoting workers' health. *Occupational medicine. 62*(8), 627-631.

Quick, J. D., Quick, J. C., & Nelson, D. L. (1998). The theory of preventive stress management in organizations. *Theories of organizational stress*, 246-268.

Quick;, Jonathan, Q., Debra, N., & Joseph, H. (1997). Stress in organizations.

Ragesh, G., Tharayil, H. M., Raj, M. T., Philip, M., & Hamza, A. (2017). Occupational stress among police personnel in India. *Open Journal of Psychiatry Allied Sciences. 8*(2), 148-152.

Rahman, A., Hamdani, S. U., Awan, N. R., Bryant, R. A., Dawson, K. S., Khan, M. F., . . . Chiumento, A. (2016). Effect of a multicomponent behavioral intervention in adults impaired by psychological distress in a conflict-affected area of Pakistan: a randomized clinical trial. *Jama. 316*(24), 2609-2617.

Rahman, A., Riaz, N., Dawson, K. S., Hamdani, S. U., Chiumento, A., Sijbrandij, M., . . . van Ommeren, M. (2016). Problem Management Plus (PM+): Pilot trial of a WHO transdiagnostic psychological intervention in conflict-affected Pakistan. *World Psychiatry. 15*(2), 182.

Rajgopal, T. (2010). Mental well-being at the workplace. *Indian journal of occupational environmental medicine. 14*(3), 63.

Ranta, R. S. (2009). Management of stress and coping behaviour of police personnel through Indian psychological techniques. *Journal of the Indian Academy of Applied Psychology. 35*(1), 47-53.

Rathod, S., Persaud, A., Naeem, F., Pinninti, N., Tribe, R., Eylem, Ö., . . . Muzaffar, S. (2020). Culturally adapted interventions in mental health: Global position statement. *World Cultural Psychiatry Research Review. 14*(1-2), 21-29.

Repetti, R. L. (1987). Individual and common components of the social environment at work and psychological well-being. *Journal of Personality Social Psychology. 52*(4), 710.

Resnicow, K., Soler, R., Braithwaite, R. L., Ahluwalia, J. S., & Butler, J. (2000). Cultural sensitivity in substance use prevention. *Journal of community psychology. 28*(3), 271-290.

Riba, M. B., Parikh, S. V., & Greden, J. F. (2019). *Mental health in the workplace: Strategies and tools to optimize outcomes*: Springer.

Roberts, S. J., Scherer, L. L., & Bowyer, C. J. (2011). Job stress and incivility: What role does psychological capital play? *Journal of Leadership Organizational Studies. 18*(4), 449-458.

Robinson, B. E., Flowers, C., & Carroll, J. (2001). Work stress and marriage: A theoretical model examining the relationship between workaholism and marital cohesion. *International Journal of Stress Management. 8*(2), 165-175.

Rodriguez-Cuevas, F. G., Valtierra-Gutiérrez, E. S., Roblero-Castro, J. L., & Guzmán-Roblero, C. (2021). Living six hours away from mental health specialists: Enabling access to psychosocial mental health services through the implementation of problem management plus delivered by community health workers in rural Chiapas, Mexico. *Intervention. 19*(1), 75.

Rodriguez, M. M. D., Baumann, A. A., & Schwartz, A. L. (2011). Cultural adaptation of an evidence based intervention: From theory to practice in a Latino/a community context. *47*(1-2), 170-186.

Rokach, A. (2014). Leadership and loneliness. *International Journal of Leadership Change 2*(1), 6.

Ruddy, R., & House, A. (2005). Psychosocial interventions for conversion disorder. *Cochrane Database of Systematic Reviews* (4).

Sabry, S., Baron, N., & Galgalo, F. (2021). Problem Management Plus When You Can't See Their Eyes: COVID-19 Induced Telephone Counselling. *Intervention. 19*(1), 121.

Sangraula, M., van't Hof, E., Luitel, N. P., Turner, E. L., Marahatta, K., Nakao, J. H., . . . Kohrt, B. A. (2018). Protocol for a feasibility study of group-based focused psychosocial support to improve the psychosocial well-being and functioning of adults affected by humanitarian crises in Nepal: Group Problem Management Plus (PM+). *Pilot Feasibility Studies. 4*(1), 1-13.

Saraf, Priyam. (2019). "A Study of Fragility, Entrepreneurship and Mental Health: Investing in Better Cognitive and Behavioral Skills for Small Medium Enterprise Entrepreneurs to Thrive in Conflict-Affected Areas of Pakistan." World Bank, Washington, DC.

Saraf, P., Rahman, T., Jimenez Gallardo, M. A., Jamison, J. C., & Lor, C. (2018). Improving mental well-being and productivity of small-medium entrepreneurs in fragile, conflict and violence affected areas: can cognitive behavioral therapy trainings help?. *World Bank Policy Research Working Paper*, (8489).

Sauter, S. L., & Murphy, L. R. (2004). Work organization interventions: state of knowledge and future directions. *Sozial-und Präventivmedizin, 49*(2), 79-86.

Sayeed, K. B. (1958). The political role of Pakistan's civil service. *Pacific Affairs. 31*(2), 131-146.

Schomerus, G., Schwahn, C., Holzinger, A., Corrigan, P. W., Grabe, H. J., Carta, M. G., & Angermeyer, M. C. (2012). Evolution of public attitudes about mental illness: A systematic review and meta-analysis. *Acta Psychiatrica Scandinavica. 125*(6), 440-452.

Selye, H. (1965). The stress syndrome. *The American Journal of Nursing*, 97-99.

Selye, H. (1974). Stress sans détresse, Montréal, Éd. *La Presse*.

Shafqat, S. (1999). Pakistani bureaucracy: Crisis of governance and prospects of reform. *The Pakistan Development Review. 38*(4), 995-1017.

Shapiro, S. L., Astin, J. A., Bishop, S. R., & Cordova, M. (2005). Mindfulness-based stress reduction for health care professionals: results from a randomized trial. *International journal of stress management. 12*(2), 164.

Siddiqi, M. (2017). Why do so few people pass the CSS exam? News & Analysis, Oct 13-19, 2017. Vol. XXIX, No. 36. Retrieved from https://www.thefridaytimes.com/why-do-so-few-people-pass-the-css-exam/

Slatyer, S., Craigie, M., Heritage, B., Davis, S., & Rees, C. (2018). Evaluating the Effectiveness of a Brief Mindful Self-Care and Resiliency (MSCR) Intervention for Nurses: a Controlled Trial. *Mindfulness, 9*(2), 534-546. doi:10.1007/s12671-017-0795-x

Sobel, D. S. (1995). Rethinking medicine: improving health outcomes with cost-effective psychosocial interventions. *Psychosomatic medicine. 57*(3), 234-244.

Sue, S., & Zane, N. (1987). The role of culture and cultural techniques in psychotherapy: A critique and reformulation. *American psychologist. 42*(1), 37.

Ten Brummelhuis, L. L., Haar, J. M., & Roche, M. (2014). Does family life help to be a better leader? A closer look at crossover processes from leaders to followers. *Personnel Psychology. 67*(4), 917-949.

Thilina, D., & Yadurshini, R. (2020). The Economic Burden of Depression: Why We Should Invest in Treatment and Prevention. *IJCMCR. 4 : 001 DOI: 10.46998/IJCMCR. 96*.

Topp, C. W., Østergaard, S. D., Søndergaard, S., & Bech, P. (2015). The WHO-5 Well-Being Index: a systematic review of the literature. *Psychotherapy psychosomatics. 84*(3), 167-176.

Torgerson, D. J. (2001). Contamination in trials: is cluster randomisation the answer? *Bmj. 322*(7282), 355-357.

Tricco, A. C., Lillie, E., Zarin, W., O'Brien, K. K., Colquhoun, H., Levac, D., . . . Weeks, L. (2018). PRISMA extension for scoping reviews (PRISMA-ScR): checklist and explanation. *Annals of internal medicine. 169*(7), 467-473.

Tricco, A. C., Lillie, E., Zarin, W., O'Brien, K., Colquhoun, H., Kastner, M., . . . Wilson, K. (2016). A scoping review on the conduct and reporting of scoping reviews. *BMC medical research methodology. 16*(1), 1-10.

United Nations (2015). Transforming our world: the 2030 Agenda for Sustainable Development. UN: New York.

University of Chicago (2018). CBT 2.0 User's Manual, available at http://www.ideas42.org/wp-content/uploads/2017/01/CBTUsersManual.pdf

US Department of Health Human Services. (1979). The Belmont Report: Office of the Secretary, Ethical Principles and Guidelines for the Protection of Human Subjects of Research, the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. In.

Van der Klink, J., Blonk, R., Schene, A. H., & Van Dijk, F. (2001). The benefits of interventions for work-related stress. *American journal of public health. 91*(2), 270.

Van Ginneken, N., Tharyan, P., Lewin, S., Rao, G. N., Meera, S., Pian, J., . . . Patel, V. (2013). Non-specialist health worker interventions for the care of mental, neurological and substance-abuse disorders in low-and middle-income countries. *Cochrane database of systematic reviews.* (11).

Vuori, J., Toppinen-Tanner, S., & Mutanen, P. J. J. o. A. P. (2012). Effects of resource-building group intervention on career management and mental health in work organizations: randomized controlled field trial. *97*(2), 273.

Washington, E. D., & McLoyd, V. C. (1982). The external validity of research involving American minorities. *Human Development. 25*(5), 324-339.

Whiteford, H. A., Degenhardt, L., Rehm, J., Baxter, A. J., Ferrari, A. J., Erskine, H. E., . . . Johns, N. (2013). Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. *The lancet. 382*(9904), 1575-1586.

Whiteford, H. A., Ferrari, A. J., Degenhardt, L., Feigin, V., & Vos, T. (2015). The global burden of mental, neurological and substance use disorders: an analysis from the Global Burden of Disease Study 2010. *PloS one. 10*(2), e0116820.

WMHD 2017 - Mental Health in the Workplace available at https://wfmh.global/img/what-we-do/publications/2017-wmhd-report-english.pdf

World Health Organization. (1992). The ICD-10 classification of mental and behavioural disorders: Diagnostic criteria for research. WHO: Geneva.

WHO. (2007). Task shifting: rational redistribution of tasks among health workforce teams: global recommendations and guidelines.

World Health Organization (2008). Mental Health Gap Action Programme (mhGAP): Scaling up Care for Mental, Neurological and Substance Abuse Disorders. WHO: 34 Geneva.

World Health Organization. (2010). Mental Health Gap Intervention Guide. WHO: Geneva.

World Health Organization, United Nations High Commissioner for Refugees. Assessing mental health and psychosocial needs and resources: toolkit for humanitarian settings. Geneva: World Health Organization; 2012

World Health Organization & Calouste Gulbenkian Foundation (2014). Social Determinants of Mental Health. Geneva: WHO

WHO. (2016). Problem management plus (PM+): individual psychological help for adults impaired by distress in communities exposed to adversity, WHO generic field-trial version 1.0. Retrieved from https://apps.who.int/iris/handle/10665/206417

World Health Organization(2018), Mental health atlas 2017. Geneva

WHO. (2018). Mental health: strengthening our response. Retrieved from https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response#:~:text=Mental%20health%20is%20a%20state,to%20his%20or%20her%20communit

WHO. (2020). World Mental Health Day: An opportunity to kick-start a massive scale-up in investment in mental health. 08-29.

Wilamowska, Z. A., Thompson-Hollands, J., Fairholme, C. P., Ellard, K. K., Farchione, T. J., & Barlow, D. H. (2010). Conceptual background, development, and preliminary data from the unified

protocol for transdiagnostic treatment of emotional disorders. *Depression Anxiety. 27*(10), 882-890.

Wilder, A. (2009). The politics of civil service reform in Pakistan. *Journal of International Affairs. 63*(1), 19-37.

Wilson, D., Stupnytska, A., Poddar, T., Bhundia, A., Morra, P., & Ahmed, S. (2007). Global Economics Paper No: 153. *Goldman Sachs*

Woodward, A., Dielemann, M., Sondorp, E., Roberts, B., Fuhr, D., Ventevogel, P., . . . Broerse, J. (2021). A system innovation perspective on the potential for scaling up new psychological interventions for refugees. *Intervention Journal of Mental Health Psychosocial Support in Conflict Affected Areas*

Yalom, I. D., & Leszcz, M. (2005). The theory and practice of group psychotherapy (5th ed.). *5th ed*.

Yung, P. M., Fung, M. Y., Chan, T. M., & Lau, B. W. (2004). Relaxation training methods for nurse managers in Hong Kong: a controlled study. *International Journal of Mental Health Nursing. 13*(4), 255-261.

Zuñiga, M. E. (1992). Using metaphors in therapy: Dichos and Latino clients. *Social Work. 37*(1), 55-60.

Details of Appendixes

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Appendix 1

Research information sheet

Evaluating a multi-component group intervention for improving psychological well-being of trainee civil servants in Pakistan: a randomised controlled study

Dear Participants

You are being invited to participate in a research study "Improving psychological well-being of trainee civil servants in Pakistan". Before you decide whether to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. You do not have to decide today whether or not you will participate in this study. If there is anything you do not understand or you have questions about the study, please contact me at the email/phone number provided at the end. Please also feel free to discuss this with friends, relatives if you wish. I would like to stress that you do not have to accept this invitation and should only agree to take part if you want to.

Thank you for reading this.

Introduction

My name is Zahoor Ahmed and I am a PhD student at the University of Liverpool, UK. I am conducting a research study in collaboration with the Human Development Research Foundation, Pakistan, with agreement from the Civil Services Academy (CSA), Lahore. I would like to thank you for giving me the opportunity to tell you about the research and request your participation. First, I would like to introduce the researchers involved. My supervisor is **Prof. Atif Rahman,** who works in the area of psychological health. He has developed and evaluated many interventions for common mental health problems in

Pakistan. **My second supervisor is Prof. Chris Dowrick,** who works in the area of primary health care. My collaborator, **Dr. Syed Usman Hamdani** is a psychiatrist and the Director of the Human Development Research Foundation, an organization that helps conduct research that promotes health and well-being of Pakistanis.

We are evaluating a tailor-made programme, intended to help trainee civil servants in coping with the stress they may face in performing their job responsibilities, by equipping them with some strategies that have been proven effective for some other groups such as business-persons. This programme comprises of 5 workshops of 1.5 hours each and will be delivered by the CSA faculty members, who are involved in your routine trainings.

The study is expected to result in refining the training workshops for use in future civil servant training programmes at various levels. By agreeing to participate in the study, you will be contributing towards a process of addressing a major aspect of civil service capacity building.

Purpose of the research

We are studying the effectiveness of a programme in reducing psychological distress and improving psychological well-being in trainee civil servants undergoing induction training at CSA

Participant selection

You are receiving this e-mail because I am inviting all the trainee civil servants (probationers) undergoing CTP at CSA, Lahore, who have agreed to share their contact information with me to take part in this study.

Voluntary Participation

Your participation in this study is entirely voluntary. It is your choice whether to participate or not. Whether you choose to participate or not, all the services/training you are receiving at CSA will continue and nothing will change. You may still change your mind at any time in future and stop participating, even if you agreed earlier.

Procedures and Protocol

Procedures

This study involves a few procedures which may be unfamiliar to you.

Random group assignment

I wish to measure how effective this training programme is in preparing civil servants to better cope with the stress they may face in performing their job responsibilities and reducing psychological distress. To find out, we will put people taking part in this research into two groups. The groups are selected by chance, as if by tossing a coin. One group of participants will receive usual Common Training Program (CTP) sessions, while the other group will receive usual training sessions alongside the workshops.

Description of the Process

If you agree to participate, I will contact you via email at 4 time-points.

1. The first email will be sent soon after you agree to participate. This e-mail will contain a link. This link will take you to a detailed assessment in the form of an online survey about your feelings, health and well-being and the ways you cope with daily stressors in your life. This will take approximately 30 minutes.
2. The second e-mail will be sent after you have submitted the online survey. This e-mail will tell you about the schedule of your training programme.
3. You will receive the third e-mail 7 weeks after the first assessment. It will contain a link to an on-line survey similar to the first. This assessment will also take approximately 30 minutes.
4. The fourth email will be sent 3 months after the first assessment. Like the third email, it will contain a link to questions similar to the earlier assessments. This assessment takes approximately 30 minutes.

I assure you that all the information that you will provide will be kept confidential and will not be shared with anyone except the research team.

Audio recording of training workshops

To ensure quality of training, all the training workshops will be audio-recorded. This will be only shared with the researcher involved in the study.

Confidentiality

We, and any researchers working on this study, ensure privacy and confidentiality for all study-related data, documents, and findings. We will not be sharing the identity of who is participating in the research.

Data usage:

The University of Liverpool processes personal data as part of its research and teaching activities in accordance with the lawful basis of 'public task', and in accordance with the University's purpose of "advancing education, learning and research for the public benefit.

Under UK data protection legislation, the University acts as the Data Controller for personal data collected as part of the University's research. Prof. Atif Rahman acts as the Data Processor for this study, and any queries relating to the handling of your personal data can be sent to him through e-mail.

Further information on how your data will be used can be found in the table below:

How will my data be collected?	All data will be collected electronically through on-line questionnaires.
How will my data be stored?	Data will be stored on google cloud, from where it will be downloaded on a password protected computer. Only the researcher and his PhD supervisor will have access to that.
How long will my data be stored for?	Data will be stored for 10 years from completion of the study.
What measures are in place to protect the security and confidentiality of my data?	All information collected about you will be kept strictly confidential. Any information about you will have a number on it instead of your name. No individual participant data will be shared with your institute (CSA). Only group results will be reported which cannot be

	linked to you to protect confidentiality. No one else except the investigator and his research supervisors will have access to the information documented during your assessment.
Will my data be anonymised?	Yes. All the data will be anonymised.
How will my data be used?	Your data will be used to evaluate how effective this training programme is in improving psychological well-being of trainee civil servants. Data will be shared with CSA and in scientific journals and conferences without disclosing individual identity.
Who will have access to my data?	Data will be stored on a password protected computer. Only researcher and supervisor will have access to data.
Will my data be archived for use in other research projects in the future?	Yes.
How will my data be destroyed?	All the electronic data will be deleted permanently from computers. Paper-pencil data will be shredded.

Reimbursements

No compensation or reward will be provided for participating in this research.

Risks

We do not expect that the programme will have any negative effects. However, it is possible that thinking about your feelings and well-being (while completing the assessment) will make you stressed, fearful or tense for a little while. During the training workshops, you may find talking about your feelings, or emotional topics difficult. You may skip any questions or sessions which make you feel uncomfortable. If you feel you need to talk to someone about your feelings, you can let me know by email. I will put you in contact with Dr. Hamdani at the Human Development Research Foundation who can assist you in finding help for coping with such feelings.

Benefits

We expect that this training program programme might be helpful to people experiencing stress. If the study shows that this training is helpful, it will be suggested to incorporate this programme in the routine trainings of civil servants in Pakistan.

Sharing the Results

The knowledge that we gain during this research, will be published in scientific journals so that other interested people may learn from this research. Nothing that identifies you will be shared in these publications. Key findings will also be shared with CSA; however, your individual assessment results will not be shared with anyone. You may request me through e-mail confidentially for a copy of your own assessment.

Right to Refuse or Withdraw

You do not have to take part in this research if you do not wish to do so. Refusing to participate will not affect you training assessment done by CSA any way. You will still have all the benefits that you would otherwise have at CSA. You may also stop participating in the research at any time you choose without losing any of your rights. Participating in this training is not a requirement of your job.

In case we do not receive a response within 72 hours, this e-mail would be followed by a reminder. Another reminder will be sent after 3 days in case of no response. In case you do not want to receive the reminders, please respond to this e-mail. In case you decline you, will not be contacted any further.

Complaint procedures

During the study, if you are unhappy, or if there is a problem, please feel free to let me know by contacting at Zahoor.Ahmed@liverpool.ac.uk or calling me at 0092 304 5492172 and we will try to help. If you remain unhappy or have a complaint which you feel you cannot come to us with then you should contact the Research Ethics and Integrity Office at ethics@liv.ac.uk. When contacting the Research Ethics and Integrity Office, please provide details of the name or description of the study (so that it can be identified), the researcher(s) involved, and the details of the complaint you wish to make.

The University strives to maintain the highest standards of rigour in the processing of your data. However, if you have any concerns about the way in which the University processes your personal data, it is important that you are aware of your right to lodge a complaint with the Information Commissioner's Office by calling +44 303 123 1113.

Who to Contact?

If you have questions now you can ask me

E-mail: Zahoor.Ahmed@liverpool.ac.uk

Phone No: 0092 304 5492172

Appendix 2

Consent Form

#	Statement	YES	NO
1.	I confirm that I have read and have understood the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.		
2.	I understand that taking part in the study involves research assessments, attending training sessions and audio recording of the training sessions. I also understand that anonymised data obtained from this research will be used in scientific publications/conferences.		
3.	I understand that my participation is voluntary and that I am free to stop taking part and can withdraw from the study at any time without giving any reason and without my rights being affected. In addition, I understand that I am free to decline to answer any particular question or questions.		
4.	I understand that I can ask for access to the information I provide and I can request the destruction of that information if I wish at any time 3 months after providing consent. I understand that after 3 months, I will no longer be able to request access to or withdrawal of the information I provide.		
5.	I understand that the information I provide will be held securely and in line with data protection requirements at the University of Liverpool until it is fully anonymised and then deposited in the university archive for sharing and use by other authorised researchers to support other research in the future.		
6.	I understand that personal information collected about me that can identify me, such as my name or where I live, will not be shared beyond the study team.		
7.	I understand that I can request for a copy of my assessments through e-mail to the researcher.		
8.	I understand that consent forms and original audio recordings/ questionnaires will be retained in University of Liverpool with Prof. Atif Rahman, until10 years after the study.		
9.	I agree to take part in the above study		

_____ _____ _____

Participant name Date Initials

Principal Investigator

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Appendix 3: Outcome measures

1. PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems:		Not at all	Several Days	More than half of the days	Nearly every day
1.	Little interest or pleasure in doing things	0	1	2	3
2.	Feeling down, depressed, or hopeless	0	1	2	3
3.	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4.	Feeling tired or having little energy	0	1	2	3
5.	Poor appetite or overeating	0	1	2	3
6.	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7.	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8.	Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9.	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

2. Brief-COPE

These items deal with ways you've been coping with the stress in your life. Obviously, different people deal with things in different ways, but I'm interested in how you've tried to deal with it. Each item says something about a particular way of coping. I want to know to what extent you've been doing what the item says. How much or how frequently. Don't answer on the basis of whether it seems to be working or not—just whether or not you're doing it. Use these response choices. Try to rate each item separately in your mind from the others. Make your answers as true FOR YOU as you can.

Use these response choices.

1 = I haven't been doing this at all

2 = I've been doing this a little bit

3 = I've been doing this a medium amount

4 = I've been doing this a lot

No.	Items	I haven't been doing this at all	I've been doing this a little bit	I've been doing this a medium amount	I've been doing this a lot
1.	I've been concentrating my efforts on doing something about the situation I'm in (Get Going, Keep Doing, Active coping)	1	2	3	4
2.	I've been getting emotional support from others (Strengthening social support, Emotional support)	1	2	3	4
3.	I've been taking action to try to make the situation better (Get Going, Keep Doing, Active coping)	1	2	3	4

4.	I’ve been getting help and advice from other people (Strengthening social support, Instrumental support)	1	2	3	4
5.	I've been trying to see it in a different light, to make it seem more positive (Managing problems, Positive reframing)	1	2	3	4
6.	I've been trying to come up with a strategy about what to do (Managing problems, Planning)	1	2	3	4
7.	I've been getting comfort and understanding from someone (Strengthening social support, Emotional support)	1	2	3	4
8.	I've been looking for something good in what is happening (Managing Problems, Positive reframing)	1	2	3	4
9.	I've been accepting the reality of the fact that it has happened (Managing Problems, Acceptance)	1	2	3	4
10.	I've been trying to find comfort in my religion or spiritual beliefs (Stress management, Religion)	1	2	3	4
11.	I’ve been trying to get advice or help from other people about what to do (Strengthening social support, Instrumental support)	1	2	3	4
12.	I've been learning to live with it (Managing Problems, Acceptance)	1	2	3	4
13.	I've been thinking hard about what steps to take (Managing Problems, Planning)	1	2	3	4
14.	I've been praying or meditating (Stress management, Religion)	1	2	3	4

3. GENERALISED ANXIETY DISORDER SCALE (GAD-7)

Over the last 2 weeks, how often have you been bothered by the following problems:

		Not at all	Several Days	Over half the days	Nearly every day
1.	Feeling nervous, anxious, or on edge	0	1	2	3
2.	Not being able to stop or control worrying	0	1	2	3
3.	Worrying too much about different things	0	1	2	3
4.	Trouble relaxing	0	1	2	3
5.	Being so restless that it's hard to sit still	0	1	2	3
6.	Becoming easily annoyed or irritable	0	1	2	3
7.	Feeling afraid as if something awful might happen	0	1	2	3

4. WHO-5 WELLBEING INDEX

Please indicate for each of the five statements which are closest to how you have been feeling over the last two weeks. Notice that higher numbers mean better well-being.

Example: If you have felt cheerful and in good spirits more than half of the time during the last two weeks, put a tick/choose in the box with the number 3 in the upper right corner.

		All of the time	Most of the time	More than half of the time	Less than half of the time	Some of the time	At no time
1.	I have felt cheerful and in good spirits	5	4	3	2	1	0
2.	I have felt calm and relaxed	5	4	3	2	1	0

3.	I have felt active and vigorous	5	4	3	2	1	0
4.	I woke up feeling fresh and rested	5	4	3	2	1	0
5.	My daily life has been filled with things that interest me	5	4	3	2	1	0

5. PSYCHOLOGICAL CAPITAL QUESTIONNAIRE (PCQ-24)

Below are statements that describe how you may think about yourself right now. Use the following scale to indicate your level of agreement or disagreement with each statement.

		strongly disagree	Disagreed	somewhat disagree	neither agree or disagree	agree	strongly agree
1	In this job/work, things never work out the way I want them to.	1	2	3	4	5	6
2	At this time, I am meeting the goals that I have set for my self	1	2	3	4	5	6
3	I feel confident presenting information to group of colleagues	1	2	3	4	5	6
4	I feel confident helping to set targets/goals in my work area	1	2	3	4	5	6
5	I can get through difficult times at work because I've experienced difficulty before.	1	2	3	4	5	6
6	There are lots of ways around any problem	1	2	3	4	5	6

7	I usually take stressful things at work in stride	1	2	3	4	5	6
8	When I have setback at work, I have trouble recovering from it and moving on	1	2	3	4	5	6
9	When things are uncertain for me at work, I usually expect the best	1	2	3	4	5	6
10	I can be “on my own” so to speak at work if I have to	1	2	3	4	5	6
11	If something can go wrong for me work-wise it will	1	2	3	4	5	6
12	If I should find myself in a jam, I could think of ways to get out of it	1	2	3	4	5	6
13	I feel I can handle many things at a time at this job	1	2	3	4	5	6
14	I always look on the bright side of things regarding my job	1	2	3	4	5	6
15	I feel confident contributing so discussion about the company’s strategy	1	2	3	4	5	6
16	I feel confident analysing a long-term problem to find a solution	1	2	3	4	5	6
17	Right now, I see myself as being pretty successful at work	1	2	3	4	5	6
18	I am always optimistic about my future	1	2	3	4	5	6`
19	I approach this job as if “every cloud has a silver lining”	1	2	3	4	5	6

20	At the present time, I am energetically pursuing my work goals	1	2	3	4	5	6
21	I feel confident contributing to discussion about the company's strategy	1	2	3	4	5	6
22	I usually manage difficulties one way or another at work	1	2	3	4	5	6
23	I feel confident contacting people outside the company (e.g., suppliers, customers) to discuss problems	1	2	3	4	5	6
24	I can think of many ways to reach my current work goals	1	2	3	4	5	6

Appendix 4

End of workshop questionnaire

Question 1: Which one of these statements is true?

a) Breathing exercise is the only way of managing stress
b) Breathing exercise is just one way of managing stress
c) I don't know

Question 2: Three components of the problem tree are?

a) Focal problem, result and causes
b) Focal problem, objectives and effects
c) Effects, focal problem and causes
d) I don't know

Question 3: The three elements of the objective tree are?

a) Objectives, purposes and results
b) Objectives, components and results
c) Objectives, effects and causes
d) I don't know

Question 4: The three steps of problem solving are?

a) Division, discussion & intervention
b) Observations, interpretation & intervention
a) I don't know

Question 5: The two categories of problem are?

a) Solvable and unsolvable
b) Personal and professional
c) I don't know

Question 6: How many scenarios are possible while managing problem?

a) 4

b) 1

c) 3

d) I don't know

Appendix 5

Training curriculum

Psychosocial skills development workshops

For

Trainee civil servants in Pakistan

My life my career

Leading Change in Times of Uncertainty

August 2019

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Chapter 1

BACKGROUND

The Psychosocial Skills Development Workshops form a group psychological intervention for addressing the psychosocial issues resulting in stress in civil servants. This manual was developed while conducting these workshops for trainee civil servants in the Civil Service Academy, Lahore, Pakistan from December 2018 to March 2019.This programme is designed to help them better manage their practical (e.g., career, family, conflict, etc.) and emotional (e.g., feelings of stress, hopelessness, intense sadness etc.) problems. These workshops were developed for newly inducted junior civil servants, but there is no reason why they cannot be adapted for use for relatively senior civil servants facing workplace stress.

The workshops are an adapted version of the Problem Management Plus (PM+), which was developed by WHO in 2013 as a 5-session intervention for adults living in adversity. PM+ is a scalable evidence-based psychological intervention that can be conducted by non-professionals that have never been trained in these techniques before and a wide range of people without professional training in mental health care (ranging from people with a degree in psychology but without formal training and supervision in counselling to community workers and other lay helpers). The training curriculum was developed by incorporating the principles of PM+ and the adaptive leadership framework (Heifetz, Grashow & Linsky, 2009).

The original PM+ is developed for application in people affected by adversity, and can be used to help people with depression, anxiety and stress, irrespective of its origins to improve most common mental health problems. However, this programme was not developed for use with the following problems:

1) A plan to end one's life in the near future;

2) Severe impairment related to a mental, neurological or substance use disorder (e.g., psychosis, alcohol or drug use dependence, severe intellectual disability, and dementia).

Who can use this manual?

This manual is aimed at:

(a) Professionals who have never been trained in these techniques before;

(b) A wide range of people without professional training in mental health care (ranging from people with a degree in psychology but without formal training in counselling to community workers and other lay helpers); and

(c) Trainers who offer training for civil servants in Pakistan. These include in house as well as visiting faculty members.

This manual may be for you if you:

1. work in a training institution for civil servants;
2. have a genuine motivation to help others and improve the civil service training and are based in a work setting that allows you to spend enough time with your participants;
3. have completed training in how to use psychosocial skills development workshops;
4. can work in a team with others; and
5. receive continuing support and supervision from a trained supervisor. (Ideally this should be a mental health professional trained in cognitive behaviour therapy (CBT) or someone extra training and practice in the methods used in the manual)

Training of trainers

Training of trainers/facilitators who are not mental health professionals should involve classroom training as well as hands on training. The classroom training should be at least 16 hours (two full days). This should be conducted by a master trainer usually a mental health professional that is competent and experienced in all of the strategies included in these Workshops Classroom training includes:

- Information about common mental health problems (i.e., depression, anxiety, stress) and structure and nature of job of civil servants in Pakistan (i.e., stress, financial problems etc.);
- Rationale for each of the strategies;
- Basic helping skills;
- Role-play (master trainer demonstrations and trainer & facilitator participation) on delivering strategies and basic helping skills.

- Conducting of at least one set of workshops as trainers or facilitator under supervision
- Hands on training
- Pre and post workshop discussion as well as supervision

Supervision by master trainers involves:

- Discussion about participants' progress;
- Discussion about difficulties experienced with participants or when delivering strategies;
- Discussion about difficulties managing group dynamics;
- Role-playing how to manage difficulties or to practise skills (to improve trainers' skills the workshops and group management);
- Trainers' self-care.

For more information about training of trainers and supervision, please refer to the accompanying Training of Trainers (TOT) Manual.

How are The Workshops Structured?

Psychosocial Skills Development Workshops for trainee civil servants are structured in the following way:

- Five group workshops
- Workshops happen once a week
- Workshops last approximately one and a half hours:
- The rough structure of the workshops is as follows.
  - Session 1 30 minutes of teaching and activities in bigger groups of about 50 people (in Houses in CSA)
  - Session 2 30 minutes for breakup sub groups of about 15 participants for activities
  - Session 3 30 minutes for presentations by sub groups in main groups followed by discussion (again in the Houses)

Each workshop includes the following:

1) *Larger Group teaching and activity (Session1 or Plenary session)*
   - Introduction of one of the strategies including:
     - Education about the strategy;

- Demonstration of the application of the strategy in one's life particularly in the context of the target group
- The scripts for presenting the case example are included in this manual.

2) *Sub-Group discussions (Session2 or Discussions)*
   - Discussion on why each strategy is important;
   - Activities (e.g., role-plays, rehearsals, partner and group exercises) and discussions to help apply each strategy to one's life;
   - Steps to complete each strategy;
   - Sharing of personal stories and experiences of using each strategy;
   - One participant may be assigned in each subgroup to take notes. The same participant or any other one can make a presentation in the Third Session.

3) *Regrouping (Session3 or Debriefing sessions)*

   After the sub group sessions, the groups will once again gather in the larger group setting. Each group will use the flip charts used by them in the sub-groups. Discussion in the larger group will help to evaluate the ideas being formulated and to eliminate any impractical ideas. It will also give the participants and idea of how the tools can be used in different ways. They can also discuss about common problems faced with the strategy and how to overcome these with an aim to support participants in learning the strategies and use them to better manage their emotional and practical problems in career or personal life;

4) *Individual-trainer discussions (if necessary)*

   - Trainers may need to make time after the session if participants require more support on how to apply these strategies.

Trainers will conduct the first and third sessions of each workshop while facilitators support them in these sessions and conduct the second session comprising of activities and discussions. The trainers and facilitators will both receive the same training.

Larger groups are held in Houses (classroom setting) and smaller ones in syndicate rooms or library.

To effectively run a group, it is advised that one facilitator does not lead more than 8 participants. According to our analysis based upon stakeholder interviews and discussions, it is better to have two trainers for a subgroup of about sixteen. One of them will be in charge of leading the session while the other monitors time and provides assistance to individual participants. Two trainers can alternate breaks or to help each other in making the same points in a different way. It also maintains the flow of workshop and keeps the interest of the group alive. Moreover, the presence of two trainers from different backgrounds allows the possibility of introducing the subject from different points of view.

1) *Role of trainers/facilitators:*
    - To lead the group/subgroup through psychosocial skills development workshops to support individual participants as they learn to practice the strategies
2) *Qualities of group trainers:*

Good trainers are likely share the following qualities:

- Passionate about helping people
- Have a good understanding of Psychosocial Skills Developments Workshop's strategies (i.e., from completing training)
- Good at communicating information in simple, interesting and creative ways
- Comfortable using basic helping skills (see Chapter 3)
- Have an understanding and respect for diversity and beliefs of their participants
  Have lots of energy to manage groups of participants

How to Use This Manual?

This manual is used to guide trainers through each workshop. You should be familiar with what will happen in every workshop before you lead that workshop. You may also have this manual with you in the session to remind you what you should be doing or to read the suggested questions, prompts or scripts (included in *italics*).

In the first session you can use any one of the case examples given in the Appendix A or similar examples.

This manual helps trainers,

- *Describe strategies* – by listing key points to tell participants and giving suggested scripts to follow
- *Describe how to use each strategy* – by giving a case example that describes how each strategy can be used in an individual's life to help them manage their problems
- *Encourage group discussion* – by suggesting questions and prompts
- *Facilitate active learning* – by describing how to lead group activities
- *Manage time* – by giving estimated time limits for each workshop

Structure of This Manual

Trainers/facilitators should try to stay as close to what is described in this manual. All the key points, suggested scripts (written in italics) and activities have been included in this manual. Presentations to be used for the first session of each workshop and pointers for the activities in subgroups are in Appendix H. This will give you all the information you need to help participants understand Psychosocial Skills Development Workshops for trainee civil servants. If you include things that are too different from what is in this manual or ignore parts of it, you may be doing something different than the intervention proposes.

It is important for you to be *flexible* when,

- There is a more sensitive way of describing a topic or strategy to the group than what is in this manual (e.g., through a metaphor or an example from civil service)
- The group dynamics/relationships do not permit you to deliver a part of the workshops as described in this manual (e.g., the group has become very distressed so you decide to include Managing Stress earlier in a workshop)

Each chapter describes what you as a trainer will need to do to complete each workshop. A checklist of materials needed for each workshop is also included at the beginning of each chapter. It is important to closely follow this with the presentations in Appendix H.

WORKING WITH GROUPS

Leading groups in a psychological intervention is very different from working with individuals. There are a number of things you should think about before working with a group.

Practical Things to Consider

- Each workshop has three sessions.
- Having 2 facilitators in the subgroups is ideal. This allows for one to lead a workshop, while the other can watch the time, monitor the group relationships and identify individuals who might be having difficulties understanding the information
- 12 participants in one sub -group is the recommended maximum number and you need to have 2 facilitators per sub-group
- It is ideal to avoid Fridays and weekends as the trainees lose interest. However, in practice this is not so easy to do given the other scheduling commitments of CTP. In that case it is important to stick to the schedule and make sure that the trainees are free by the time they are committed to be.
- While it is useful to have some psychologists in the group, the use of trainers from the civil service background as the participants/trainees allows more possibilities of the interaction and keeps the interest of the group alive. It has been noticed that at this stage probationers are apprehensive about the future course of their career and any training which could fit into their civil service training and might be useful to their future is welcome. In case, we are not able to provide that kind of feeling of usefulness, the response of the participants would not be positive.

How to Manage a Group?

Using your "basic helping skills" is very important when managing a group. Please read about these skills first in Chapter 3. Some useful tips are:

1) Keeping to time without cutting short valuable group discussion

- Reminding participants about time schedules throughout the programme is helpful
- Break times can be used to return to group discussions that you need to cut short
- Sometimes you might decide that a group discussion is very important to continue with and shorten another section of the group, for example, if the group is learning about a strategy and how to apply it to one's life. In this case discussions on helping one participant manage their practical or

emotional problem, might also be helpful for the group as a whole. If you decide to do this, think about how you can make time to cover the topic you have skipped (e.g., ask the group to stay longer, ask the group to arrive on time the following day to start early, make the breaks shorter etc.). Always talk with your supervisor about these decisions to make sure you have not skipped important information.

- Unless absolutely necessary, it is important to stick to the timetable provided as the trainees have other training commitments as well. Moreover, holding the training within a limited time allows the discussion to remain focused and productive. Otherwise, there is a possibility that the training may go, way-ward and the thoughts become scattered.

2) Managing dominant participants

- A dominant participant might be someone who talks a lot in the discussion, doesn't let other participants share their stories, talks over the top of others or rejects other participants' opinions. They might force the group to manage their personal problems too.
- Be sure to always use your basic helping skills when managing dominant participants
- When a participant is being dominant, you use skills to manage them during the group workshop and also on their own.
- During the group workshop, you can thank the person for their contribution and then invite others to share. e.g.
    - *"Thank you (name). What you are saying is very interesting but I'd also like to hear from others in the group. Has anyone else had a similar or different experience?"*
- If a participant is causing problems in the group and not responding to your management, you should speak to them on their own during a break or at the end of a workshop. Explain to them that it is important that everyone has a turn to talk or have their problems managed in the group. Be careful not to start with saying something negative to the person as they may not listen to your suggestion. e.g.
    - *"You have been very engaged in the programme which is good. However, it is very important that everyone in the group has an opportunity to speak. And I have noticed this is not happening at the moment. So, I will ask you to watch that you are respecting everyone in the*

group, not talking over the top of others and giving everyone a chance to talk. This might mean waiting and letting someone else talk first when there is a discussion. Does this sound okay to you?"

- There might be reasons why the person is being dominant in the group (e.g., they do not like other participants from different backgrounds or occupational groups, they believe they need the most help in the group, they believe they should be dominant or speak for others because of their position in the group or experience or educational background or they might think they already know about the strategies and maybe more than the trainers!) It would be helpful to understand what these reasons are and help the participant and the group to manage them.
    - Consider asking these questions to the individual in private: *"Are there any problems you are having in the group that is causing you to talk over the top of other participants? I would like to be able to help you manage these if this is possible."*
    - "I understand you are already aware of these strategies but many of the group are not. Would you please let me slow down for their sake?

3) Encouraging discussion with a quiet group

- Case examples are helpful for encouraging group discussion. You might ask the group to talk about the case example if they are not talking about personal problems.
- Sharing other examples, you are familiar with (e.g., from the civil service, from previous groups you have led) can also help participants feel more comfortable joining discussions. When giving examples, do not include real people's names or stories that might easily identify who they are to ensure confidentiality-
- Talking individually to participants to help them participate in the group can also be helpful
    - *"I have noticed you are very quiet in the group. Is there anything I can do to help you engage more in the discussions?"*

4) Managing distressed individuals

- Communicating concern and validating a participant's distress is the best first response Giving the participant time to calm down is also important. Being quiet and not moving the discussion on or moving onto another topic is one way of allowing space for this to happen.
- If the participant is having difficulties calming down by themselves, you can ask them if they would find it helpful if the group practices Managing Stress together.
    - *"Would you find it helpful if we practiced Managing Stress (deep breathing) as a group?"*
- If a participant's distress is very strong and interfering with the group, you can have the second trainer or facilitator, take the participant out of the group and manage their distress. This way you can continue with the group without wasting time. After 10 minutes, the participant might decide to re-join the group or take some time away to calm down on their own. If you do so be sure to encourage them to come back to the group, or check on them after 10 minutes if they have not returned.

5) Managing group discussions that go off-topic or discuss unhelpful strategies or those outside of the scope of the workshops (e.g., traditional healers, problems with CTP structure etc.)

- You will need to be firm when re-directing group discussions. Also be sure to use your basic helping skills!
    - *"I can see this is an interesting discussion but we have moved away from the focus. Let's come back and we can discuss this topic during the break."*

6) What to do if a participant drops out, attends late or irregularly etc.

- As best we can, we should try to prevent anyone from dropping out of the group (without forcing them to stay against their will)
- Be sure to speak with participants who are not engaging in the programme. They might be regularly showing up late or leaving early or missing sessions.
- Find out what the reason is for their disengagement

- You can review the discussion on reasons for and problems with joining the group and the participants' individual goals. This discussion might motivate them to be more engaged in the group. Or it might help them decide to drop out of the group.
- If participants drop out, this is okay. These workshops will not be suitable for everyone and participants should not be forced to stay if they do not want to. If this happens, be sure to write down in your notes the reason for their dropping out. This information will be very important to gather.
- You should not ask a participant to leave the group. If you believe a participant is disrupting the group a lot, talk with your supervisor about this or ask a trainer/facilitator to take him or her out of the group.

7) Participants disclosing too much information

- Sometimes participants will share very personal information. This might make others uncomfortable. It will be your job as trainer/facilitator to decide if the information being shared in the group is too much or too personal.
- If you decide a participant is sharing too much information or it is too personal, you can do one or all of the following:
    - Ask the participant to watch how much they are sharing and try to reduce it by themselves
    - Decide on a secret sign you can give to the participant if they are sharing too much information so they can stop (e.g., raising your hand)
    - Agree that you will gently cut them off when they are sharing too much information (e.g., *"Thank you (name) for sharing this. It sounds like it has been very difficult for you. I wonder whether others would like to share their experiences."*)
    - Ask the participant to stop themselves from sharing too much but instead they can tell you what they would like to say on their own during the break or at the end of the workshop

Chapter 2

INTRODUCTION

This manual describes an adaptation of WHO's PM+ programme which is a scalable psychological intervention program including the strategies of Managing Stress, Managing Problems (or problem-solving counselling), Behavioural activation (experimental mind set), Strengthening social support and Staying calm. By combining these strategies, this program aims to address both psychological problems (for example, stress, fear, feelings of helplessness) and, where possible, practical problems (for example, career problems, conflict in the family, social support, work life imbalance, and so on).

Psychosocial Skills Development Workshops aim to reduce a range of mental health and practical that civil servants present with and identify as being of concern to them. However, given the briefness of this program, it does not deal with the full range of difficulties someone may experience. As a result, it may be best to use it in addition to other appropriate services, supports or community programs. The programme does not involve diagnosing mental disorders, even though it is likely to help people with a variety of mood and anxiety disorders, post-traumatic stress disorder and adjustment disorder.

Different methodologies are used for teaching purposes in these workshops, namely presentations, open and free discussions, activities and role play to make the workshops attractive and useful.

Below is a brief description of and rationale for each of the strategies introduced in different workshops.

1. **Managing Stress (Workshop 1)**

Teaching the participant, a brief stress management strategy (slow and deep breathing) will help participants better manage problems related to their day to day to life (career and personal) and stress. It can help the person to calm down at moments of stress. Managing Stress is introduced very early on and should be practised at the end of every workshop also.

2. **Managing Problems (Workshop 2)**

This is a strategy to apply in situations where participants are experiencing practical problems (e.g., job performance difficulties, conflict in the family or in office, work-life imbalance, and so on). You and the participants will work together to consider possible solutions to the problem that is causing them the most

concern. Jointly you can choose those solutions that are most helpful to influencing their problems and then plan a strategy to carry out these solutions. The problem management technique called Problem Tree was used.

3. Get Going, Keep Doing (Workshop 3)

This strategy is aimed to improve participants' levels of activity (e.g., social activities or carrying out necessary tasks at work or in personal life). Many participants who have reduced their activity are feeling depressed. Depression can look different in different people but often involves feeling easily tired, lacking energy and motivation, experiencing low mood, not enjoying activities previously enjoyed, and feeling hopeless or worthless. Often people can also experience different bodily complaints (e.g., they can get headaches or backaches). People under stress often stop doing things they used to do. Get Going, Keep Doing aims to increase the participants' activity levels, which has a direct impact on their mood.

4. Strengthening Social Support (Workshop 4)

Individuals with emotional problems can be isolated from supportive people and organizations. Strengthening participants' social support (e.g., with trusted friends, family, co-workers or mentors) promotes well-being. If a participant appears to have good social support and is using it regularly, you may only need to encourage them to continue to do so. However, for other participants, you may need to spend some time discussing how they can strengthen their social support and help them develop a practical plan to receive more social support.

5. Staying Calm and Looking Forward (Workshop 5)

This workshop reviews the strategies learnt in the previous workshops and focuses on how to use them in daily life. This would give the participants' confidence in these tools.

WORKSHOP-BY-WORKSHOP OVERVIEW

OF THE PSYCHO SOCIAL SKILLS DEVELOPMENT WORKSHOPS FOR TRAINEE CIVIL SERVANTS

Workshop 1

STRESS MANAGEMENT

Workshop 1			
Content	**Time**	**Moderator**	**Venue, participants and tools required**
Welcome and Introduction	20 Minutes	Researcher	Whole CTP Presentation and projector
Session 1 (Plenary sessions) in Houses Workshop rules What are the strategies Vicious cycle of Problems Understanding stress Managing Stress	30 Minutes	Trainers Supported by facilitators	Larger Group Setting Presentations
Session 2 Discussions and activities in subgroups	40 Minutes	2 Facilitators per Subgroup	Subgroups of 10-12 Handouts to be used as pointers Each subgroup would need flip charts and markers

Workshop 2

MANAGING PROBLEMS

Content	Time	Moderator	Venue, participants and tools required
Plenary Session (Session 1) in the Houses			
Review of Workshop 1 Workshop objectives Understanding problems and need Problem Trees Objective Trees and action plans	20 minutes	Trainers Supported by facilitators	Larger Group Setting Presentations
Session 2 in Sub Groups			
Listing and categorizing problems	10 minutes	Subgroups led by 2 facilitators each	Subgroups of 10-12 Handouts to be used as pointers Each subgroup would need flip charts and markers
Selecting the most demanding problem	5 minutes		
Cause and effect analysis methods (problem tree)	10 minutes		
Making objective tree	10 minutes		
Making plan of action	10 minutes		

Session3 in the Houses			
Presentations by trainee civil servants and discussion	20 minutes	3 Trainers	Larger Group Setting Presentations

Workshop 4

STRENGTHENING YOUR SOCIAL SUPPORT

Content	**Time**	**Moderator**	**Venue, participants and tools required**
Plenary Session (Session 1) in the Houses			
Review of Workshop 3 Workshop objectives Three Scenarios Understanding networks and their significance	40 minutes	Trainers Supported by facilitators	Larger Group Setting Presentations
Session 2 in Sub Groups			
Identification of network member/partners	10 minutes	Subgroups led by 2 facilitators each	Subgroups of 10-12 Handouts to be used as pointers Each subgroup would need flip charts and markers
Making a network for addressing the problem	20 minutes		

Session3 in the Houses

Presentation by participants in larger groups	20 minutes	Larger Group Setting	Subgroups Presentations
Ending the workshop Stress management	5 minutes		

Workshop 5

STAYING WELL AND LOOKING FORWARD

Content	**Time**	**Moderator**	**Venue and participants**
Plenary Session (Session 1) in the Houses			
Review of Workshop 1- 4 Workshop objectives Staying calm and looking forward What makes you happy and what sad Triangle of peace	30 minutes	Trainers Supported by facilitators	Larger Group Setting Presentations
Session 2 in Sub Groups			
Preparing future plan of action	25 minutes	Subgroups led by 2 facilitators each	Subgroups/Handouts to be used as pointers Each subgroup would need flip charts and markers
Session3 in the Houses			

Presentation of future plan in larger groups	20 minutes	Larger Group Setting	Subgroups Presentations
Ending the workshop	5 minutes		
Stress Management exercise Evaluation and feedback			

Chapter 3

BASIC HELPING SKILLS

Before covering the specific strategies of the Psychosocial Skills Development Workshops, we will discuss basic helping skills, which focus on communication in the workshops and building a relationship with your participants. Building a relationship based on trust and respect is essential for all forms of psychological support. When reading through the description of these skills, try to think back to a time when a close friend or family member was thankful to talk to you about a problem they were having. It is likely that you used a lot of these skills while you were listening to them. These skills can be very natural and show participants that you are listening and willing to support them.

These basic helping skills are the groundwork for the workshops and essential for their success.

a) Respecting participants

You should have a genuine wish to help each participant, be open to new ideas and have an interest in listening to other people. Overall, care should always be provided in a way that respects the dignity of the person, that is culturally sensitive and appropriate, and that is free from discrimination on the basis of race, colour, gender, age, language, religion, political or other opinion, national, ethnic, indigenous or social origin, property, birth, or other status. In case of civil servants, care should also be taken to avoid bias or any discrimination because of the occupational groups. These attitudes are important to form relationships with your participants. Without a good relationship, the intervention is unlikely to benefit the participants.

It is important not to have a condescending attitude towards the trainee civil servants. Having passed a very competitive exam which selects a very small percentage of the educated population of Pakistan, they are now considering themselves as part of an elite group and are not willing to take any such attitude lightly. They will not engage with anybody who considers themselves to be more educated than them. This is also one reason why the psychologists might have difficulties in engaging with the participants

b) **Cultural, gender and linguistic understanding**

Before conducting the group programme, you should have a good understanding of the local culture and setting within which you will be working. This is usually not a great problem if you are from the civil

service yourself and have a similar cultural background. Nonetheless, there can be enormous differences within countries, regions and communities. Societies are complex and have many cultural groups and influences, and you may not always be familiar with each culture. This includes gender roles and expectations and various religious beliefs and practices of your participants. At times, you may need to learn more about a person's cultural belief system. You can do this by asking participant about their beliefs and the customs of their group, religion or culture. By asking these questions, you express respect for the possible differences and help reduce the chances of offending them or missing important information.

Gender and regional affiliation should be ignored in the context of formation of groups. This is important because no groups formed in the CSA are based upon gender and regional or service affiliation. In fact, there is a conscious attempt to mix up the participants. Therefore, if this practice is done in the current workshops it would result in resentment, the workshops will standout and the participants will not be comfortable in participating in the workshop. Moreover, certain religious groups and genders would feel discriminated against. "Group tracking" might not work here.

It is also important to relate the ideas of the workshop to the expectations by the Civil Service of Pakistan. This includes their vision of the importance of psychosocial skills in enhancing their ability to address the major issues and problems facing the society and their self-esteem. They would take an interest in the workshops if they feel that these workshops provide them tools for becoming better professionals.

There may also be times when you decide that it is important to challenge particular cultural beliefs or practices (e.g., girls are not suited for certain jobs), that are clearly harmful. You need to do this with extreme sensitivity so that the participants still willing to continue with the workshop.

Our experience of conducting the workshop has shown that the use of local language or translation into local language is not usually necessary. However, while the use of English language is preferred in the presentations, the group activities are better carried on a bilingual Urdu/English basis.

c) **Confidentiality**

Trust and confidentiality are important in your relationship with the participants. Participants need to know that when they speak openly about personal things, that information is going to remain confidential or private. This is especially true when participants are sharing information regarding their careers or personal life.

A major concern of the trainee civil servants is the possibility of assessing their performance through the activities and outcomes of these workshops and using them for their assessment by the faculty. This would negate the purpose of the whole purpose of the workshops as honest answers might not be forthcoming. It is therefore important to assure them that their performance in these workshops has nothing to do with their performance in the civil service or even in the CTP. They need to be assured that their answers to the questionnaires will not be shared with the CSA. This would be done through provision of a secure website which will receive the results of the questionnaires which is not accessible to the CSA faculty.

However, it is also very important for a participant to be aware of any legal boundaries to this confidentiality. For example, you may have to break confidentiality and tell the appropriate agency or authority when a participant appears to be at risk of harming their life or someone else. It might also be necessary to share some problems being faced by certain participants in order to get professional help.

Ongoing supervision is another limit to confidentiality as you will be discussing your participants' problems and progress throughout the intervention with your supervisor.

d) **Communicating concern**

Communicating concern to your participants is an important skill. Try to understand, as best as you can, each of your participant's situations, including the emotions they are experiencing. At the other extreme, it is also important that you do not get too involved in participant's feelings and take them on as your own. This can cause you to feel stressed and overburdened by your work.

Some examples of statements that show concern include the following:

That sounds like it was very challenging/upsetting/frightening (and so on) for you.

I can see in your face how painful this was for you.

You have experienced many difficulties.

You went through a lot.

I can hear how sad/frightening this was for you.

e) **Non-verbal skills**

Non-verbal skills also communicate to participants that you are listening to them and can also be a way of communicating concern. These include maintaining culturally appropriate eye contact, nodding of your

head and keeping your posture open (e.g., avoiding crossing your arms and sitting with a stiff position or turning away from the participant). Sometimes showing emotions similar to those of your participants shows that you are hearing what they are saying. This might mean expressing sadness on your face when they express sadness (because they have teary eyes). You can also use brief verbal indications that you are listening, such as “uh-huh”, “okay”, “I see” and “mmm”. In Urdu "jee", and "Achha" are appropriate terms.

f) **Praising openness**

To help participants feel comfortable talking about personal or related, difficult or embarrassing topics, try to thank or even genuinely praise them for being so open. Throughout the intervention, you may also praise the participants 'efforts to engage and to get better.

Some examples are shown below.

Thank you for telling that to me.

You were very courageous in sharing those intimate feelings with me.

I can see that you are really trying to practice breathing regularly.

Use local proverbs: e.g., you *double happiness and halve sorrow by sharing what’s on your mind, those times did not stay forever, these times will not stay forever*.

It is also important to use the diction of the civil service of Pakistan in order to make the junior civil servants open up to trainers. This is one reason why senior civil servants are shown to be more effective trainers. On the other hand, it is important to note that while these junior civil servants have yet to experience any field work or perform any real work as a civil servant, they are seeing themselves in their future roles and would like to be treated as such.

g) Validating

Many participants will feel embarrassed talking about their career or personal problems in a group. They might think that no one else feels the same way as them. They may also think that talking about emotions or personal problems is a sign that they are becoming ill, going crazy or that they are weak or they cannot run their jobs well, which will affect their reputation in their respective service. Some participants might

even blame themselves for how they feel. It is important that you help participants to dispel these myths. You can do this by normalizing participants' problems by helping them understand that many other people experience the same reactions, and difficulties. This might occur naturally in the group, if other participants also share similar difficulties. This is "validating" participant' problems, which means that you are letting them know that their reactions are understandable. This is a very good way of communicating concern too. However, while by telling them you know what they are going through, you might be trying to validate their experience, it can sometimes have the opposite effect for participants, as they may not believe you. The use of Civil Servant, as trainers can help.

Some examples of validating are shown below.

You have been through a very difficult experience and it's not surprising that you would be feeling stressed.

What you have just described is a common reaction for people to have in these situations.

Many people I have worked with have also described feeling this way.

Many civil servants have experienced these issues

The reactions you have described are very common.

I am not surprised that you are so scared.

Don't ask the group whether they had experienced similar things

h) Putting aside your personal values

At all times you will need to respect the participants' personal values and beliefs. This can be challenging, especially when you do not agree with their values or beliefs. You should not judge, them no matter what they might say to you. This means not allowing your own personal beliefs or values to influence how you respond to the participants. The experience of having someone just listen without judgement might be something the participants have not experienced before particularly in a training and assessing environment like CSA and this can greatly help them to trust you.

i) Giving advice

You should generally not give advice to participants. Giving advice is different from giving important or helpful information. Giving advice means telling a participant what to do or what not to do.) It is important to establish a psychological advice service in consultation with the CSA for those trainees' civil servants who have serious psychological issues which are beyond the scope of these workshops.

All trainers will feel tempted to give advice at some time. This is a normal. For example, a participant who is feeling hopeless and showing signs of depression might find the Managing Problems strategy challenging, especially thinking of potential solutions to help with their problems. It would be tempting to advise the participants what solutions would be good to try. However, you should avoid giving direct advice. If the participant has been relying on your advice, they are unlikely to be able to manage their own problems in the future. Other participants may give advice to each other during the intervention and you do not need to tell other participants not to give advice.

One strategy that can be helpful to use in such situations is asking participants what they would suggest or say to a close friend or family member in a similar situation. For instance, a participant who is withdrawn and depressed might not seek out social support because they do not want to burden others. Rather than giving advice that they should ask for support and that their thoughts are too negative, you might ask them, "*What would you say to a close friend or family member who was thinking the same? Would you want them to be alone with their problems or ask you for help? And would you feel burdened by that?"* This type of questioning may help the participant to think about their concerns and behaviours from a different viewpoint, without you directly telling them to do something different.

There are two exceptions to this rule about giving advice.

1. When delivering psychosocial skills development workshops for civil servants, you will be advising participants to become more active, seek social support and practise stress management, as these strategies are part of the workshops.

2. While teaching the strategy Managing Problems, your aim is to help the participants decide how helpful the potential solutions are in managing the problem. At this stage, participants may have a number of obviously unhelpful solutions (e.g., solutions that cause problems for their emotional or physical health, harmful or illegal acts and so on). You will need to help participants consider whether solutions are helpful or unhelpful. To discourage participants from focusing on an unhelpful solution, you can ask what they would have advised a close friend or family member experiencing this problem to do (e.g., *"Would you*

have advised them to use this solution?"). If a participant continues to focus on a solution that is obviously unhelpful (e.g., doing something illegal), you may be direct and identify these solutions as unhelpful. It will be important for you to give good reasons why the solution is not considered helpful (in other words, by commenting on the problematic or harmful consequences), but these should not be related to your values. Also, you would have to advise them not to use unsolvable problems.

The participant-trainer relationship

For some people, attending such a group may be akin to admitting weakness. Because of this, they may have a difficult time getting involved in the workshops as a whole or parts of it. Others may see you as someone similar to a doctor or a traditional healer, and expect to be "fixed" or "healed" by you. It is important that throughout the workshops you normalize participants' feelings as well as educate them about your role.

We encourage you to liken your role to that of a teacher or mentor (see the end of this section for some alternative metaphors). For example, you may say:

> *Teachers or mentors provide information to students and help them learn. However, they cannot sit an exam for the student or tell them what to write. They can only help prepare them for the exam as much as possible. It is up to the student to listen in class and study to do well in the exam. The student is ultimately responsible. Although you are an adult, it is the same with our relationship. I am going to teach you about some important and helpful strategies, but ultimately you are responsible for practising those strategies. I cannot do them for you. You might compare your everyday life to the exam a child will sit. You will be responsible for how well you apply the strategies in your everyday life. Nevertheless, I will support you and help prepare you to do the best you can.*

Similarly, you should also emphasize to the participants that they are all "experts" too. As a trainer, you are the expert of emotions and how to detect and reduce poor emotional well-being. The participants are the experts of their own lives, which you will only know a little about. The participants are also experts of their particular type of problem and how it affects their lives. The aim is to bring together the two types of expertise. This is important for building the confidence of the participants and dispelling any myth that your task is to "fix" their problems.

It is important to respect the participants as accomplished people with reasonable intelligence and knowledge who have excelled in a nationwide competitive exam recently and would like to be taken seriously. This respect or lack of respect on the part of the trainers could play a major part in the success or failure of the workshops.

Alternative metaphors to explain the participant-trainer relationship

- **Adult education metaphor:** Psychosocial Skills Development Workshops for trainee civil servants is like teaching an adult a new skill, such as using new agricultural equipment or a technique. The teacher will give all the information so the trainee can use the new equipment or strategy. However, it is the trainee who will have to apply the new equipment or strategy on their own land, without the teacher being there.

- **Medical metaphor:** Although the doctor does a lot to help heal a physical disease by giving you recommendations for intervention, it is the patient who is ultimately responsible for their recovery. They need to follow the intervention recommendations, which might involve avoiding particular types of food, taking medication or using various ointments. The doctor does not do these things for the patient, but teaches them how best to follow these recommendations and supports the patient. You might explain,

  > *"I will give you some recommendations to improve your emotional well-being and life situation, and will train and support you in applying these strategies, but you are responsible for practising them and applying them in your everyday life."*

- **Sports coach metaphor:** A coach's role is to teach and support an athlete's exercise programme. However, the coach does not run the race for the athlete. The athlete is responsible for following their coach's instruction and advice about training. The same relationship applies with you and the participant. Your role is to teach the trainee the strategies and coach them as they practise the strategies in real life. However, the participant must ultimately use them in their everyday life. You cannot do this.

- **Mentor-junior metaphor**: A mentor can advise on the basis of his or her own experiences but cannot run his or her junior's career or life. This metaphor is most suitable in the case of trainee civil servants.

The reluctant participant

Some participants will initially feel hesitant about talking in the group. This may be for a range of different reasons, such as:

- Lack of trust in you or others in the group;
- Psychological counselling being unknown in the culture;
- A lack of understanding or misperceptions about what the programme actually is;
- A lack of understanding of your role as a trainer;
- Being forced to attend the workshops;
- Feeling embarrassed about the experiences they have been exposed to;
- Feeling embarrassed about how they are coping now;
- Some participants would display an arrogant attitude assuming that there is nothing new the workshops can teach them

You may find that with time and a consistent use of the helping skills described here, many participants will begin to relax and open up. However, some participants may remain quite reluctant or shy. As a trainer it is important that you discuss this with your supervisor. You should respect the fact that a participant may not be ready to be completely open at the time of undergoing the workshops. There may be unknown reasons that contribute to this, and you may never know these reasons. These participants can be somewhat challenging to talk with, as they may not give you a lot of information. While you may want to gently and respectfully encourage participants to talk, you should never pressure them. It is important for you to show a readiness and openness to listen if they want to share private information about their distressing experiences, but the decision is entirely up to them. If a participant refuses to talk further about a topic, it is important to your relationship with them that you respect this.

For instance, you may say, *"I can see that this is upsetting for you to talk about and I want to respect that. However, if you do want to return to talking about this topic, I want you to know that I am ready to listen to you at any time. "If* possible, you may offer them an opportunity to talk with you privately at the beginning or end of a group session.

Or, you may find that a participant appears very distressed while discussing a particular topic, but has not said that they do not want to talk about it. In this situation, you may want to say that it is okay to stop talking about this topic if they prefer that. Some participants may believe that there is an expectation that they have to do everything you suggest, including talking about sensitive and personal topics.

For instance, you may want to say, *"You seem very upset talking about this. I am very willing to listen to your story and help you talk about it but I want you to know that you can decide what we talk about, and if you need to stop at any point or if you do not want to talk about a particular part of the story, then this is okay."*

Physical contact

It may or may not be appropriate depending upon the gender etc

In general, we would encourage you not to use physical contact or touch to express support and concern to participants. This avoids any problems associated with participants misinterpreting the meaning of this contact or feeling uncomfortable as a result.

The setting

While the setting of these workshops is CSA where the CTP is taking place, it is important to provide a setting appropriate to each of the sessions of the workshops. The larger groups are held in lecture halls (Houses) in a classroom setting where the participants can be given presentations on the major theoretical aspects of the workshops. The sub groups better be held in a round table setting where all participants have a chance to equally participate in the activities and discuss the issues and the practice of the tools given during the workshop among themselves. In the lecture halls (Houses), the trainer would be facing all the participants with some of the facilitators sitting in the back and assisting him. In the subgroup setting, the facilitators who may choose to sit with the participants or at a non-obstructive location.

For the last session the House venues (lecture walls) maybe used. The groups will come back in with a larger group setting in the lecture halls where one participant from each subgroup would make a presentation and discussions will be carried it out on the work of the subgroups.

Managing your own distress

Listening to and working with people who have experienced a lot of stress can be tiring and even distressing for some people. It is not uncommon for trainers to feel affected by or even overwhelmed by repeatedly hearing about adversity. To prevent feeling overwhelmed or even experiencing excessive feelings of distress (e.g., stress, low mood, anxiety, anger, hopelessness and so on) you should consider the following:

- Speak with colleagues and your supervisor regularly
- Schedule adequate breaks between groups
- As we have reduced the duration of the workshops to only one and a half hour and they would be moving between the group to sub group and back to the group, this would automatically allow them some relaxation and relieve boredom due to change of venue. This makes the workshops less monotonous and more acceptable to focus groups.
- Do not lead too many groups at one time
- Ask for help (e.g., talk to your supervisor or senior faculty of CSA) if you are experiencing distress or you find that your work is bothering you when you are doing other tasks (e.g., thinking repetitively about a particular participant when you are trying to sleep)

Introductory Sessions

Before the training starts it is important to have a number of interactions with stakeholders. The researcher held a workshop with all participants of CSA, faculty and the trainers/facilitators. (Intervention and control groups). In this presentation he focused on the importance of this kind of interventions for the civil servants. This allowed us to gain the support of the faculty and the leadership of the civil service academy who provided the facilities and incorporated the training program into the CTP. I also emphasised the evidence-based nature of these workshops and the importance of mental health for a successful career. The presentation also helped to gain the support of the trainers/facilitators who would then later on be able to deliver the workshops. It also helped the trainers/facilitators to prepare themselves for answering similar questions by the trainee

civil servants. The presence of control group was necessary to gain their support for filling in outcome questionnaires.

The important points of the presentation were:

- This is research and evidence-based training program.
- We will not share findings with CSA Faculty.
- The programme will not attempt any kind of judgment about the psychological health of the trainees. The purpose is not diagnostic or evaluation but providing tools to the trainees for improving psychosocial skills.
- The training program is not for those who are affected by illness. Rather it is more of preventive in nature. The purpose is to create awareness for psychosocial issues and to provide support to certain people who are on the borderline.
- The training workshops do not necessarily address serious psychological issues for which individual therapy/medication might be required.
- Some serious psychological issues would require medical treatment or more advanced psychotherapy which is beyond the scope of these workshops. The participants (trainees) who feel that they need individual psychological therapy would be recommended to a penal of experts.
- It is important to realize that some of the participants would have previous experiences of some of the tools. Participants need to bear with the group and display and understanding that we are attempting to bring the whole group at the same level in terms of understanding to these tools.
- It would also be important to emphasize that these are more advanced tools available for these purposes. We have intentionally adopted some of the simplest tools in order to make them acceptable to everybody and in order to make sure everybody can practice them.
- These workshops are not about the stress caused by CTP. They do take the stress caused by training programs as an example. They are primarily focused on providing certain tools for psychosocial skills development which can be used during the training course as well as after it in the long term.

- It is important that all CTP participants whether they attend the workshops or not, fill in the online questionnaires. This will help us to judge the impact of the workshops and adapt them for future use in civil service training programmes.

Chapter 4

WORKSHOP 1 -STRESS MANAGEMENT

Workshop 1			
Content	**Time**	**Moderator**	**Venue, participants and tools required**
Welcome and Introduction	20 Minutes	Researcher	Whole CTP Presentation and projector
Session 1 (Plenary sessions) in Houses Workshop rules What are the strategies Vicious cycle of Problems Understanding stress Managing Stress	30 Minutes	Trainers Supported by facilitators	Larger Group Setting Presentations
Session 2 Discussions and activities in subgroups	40 Minutes	2 Facilitators per Subgroup	Subgroups of 10-12 Handouts to be used as pointers Each subgroup would need flip charts and markers

Preparing for Workshop **1**

• Make sure the case example is appropriate for the group you are leading and make any necessary changes
• Make sure you bring:
  ○ Presentation of the Workshop
  ○ Laptop and Projector
  ○ Paper and pens for participants in case they want to write down notes
  ○ Flip charts and markers for activities.
  ○ Balloon (or balloons) for Managing Stress
• Read 'Helpful Hints for Managing Stress' (Appendix A)

There are three major unique features of these workshops.

a. These workshops use these strategies for dealing with Workplace stress rather than other forms of adversity etc.

b. The audience is a group of civil servants studying at the Civil Service Academy (CSA) belonging to Pakistan, a developing country.

c. The audience is yet to experience workplace stress and these workshops are mainly prophylactic in nature.

Provide information about logistics:

- Directions to the toilet (not necessary if in CSA)
- When break times occur and what will happen (change of settings etc.)
- Workshop will be approximately one and half hour

Describe today's workshop plan:

- To learn about the programme and how it can be helpful for everyone present

- Introduce first strategy that helps manage stress

Provide brief information about your role:

- To support the group so everyone learns how Psychosocial skills can be helpful for them
- You have experience in helping people who are having emotional and practical difficulties and understanding of the circumstances of the Civil Service of Pakistan.

Group Guidelines

Provide brief introduction to group discussions:

- Everyone will have the opportunity to discuss their problems and emotional difficulties related to their career or personal life and to learn some new strategies for managing these
- Helpful for the group to support each other as they try new things and learn from each other
- Sometimes discussions might not focus on problems everyone is experiencing, but it is still important to stay involved
- Important to decide on group rules to help everyone feel comfortable participating in group discussions. In the workshops, a number of rules were suggested for effective conducting of the workshops. These included:

    - Whatever happens in the workshop, remains in the workshop and should not be discussed outside the workshop;
    - While the trainers' facilitators might feel that they have to more to share with the trainee civil servants, the trainee civil servants have many other commitments and they would not be in a position to fully concentrate in the case the workshops exceed the given time; Time management is the key
    - Do not share any information about another civil servant outside the workshop while you did not want to have similar information about yourself shared.
    - Be humble and do not assume that you know everything. Be patient and listen what the trainers/facilitators are saying. It is possible that 90% of what they say is already within your knowledge, however even if they give you 10% extra, you

might be able to learn something. Pay attention to the workshops not just because you might be able to learn something but in respect of other people might be able to learn something.

- It is important that the group is comfortable in sharing their feelings among the group as well as with the trainers/facilitators. In order to do this a number of factors need to keep in mind.

    1. The self-esteem of the trainee civil servants. It is important to show sensitivity towards their concern that their answers during the workshop may reflect on their performance within the CTP. It has to be made absolutely clear that this training workshop is not meant for their assessment and is primarily to give them tools for addressing psychosocial problems during their life and career.

    2. Making sure that they understand that disclosing any issue during that the workshop will not reflect on their future career.

    3. Developing understanding among the trainee civil servants of the importance of the tools given through this workshop for their career. At this stage they are not interested in anything which is not related to their future career and it is important to establish a link to their professional performance and the development of psychosocial skills. This will ensure that they remain interested.

    4. Trainers and facilitators should provide examples from their own experience or from the experience of anybody particularly from the civil service they know in order to allow the trainee civil servants to understand that there should be no stigma attached to such psychosocial problems and their presence is not a reflection of one's weakness or "Un-officer like behaviour".

2. Encourage open discussion about group rules/expectations

- All personal information about participants must stay in the group
- Tell participants the 3 limits to confidentiality:

- If someone's life is believed to be at risk- e.g., risk of harming their life or someone else's life, or someone else is harming the participant.

- The intervention team including your supervisor will know information about participants and what happens in the group. Explain the supervisor is a trained professional and their role is to make sure participants are receiving the workshop properly.

- The whole group is responsible for keeping confidentiality, including group trainer (s) and participants (e.g., participants should not talk to each other about participants outside of the group, and they should not talk to family or friends about participants in the group).

- Ask participants to suggest rules

    - *"What are other important rules to help you feel comfortable participating in the group?"*

3. Display rules on slide

- Show slide in each workshop so, you can refer to them at any time (this may be relevant when you believe a rule is being broken)
    - The Group Guidelines Slide may include many of the rules relevant to your group. Group can be consulted on this.
    - These guidelines should be given in a slide which can be displayed from time to time. This slide should be kept separate from the main presentation so that it can be shown whenever necessary.

- Be sure the following guidelines are included:

    - Support and respect everyone's different experiences with stress

    - It is OK to get upset in the group

    - Listening and contributing are equally important

    - Switch off cell phones or put them to silent mode.
    - Attend all the workshops on time
    - Practice these strategies between workshops

Introduction

Purpose of Introduction to Psychosocial Skills Development Workshops

- To help participants (accurately) understand the workshops.
- To give participants hope that there are good strategies to help them with their problems

Give overview of the workshops.

- Use 'Five Steps to Break the Vicious Cycle of Adversity' Slide as you describe these

Key points to include:

- These workshops help manage both practical problems (e.g., problems related to work, work life imbalance housing problems, family conflict) and emotional problems (feelings of sadness, hopelessness, worry, stress etc.)
    - The strategies taught and described are about the problems that civil servants face in their everyday life (e.g., how to get successful in one's in the face of adversity, deal with workplace stress and pressure strategies to take important decisions how to make the best use of the given resources, keeping a balance in the personal and business lives, staying calm and controlled during tough situations and making right decisions.
    - Give examples you know many participants or civil servants are experiencing
- 5 strategies are taught in workshops 1-5
- Every workshop will last for one and a half hours in which we will learn these five core strategies.
- The workshops are divided into three sessions. The bigger groups will be held in houses. (Houses are used for conducting group wise lectures during the other courses of the CTP. In these lecture halls about 50-80 peoples can sit. They were named after great leaders of Pakistan and Pakistan movement. The five halls were named Sir Syed House, Jinnah House, Iqbal House, Johar House and Liaqat House.)

- Firstly, in a group of about 40, Power Point presentations will be used to convey the main concepts. These presentations in Appendix H contain all the material from the manual adapted in accordance with the needs of the civil servants as well as the charts and graphs.
- For the second session, the population is divided into smaller groups of 10 to 12 each where participants will sit around table and there will be no presentation. Points are written on a flipchart and given to the facilitators to enable them to ask the question. They will be given time limit to be allowed for discussions for each set of questions. The main points of the discussions will be noted down by one of the participants. However, at times the Co-trainers can display certain slides on the screen so that the participants remain focused point. This practice varies from trainer to trainer and subject to subject.
- Finally, the trainee civil servants will be again brought into larger setting in houses and asked to discuss the gist of their discussions with their colleagues by making presentations.
- A case example is read to describe each strategy and how it can help someone in their daily life. The examples shall be developed by participants themselves in Subgroups. A set of examples developed on the basis of the examples used by actual trainee civil servants in our RCT is in Appendix B.
- The programme works best if participants come to every workshop
- To get the most out of the workshop's participants should practice strategies between workshops
- If a participant cannot attend, they should tell in advance. The purpose of the psychosocial skills development workshops is to provide the civil servants with tools to deal their psychosocial problems and workplace stress, which is likely to occur during various phases of their career and make them successful in their career and life. Through this program, we propose to introduce some tools which can provide effective and evidence-based Program for stress and Problem Management Strategies to manage the problems occurring in everyday life of civil servants in Pakistan.
- However, these are merely tools and the actual success of the psychosocial development process depends upon how effectively you use these tools.

- Continue the script

"This program is based on five workshops. There will be a workshop every week which will last about one and a half hours. The purpose of these workshops is to manage everyday problems of civil servants which include attaining progress in their career even during difficult times; decision making, best use of the given resources and the problems related to practical life, for example, keeping a balance between personal and professional lives: staying calm in the adverse situations and with these strategies, helping them to make decisions regarding their jobs. These strategies will not only help you to manage everyday problems but will also improve your decision-making during adverse situations and will also enhance your overall health. Alongside this, you will get help to manage your everyday routine well; your stress level will decrease and social support will strengthen. In each session, we will learn a new strategy and side by side will exercise it also. You will be able to achieve success in managing your problems only when you will practice the strategies learned and will keep exercising them after the completion of these workshops.

These workshops are adapted from PM+, which has been devised by World Health Organization in collaboration with the experts from around the world. Currently, the training sessions of this program are being held in Europe and Middle East and in many other countries;(including Turkey, Jordan, Syria, Iraq, Kenya, Ukraine, Sudan.) In Pakistan, the training sessions of this program have been conducted in Peshawar, Swat, and Rawalpindi. All these strategies are evidence based and they have been proved effective for the people of many countries including Pakistan. Its efficacy has been proved by research. (Human Development Research Foundation) HDRF successfully implemented this program through a World Bank project in KPK and FATA for SME entrepreneurs to help them face adverse business circumstances and enable them to utilize their skills and abilities to better manage their businesses.

As a thousand miles' journey begins by taking a small step, similarly, this program takes five steps towards the betterment in your personal and professional progress. You will learn a new strategy at each step. I believe that the strategies which we will discuss in the coming weeks will help you improve your everyday problem management skills which will eventually improve your business and you will feel better and more peaceful.

Our purpose is not to teach you, rather we will learn together how to manage our adversities through each other's experiences."

It is important to realize that some of you would have previous experiences of some of the tools we are introducing for stress management and problem management. However, I would request you to bear with the group and display and understanding that we are attempting to bring the whole group at the same level in terms of understanding to these tools.

It would also like to emphasize that these are not the most modern tools available for these purposes. We have intentionally adopted some of the simplest tools in order to make them acceptable to everybody and in order to make share with everybody can practice them.

This is not a cribbing forum or exchange of ideas for reform of CSA. The purpose is to introduce some tools which will help you in your life and career

I understand your apprehensions that in case of serious illnesses like suicidal thoughts or depression, such workshops would not be of any use. These workshops are meant for sub clinical populations and the purpose of these workshops was to address a relatively mild form of stress and to provide coping tools rather than address severe illnesses. In case of serious problems, participants could confidentially allow us to share their names with a panel of psychologists and refer them to them so that they could be provided with more professional help and medication if necessary.

There is no way that some serious psychological issues would require medical treatment or more advanced psychotherapy which is beyond the scope of these workshops

We have intentionally adopted some of the simplest tools in order to make them acceptable to everybody and in order to make sure everybody can practice them.

- Discourage too much personal disclosure in this activity, as it is only brief and introductory.
- Be aware that some participants may not feel comfortable disclosing specific information. Encourage participants to share only what they feel comfortable with.
- Be prepared that some participants may express some distress in this activity.

2. **Do you agree on the importance of the skills we are preparing to develop?**
    - Refer to the Advantages Disadvantages Table below for ideas for questions to encourage discussion
        - **Note:** You only need to choose 1-2 questions from the table.

Suggested script for examples of how to use the questions to encourage discussion:

What do you think you will personally get out of this programme? " "*I also understand that it can be challenging for some people to join a programme like this. What are some of the problems for you in joining the programme?*"

Reasons and Challenges Table

Reasons to Join Psychosocial Skills Development workshops for civil servants **(Advantages)**	**Challenges to Joining Psychosocial** Skills Development workshops for civil servants **(Disadvantages)**
"Lots of people have benefited from this programme."	*"I also understand that it can be challenging for some people to join a programme like this."*

• What do you think you will personally get out of this programme?
• What might improve in your life if you join these workshops?
• What do you think you might be able to do that you cannot do now?
  o Maintaining a balance between family and career (e.g., spending time with children, friends, doing pleasant activities together)
  o Better at job related tasks (e.g., decision making, completing work
	• What are some of the problems for you in joining the programme?
	• What will you have to give up or lose if you join these workshops?
	• Will the workshops reduce your time with your family or work? Or CSA activities
	• Will the programme take you away from other important duties?
	
	Examples:

on time, better problem management) o Self-care (e.g., getting out of bed, washing yourself, getting dressed) If your emotional problems reduce, how might this be good for other areas in your life? • If your problems reduce, how might this be good for other areas in your life? o For example, your relationships, your work, your other duties • How might your everyday life look if your emotional wellbeing improved?	• Time away from housework • Time away from other interests • Could be doing casual work • Giving up personal time • Taking away time from religious activities particularly if the workshop is held on Friday.

What is Stress?

Purpose of 'What is Stress?'

- To help participants understand common reactions to stress
- To help participants feel that their reactions are understandable and not a sign that they are weak
- To give participants hope that these reactions are not permanent (i.e., they can be influenced by them using the strategies) of these workshops
- To build group relationships by sharing similar stories

Steps to 'What is Adversity?'

1. **Define 'stress'**
    - Adversity = any very difficult, stressful or negative life event
    - Examples:
        - Death of a loved one

- Poverty
- Unemployment, loss in business
- Relationship difficulties- e.g., with partner, family members, friends, in the community, boss, local politician
- Insecurity/attacks/violence
- Physical problems- illness and disease, injuries and disabilities
- Difficult work situation / Resource limitation

- Tell participants there are many different reactions people have to adversity

Optional activity:

- Make these slides showing the vicious cycle of adversity or stress/low productivity easily accessible so that it can be displayed from time to time during the presentation.
- Invite participants to create a story about stress. Give them the following questions to answer:

1. *List problems civil servants face in their careers- practical or emotional problem*
2. *What might have caused these problems?*
3. *How might these problems cause other problems in his life- e.g., negative feelings, inability to carry out particular tasks, problems with different relationships, health, career etc.*
4. *Is this story something that you have seen other people in your family or service group face? Or if you are willing to disclose, is this something you have faced/are facing?*

- Give participants 5 minutes to create story
- Everyone will have 1 minute to tell the story they have created to the rest of the group (i.e., answering the 4 questions above)

2. Group discussion on common reactions to adversity

- Continue to discuss common reactions to adversity (from previous activity)
- The trainers may begin the discussions and conversation by highlighting the first presentation made by the supervisor/supervisor/principal investigator in which he explained the importance of tackling stress workplace stress by the civil servants. The importance of developing tools to address psychosocial issues for one's career and life needs to be particularly emphasized.

Suggested prompt questions:

- *"What were some of the problems civil servants were experiencing as a result of stress?"*
- *"Many of you have said you want to deal with problems and be more involved in activities with your families and community. Do you see that depression and anxiety are problems for many people in* civil service?
- *"How do you see these problems (*i.e., identified by participants) affecting other *civil servants* (e.g., people isolating themselves or not caring for themselves?"
- *How these problems are affecting civil servants' private lives and their careers?*
- *"Do these problems* (i.e., identified by participants) *affect all civil servants or particular groups* (e.g., men, women, older, younger, occupational groups etc.)?"

Key points to include:

1. By adversity we mean any stressful or difficult life experiences
2. E.g., being affected by natural disasters or war, or facing difficulties in performing their jobs, workplace stress.

- People will experience a range of different reactions to adversity., intense fear, hopelessness, extreme sadness, tiredness, severe headaches
- These feelings and reactions cause problems in peoples' lives
- E.g., unable to get out of bed, difficulties completing daily routines like work, conflict with family, not going out or enjoying pleasant activities anymore
- For most people these reactions reduce over time
- For some people these feelings get stuck

3. Learning strategies to manage these feelings can be helpful

Managing Stress

Purpose of 'Managing Stress':

- To inform participants about how adversity causes stress
- To help participants understand how stress affects the body

To introduce a basic strategy to manage stress through calming the body **Steps to 'Managing Stress':**

1. **Introduce 'Managing Stress' as the first strategy of the Psychosocial Skills Development Workshops**
2. **This strategy focuses on Managing Stress through our bodies**
3. **Talk about what stress is and how it affects the body**
    - Ask participants to give their definitions of stress
    - Ask participants how stress affects their body (if they have not said this in their definition previously)
        - E.g., headaches, pain in the body, stomach-aches, tingling, dizziness, racing heart, difficulties breathing
    - Ask participants (if comfortable) to share examples of times they felt stressed and what happened how they dealt with it.
    - Sometimes people experience physical problems and this can increase their stress. Regardless of whether the physical problems are or are not caused by stress, learning ways to reduce stress may also help alleviate the physical problem.

Key points to include:

- One of the common reactions to adversity is stress
- Stress can affect our body in the short term (e.g., our breathing and heart rate can quicken in a situation where we feel stressed or scared) and in the long term (e.g., over time stress can cause us to experience headaches, pain or discomfort in the body)

- It is important to emphasize that while there are many different strategies for dealing with stress, we are focusing on only one out of them which is supposedly the easiest one. The idea is to encourage regular practice by everyone, without denying the efficiency of any other method for stress management. Being an educated group, the audience is likely to point out the other, more complicated ways of dealing with stress like mindfulness, meditation etc.

- Certain participants who have previous understanding of some of the tools being used in these workshops might undermine the simple ideas presented in the workshop. They would think that they already in these in fact would try to take the workshop. It is important to inform them that in order to

take the whole group along, it is important that we stick with the simple ideas. An example of this would be that instead of breathing exercises some of the participants would stand more complicated stress management tools like meditation and mindfulness. It is one way of dealing with such participants is to encourage them to share their ideas with their group while displaying understanding that the use of simple tools of the workshops is for the purpose of taking everybody along.

Activity:

- Invite all willing participants to count the number of breaths they take in one minute (group facilitator will keep time). One breath = breathing in and out. Tell participants not to change their breathing
- Start timer for 1 minute and participants count their breaths in their heads
- After 1 minute, invite participants to tell you their number and write these on a board or large sheet of paper
    - **Note**: do not be concerned about the differences in these numbers or if any seem unusual
- 10-12 breaths per minute is the optimal number for feeling relaxed- you may comment on participants' scores

- **Teach Managing Stress**

Steps to follow:

1. Managing Stress helps relax the body and calm the mind to reduce stress
2. Ask participants to stand up to complete this exercise
3. Invite participants to release any tension in body (shake arms and legs, roll shoulders back etc.)
4. You will teach them a slow breathing exercise
5. Imagine a balloon inside the stomach and their job is to blow the balloon up (demonstrate with real balloon)

- That is, when they breathe in the stomach will expand

- We are aiming to *not* breathing with the chest (our breaths are shallower from the chest)

- Placing one hand on the stomach and one hand on the chest can help participants make sure they are breathing from the stomach and not the chest

6. Trainers and Group facilitators demonstrate stomach breathing and then asks participants to try for 1 minute
7. Invite participants to focus on slowing breathing down once they can breathe from their stomachs

- Count 1, 2, 3 (timed with seconds) to breath in and 1, 2, 3 to breath out

8. Practice for 1 minute while counting aloud for the group
9. Continue to practice for 2 minutes without counting aloud (ask participants to count in their heads or follow the sound of a clock or other rhythm)

Demonstrate breathing exercise before participants and instruct them to do the exercise side by side with you.

- *Before we start, I want you to relax your body a little bit. Shake out your arms and legs and let them go floppy and loose. Roll your shoulders back and gently move your head from side to side.*

(You can also ask the participants to imagine that they are at a place which is very peaceful, surrounded by greenery and where they feel happy and safe so that they can take breaths in a better and focused way.)

- *Now, placing your hands on your stomach (belly), I want you to imagine you have a balloon in your stomach, and when you breathe in you are going to blow that balloon up, so your stomach will expand. And when you breathe out, the air in the balloon will also go out, so your stomach will flatten. Watch me first. I am going to exhale first to get all the air out of my stomach. (Demonstrate breathing from the stomach – try and exaggerate the pushing out and in of your stomach. Do this for at least five breaths.)*

(Alternative example: You must have seen a new born baby, when it inhales the air, its stomach expands like a balloon); look at me, I will first of all I will breathe out all the air from my stomach (Breathe through your stomach; try to demonstrate how air will be inhaled and exhaled from the stomach. Do it at least 5 five times over with your breaths.)

Okay, so now you try to breathe from your stomach with me. Remember, we start by breathing out until all the air is out, and then breathe in. If you can, try and breathe in through your nose and out through your mouth.

(Practice this exercise with the participants for at least two minutes.)

- *Great! Now the second step is to slow the rate of your breathing down. So, we are going to take three seconds to breathe in and three seconds to breathe out. I will count for you; 1,2,3,4…*

- *Now, breathe in; 1, 2, 3...and breathe out, 1, 2, and 3. Do you notice how slowly I count? (Repeat this for approximately two minutes.)*

- *That's great. Now when you practice on your own, don't be too concerned about trying to keep exactly to three seconds. Just try your best to slow your breathing down, remembering that when you are stressed you will breathe fast.*

- *Okay, so you try on your own for the next few minutes.*

Allow the participants to practice trying to slow down their breathing on their own for at least two minutes. Try to count their breaths in and out so you can judge whether they are doing it too quickly. Afterwards, spend some time talking about any difficulties they had.

"Okay, so how was it doing it on your own? Was it more difficult trying to keep your breathing to a slower rate?"

Encourage the participants to practise this strategy regularly but also to practise it when they feel anxious or stressed.

You will end every workshop with Managing Stress, but you may also choose to use it if you notice that if participants are becoming stressed or anxious in the workshop. In these situations, ask the participants

if they are feeling anxious or stressed and whether they would feel comfortable if you stopped the conversation to practice Managing Stress together. Ask them whether they would like to do it themselves or whether they would like you to lead them in it (i.e., count the breathing in and out).

- **Discuss participants' experiences of trying Managing Stress**
    - Ask the group what they found good about Managing Stress
    - Ask them what they found difficult about doing Managing Stress
    - Address any difficulties participants had (see helpful hints: Appendix A) Different people experience different types of problems while doing breathing exercise. Some common problems are given as under: Always discuss with your supervisor about the problems that participants are facing during practice of breathing exercise.

Table No. **Table of Guidelines Related to Managing Stress**	
Problems	**Solutions of the Problems**
1. If participants are concerned about breathing correctly (e.g., keeping to the three seconds in and out, breathing from their stomach)	• Encourage the participants not to be worried about following the instructions exactly. • Help them to understand that the main aim is simply to slow their breathing down in the way that best suits them, even if it means that they are not keeping to the counts of three or even if they are not breathing from their stomach. • Once they have mastered how to slow their breathing down, they can try to use the counting or breathe from their stomach.
2. The participants cannot slow their breathing down when they are at the peak of their anxiety or stress.	• Say to the participants that this would be very hard for anyone to do straight away, even a trainer. • Spend some time helping participants to identify early signs that they are beginning to feel anxious or stressed so they can start slow breathing earlier. • If this is too difficult, help them to schedule specific times throughout the day to practice slow breathing so they learn how to use it before they get too anxious.

3. Focusing on breathing makes participants speed up their breathing and feel more anxious.	• Help them to focus on a ticking clock and breathe to the count of the clock rather than focus only on the breathing (or a musical beat in a song).
4. They might also experience feelings of light-headedness or dizziness, or feel they are losing control 5. Female trainers are at times uncomfortable with practicing the breathing exercises with a male participant.	• Remind them that these sensations are safe and they are not losing control. • Encourage them to focus just on blowing all the air out (just the breathing out) and letting the in-breath come naturally (or by itself). • Then they can return to focusing on the whole process of breathing (in and out). Ask a male trainer to help out.

Ongoing Practice:

1. Discuss practicing Managing Stress between workshops:
    - *We encourage participants to practice strategies between workshops. Why might this be important?*
    - Ask them to think about at what times and in what situations Managing Stress would be helpful:
        - E.g., regular practice every day, in times when they feel stressed, anxious or when they pray etc.

    - Exams, viva, interviews.
- Ask the group to think of ideas of how they can remember to practice Managing Stress daily (discuss using aides to remind themselves for instance., doing this exercise alongside other important activities: for instance, before or after taking a meal or after offering prayers)
- Participants can use music or ticking clock (etc.) to help them keep slow breathing pace (if needed)

2. Tell participants that at any time in the programme that you notice someone is experiencing strong emotions (e.g., anxiety, stress, sadness etc.) you may lead the group (or participant) in Managing Stress as the first response. This will help participants notice when to use this strategy and improve their abilities to use it when feeling overwhelmed by distressing emotions.

3. One hindrance in performing the breathing exercises is the feeling embarrassment in doing any such activities which are physical in nature in public in Pakistani culture. In particular we found that the females, despite being working with other gender on regular basis and generally being comfortable with them, had some issues performing these breathing exercises with the male participants. However, an interesting phenomenon was that the female trainers were more reluctant to be involved in the breathing exercises whereas few female participants had any problems in this regard.

Ending the workshop

1. Ask participants to say one thing they learned in today's workshop that has been helpful
    - If you believe an important point has not been raised, give brief summary of this
2. Remind participants to regularly practice Managing Stress
    - Ask participants to call out the days/times they are going to practice Managing Stress
    - Asking any friend or a family member to remind them to do the breathing exercise
    - This responsibility can also be given to any group member as well to remind everyone (through a call or WhatsApp message)

3. Remind them of the next workshop- time and location- and tell them the topics that will be discussed (i.e., how to manage practical problems)

4. There was a general agreement that WhatsApp group would not be appropriate to make between the participants of the workshops. Firstly, the groups formed were not natural groups. There was no natural affinity or friendship between the groups providing the confidence to share their problems with each other. They were worried that other members of groups, being their competitors would use the knowledge of their problems against them. However, they said that they would be more comfortable in making a WhatsApp group of their own in which they can decide the participants and share their problems and workout solutions. Secondly, during the training civil servants would be developing an understanding of the different strategies step by step and they would not be able to utilize them effectively if they shared with each other half baked. There was also a research concern about possible contamination of data because of the sharing of information between the intervention group and the control group.

Chapter 5

WORKSHOP 2 -MANAGING PROBLEMS

Content	Time	Moderator	Venue, participants and tools required
Plenary Session (Session 1) in the Houses			
Review of Workshop 1 Workshop objectives Understanding problems and need Problem Trees Objective Trees and action plans	20 minutes	Trainers Supported by facilitators	Larger Group Setting Presentations
Session 2 in Sub Groups			
Listing and categorizing problems	10 minutes	Subgroups led by 2 facilitators each	Subgroups of 10-12 Handouts to be used as pointers Each subgroup would need flip charts and markers
Selecting the most demanding problem	5 minutes		
Cause and effect analysis methods (problem tree)	10 minutes		
Making objective tree	10 minutes		
Making plan of action	10 minutes		
Session3 in the Houses			

Presentations by trainee civil servants and discussion	20 minutes	3 Trainers	Larger Group Setting Presentations

Preparing forWorkshop2
• Read through 'Notes on Managing Problems (Appendix A) Presentations Vicious Cycle of Adversity slide Read the Helpful Hints for Managing Stress (Appendix A) • Markers and Flip charts for sub-groups • Note pads and pens for note takers

Welcome

- Welcome the group back
- Tell participants the plan for today's workshop:
  - Review of Managing Stress practice
  - Introducing the next strategy to deal with practical problems
  - Practising Managing Stress to end the workshop

Managing Stress Practice Review

1. **Review Managing Stress home practice**
   - There are 3 possible experiences people will have with any home practice:
     1. Successfully completed their action plan
     2. Tried to do action plan but it was unsuccessful
     3. Unable to do action plan
   - All experiences are okay and important to share (especially normalize experiences 2 and 3 above)
   - Everyone can learn from other participants' experiences, especially experiences that were unsuccessful

- Then invite participants to share their experiences of practising Managing Stress during the last week

- *"How did people go practicing Managing Stress?"*
- *"What happened when you practiced Managing Stress?"*

2. **Respond to and manage any difficulties participants had in practicing Managing Stress**
    - **Note:** see 'Helpful Hints for Managing Stress' (Appendix A)
    - Encourage other group members to suggest ideas of how to overcome problems

- "*Does anyone else have any ideas about what (name) could do to overcome this problem?"*
- *"Have others had similar problems? And what did you do?"*

Managing Problems: Education & Case Example

Purpose of 'Managing Problems':

- To help people better **manage** practical problems (i.e., not all problems will be solved)
- Teach participants the steps to follow to manage a problem
- Managing practical problems can help people feel most positive and hopeful
- Teach Problem Tree method.

Steps to 'Managing Problems':

Before introducing the workshop on managing problems ask the participants when are they in a better position to manage their problems; when they are in stress or when they are relaxed.

Suggested script

- *Problems and difficulties are a normal part of human life. We saw in the previous workshop that sometimes these problems and difficulties become a cycle of distress which needs to be addressed. Today we will tell you how to get out of this cycle of distress through managing problems. We will show you how to manage problems by following some simple steps. There they would be problems*

which we cannot immediately deal with or which we need more time or support to deal with. There are also certain aspects of the problems which we can address and decrease intensity of the problems even if we cannot completely solve them. In the previous workshop we identified some of the problems one's likely to be faced by the civil Servants. In this one we will see how to manage these problems.

- *This workshop will present two main ideas for problem management one of them would be a simple classification of the problems in to solvable and unsolvable and then observing the steps of the four steps towards managing problem. These four steps would be observation, interpretation, intervention and review.*
- *In order to understand problems, it is important that they would be observed without objectively.*
- *After the identification of the problems, it is important to interpret their true nature. This would involve the classification into solvable and unsolvable. Some of the problems which within one's power like house hold issues etc. which you can either solve or decrease in intensity. However, there are some problems which are beyond once power in the given time and these are problems for which you cannot do anything like making environment clean, increasing the morality in the society etc. We would focus on those problems which are within our powers and whose solution is possible and should not worry about those problems for which we cannot do anything in the short term. For those problems about for which we cannot do anything in short term, we will have a later workshop.*

- *The other main tool that we are going introduce for managing problems is that of making a problem tree. This is explained in the presentation slides. Basically, a problem tree has roots, stem and branches. The branches which are visible, are the visible issues we face while the stem is the main problem. The underlying causes are the roots which are not visible but which need to be addressed in order to address the problem. When we convert a problem tree into an objective tree by turning it upside down, the causes turn into objectives and the problem turns into the main objective. Once we realize this, we can formulate an action plan to address any problem.*
- *Problem tree analysis (also called Situational analysis or just Problem analysis) helps to find solutions by mapping out the anatomy of cause and effect around an issue in a similar way to a Mind map, but with more structure. This brings several advantages:*

- *The problem can be broken down into manageable and definable chunks. This enables a clearer prioritization of factors and helps focus objectives;*
- *There is more understanding of the problem and its often interconnected and even contradictory causes. This is often the first step in finding win-win solutions;*
- *It identifies the constituent issues and arguments, and can help establish who and what the political actors and processes are at each stage;*
- *It can help establish whether further information, evidence or resources are needed to make a strong case, or build a convincing solution;*
- *Present issues - rather than apparent, future or past issues - are dealt with and identified;*
- *The process of analysis often helps build a shared sense of understanding, purpose and action.*
    - *The first step is to discuss and agree the problem or issue to be analysed. Do not worry if it seems like a broad topic because the problem tree will help break it down. The problem or issue is written in the centre of the flip chart and becomes the 'trunk' of the tree. This becomes the 'focal problem'. The wording does not need to be exact as the roots and branches will further define it, but it should describe an actual issue that everyone feels passionately about.*
    - *Next, the group identifies the causes of the focal problem - these become the roots - and then the consequences, which become the branches. These causes and consequences can be created on post-it notes or cards, perhaps individually or in pairs, so that they can be arranged in a cause-and-effect logic.*
    - *The heart of the exercise is the discussion, debate and dialogue that is generated as factors are arranged and re-arranged, often forming sub-dividing roots and branches (like a Mind map). Take time to allow people to explain their feelings and reasoning, and record related ideas and points that come up on separate flip chart paper under titles such as solutions, concerns and decisions.*
    - *Discussion questions might include:*
        - *Does this represent the reality? Are the economic, political and socio-cultural dimensions to the problem considered?*
        - *Which causes and consequences are getting better, which are getting worse and which are staying the same?*

- *What are the most serious consequences? Which are of most concern? What criteria are important to us in thinking about a way forward?*
- *Which causes are easiest / most difficult to address? What possible solutions or options might there be? Where could a policy change help address a cause or consequence, or create a solution?*
- *What decisions have we made, and what actions have we agreed?*

- *. The Problem tree can be converted into an objectives tree by rephrasing each of the problems into positive desirable outcomes - as if the problem had already been treated. In this way, root causes and consequences are turned into root solutions, and key project or influencing entry points are quickly established. These objectives may well be worded as objectives for change.*

3. Tell participants to focus on managing practical problems

- Define practical problems by giving 2 examples (e.g., career problems, work life imbalance, time management, training, conflict with family or friends etc.)
- Then ask participants to recall out other examples of practical problems
- If a participant identifies an emotional problem (e.g., feeling sad, stressed) for which other strategies are well suited, tell them that this is a problem and one that the workshops will be dealing with but that the Managing Problems strategy is especially good for practical problems.
- Also mention that emotional problems might improve once practical problems have been solved or managed

Discuss the differences between solvable and unsolvable problems

- First tell participants that Managing Problems aims to see what parts of the problem can be solved or influenced. This means you might not always be able to solve the whole problem.
- Give an example of a problem that cannot be solved by the participants)
- Invite participants to give other examples of problems that cannot be solved
    - If they give a problem that can partly be solved, help them understand how this problem could be solved.

"*I can see how this problem looks unsolvable but I think you could solve this problem if you were able to….”*

- Participants might say problems that are partly solvable. Discuss the idea that Managing Problems can be used to solve part of a problem or influence it

"*While we cannot completely solve the problem of poverty, we might be able to do things to improve the situation, such as looking for work."*

- Write some problems that are unsolvable (out of their influence such as terrorism, insecurity, instable government) on sticky notes for the participants and put them outside the circle far from participants
- Write some solvable problems (participants can influence) such as; increased productivity, conflict with family, friends and colleagues, work life balance, self-care, better management of the business) and put them inside the circle
- Tell them you will read them a problem
- Participants decide if the problem or part of it is solvable or unsolvable
- Read the following problems in random order (or 6 problems you have decided are more appropriate):

  1. Solvable: unemployment, conflict with partner, child refuses to go to school (from list)

  2. Unsolvable: death of a loved one, power outages, and family member has AIDS (or other serious disease)

- Ask the participants to reach out and pick the note without getting out of the circle. Ask if they believe it is solvable.

In order to understand problems, it is necessary to observe them properly and objectively. It is also necessary to understand the nature of the problems. Some of the problems are within once's control like household problems etc. These are the issues which are solvable in nature. Either they can be solved on their intensity can be decreased. These are termed solvable problems. However, there are certain problems beyond one's control These are the problems which individuals cannot do anything about, at least in the short term, like raising the ethical standards of the society, improving the economy or changing the CSA curriculum etc. These are called unsolvable problems. In these workshops, we should think of problems within our control which we are in a position to solve or decrease the intensity instead of problems which cannot be addressed in the short term.

In the large group discussions in the first session of the workshop, the trainers would explain the methodologies of the identifying problems and formulating their solutions. One of the basic steps is listing, followed by observing, interpreting and thinking of solutions. The other important tool which should be introduced is the problems tree. In the large group, the idea was introduced along with the objective tree. This has been explained in the presentation in detail. The trainer may also use the notes at the end of the manual.

If there is time available in the bigger group, one problem can be selected for which problem trees and objective trees can be demonstrated. For the solution it is advisable to allow the participants to think freely. Then the rest of the group should be allowed to comment whether a certain solution is practical or not. This will eventually short list the possible solutions and eliminate the impractical or wild solutions, without the feeling that the trainer or facilitator is imposing his or her ideas on the group.

Read some examples from Appendix B

- To engage the group, ask them to
    - Think of any additional potential solutions to the case example's list as you read through them;
    - Reflect on which solutions they would have chosen if they had this problem;
    - Offer alternative ways the participant could remind him/herself to carry out the action plan;

Managing Problems: Participant Problems

Make sure there is a visual reminder of each of Managing Problems' steps and that it is visible to all participants. To deliver Managing Problems well you must be familiar with the trainers' notes and presentations.

In the second session in sub-group settings, the participants themselves will identify the problems, which they will form problem and objective trees and action plans. The important thing is to not let them focus on unsolvable problems and tell them that for the unsolvable problems strategies will be suggested in the following workshops.

It is also important to not let them use this workshop to vent their anger on the training program itself as that would only lead to a negative reaction. They may politely be told that the tool was not introduced for

such issues but rather to provide them with a tool for psycho social development in future which will help them in long term in their careers and lives.

After sub group sessions (discussions) the groups will once again gather in the larger group setting for the third session. Each group will use the flip charts used by them in the sub-groups to present their problems trees, objective trees and action plans. Discussion in the group will evaluate the ideas being formulated and to eliminate any impractical ideas. It will also give the participants an idea of how the tools can be used in different ways.

Managing Stress

1. **Remind participants why this strategy is helpful**
    - It helps the body relax which can help participants feel less stressed; remind participants of the tight coil metaphor.
2. **Lead the group in Managing Stress**

Steps to follow:

1. Participants relax their bodies (move arms and legs, rock head side to side, roll shoulders back)
2. Instruct participants to breath from their stomach (balloon in their belly)
3. Once everyone is comfortable with step 2, begin counting 3 seconds for the in-breath and 3 seconds for the out-breath. Continue for a minute
4. Stop counting and encourage participants to count themselves or keep the rhythm of slow breathing going (if you have a clock, you could encourage participants to follow the ticking of the seconds to keep the rhythm slow)
5. Continue for several minutes

Chapter 6

WORKSHOP 3- GET GOING KEEP DOING

Content	Time	Moderator	Venue, participants and tools required
Plenary Session (Session 1) in the Houses			
Review of Workshop 2 Workshop objectives Three Scenarios Challenges of adversity Fight or flight mode Breaking the vicious cycle	30 minutes	Trainers Supported by facilitators	Larger Group Setting Presentations
Session 2 in Sub Groups			
Group discussion and sharing of experiences	30 minutes	Subgroups led by 2 facilitators each.	Subgroups of 10-12 Handouts to be used as pointers Each subgroup would need flip charts and markers
Session3 in the Houses			
Presentations by trainee civil servants and discussion	30 minutes		Larger Group Setting Presentations

Preparing for Session 3
List of participants' problems written down in the last workshop Read the Helpful Hints for Workshop 3 and presentations.

Welcome

Welcome the group back

Tell participants the plan for today's workshop:

- Review of Managing Stress practice
- Review Managing Problems and continue with the same or a new problem
- Introduce next strategy to deal with feelings of low mood and inactivity
- Practice Managing Stress to end the workshop

Managing Stress Practice Review

1. **Review Managing Stress home practice**
    - Invite participants to share their experiences of practising Managing Stress during the last week. Ask 1 or 2 participants to do so for 2 minutes each.

- *"How did people go practicing Managing Stress?"*
- *"What happened when you practiced Managing Stress?"*

Managing Problems Review

1. **Invite participants to share their experience of completing their Managing Problems Action Plan during the week**
    - Before asking for experiences, educate participants about home practice
        - There are 3 possible experiences people will have with any home practice:
            1. Successfully completed their action plan
            2. Tried to do action plan but it was unsuccessful
            3. Unable to do action plan
        - All experiences are okay and important to share (especially normalize experiences 2 and 3 above)
        - Everyone can learn from other participant's experiences, especially from experiences that were unsuccessful

- Review as many participants' action plans in the larger group if possible but not more than 3-5 minutes. Watch the time.

- *Did anyone solve all or part of their problem by completing their Action Plan this week?*
- *Of those of you who completed their Action Plans for Managing Problems, would you like to share what happened?*

2. Respond to and manage any difficulties participants had in completing their Action Plan

- See Helpful Hints for Managing Problems (Appendix A)

- *"At some point in this program you will probably all encounter a problem in completing your action plan. Perhaps the action plan was unsuccessful in managing your problem or maybe you were unable to carry out your plan. These experiences are okay and do not mean you have failed in anyway. They are also important learning opportunities for us all. So did anyone have any problems doing their action plan in the last week?"*
- *"What kinds of difficulties did people have completing their Managing Problems Action Plan over the last week?"*
- *"Of those of you who had difficulties completing your Action Plans, would you like to share what happened so we can work through the problems as a group?"*

Suggested script:

I will start with an example: Mr. Ahmed was under a lot of pressure because of his work. His boss was demanding and uncompromising. He did not understand the limitations of resources of Mr. Ahmed. On the other hand, Mr. Ahmed's wife is not happy and wanted to go to a bigger city. Mr. Ahmed was trying hard to perform his job as well as keep family satisfied. He used to read a lot. Mainly he was interested in literature. However, during this stressful life, he had given up reading and could not find time for reading as a result of the stresses of job and family. Mr. Ahmed health was suffering. He found it difficult to manage his job and work life balance.

Ahmed recalled his workshop. He recognized that he was stuck in a vicious cycle of stress/low productivity. However, he did not know how to begin to these activities he liked because he could not find time to do so. It required extra efforts to take out time and to continue reading literature.

Purpose of 'Get Going Keep Doing':

- Teach participants that stress can cause people to become stuck in low mood and productivity
- Reassure participants that problems with low mood and inactivity is not uncommon (not a sign they are going crazy etc.)
- Teach participants that becoming active (e.g., engaging in hobbies, doing things that the person finds pleasurable) through Get Going Keep Doing, can break this cycle of low mood and productivity
- Get Going Keep Doing improves mood which can also help people feel more confident in solving their practical problems

Steps to 'Get Going Keep Doing':

Introduce Get Going Keep Doing as the 3rd strategy

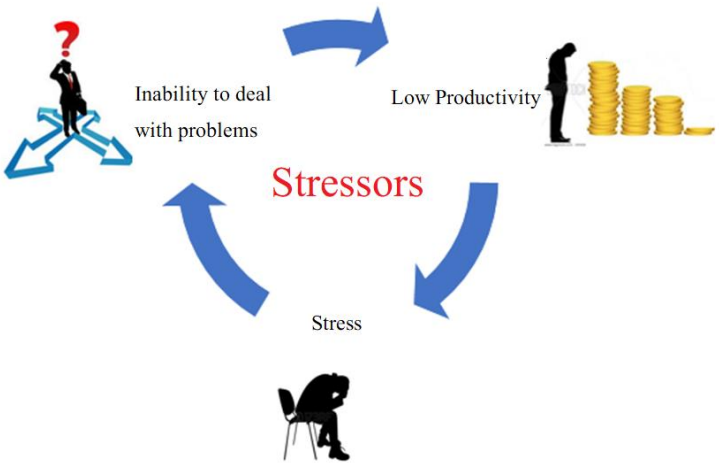
Key points to include:

- Stressful conditions can cause change in people's mood- they can feel very sad and hopeless
- Over time, if this mood does not improve people can feel a lack of energy and motivation to do things
- People might find they do not enjoy things they used to enjoy
- This can start a cycle, called the vicious cycle of adversity/low productivity

Show and explain the Vicious cycle of adversity/low productivity

- Show participants the slide of the vicious cycle of adversity/low productivity
- Slowly explain each part as you point to the picture: low mood leads the person to stop doing things they used to do that causes their mood to worsen more. When the mood worsens, it makes it harder to do things so they withdraw more.

Vicious cycle of adversity/low productivity:



- Invite participants to share stories of their low mood, lack of motivation, being stuck in this cycle etc.

"Does this cycle or what I described about (Ahmed's case) sound familiar to any of you? Would anyone like to share their experiences of feeling sad (or depressed) and not being able to do activities?"

Prompt questions to emphasise the vicious cycle of adversity/low productivity in the person's story:

"So, when you felt sad, what specific activities did you find hard to do or no longer enjoyed doing?"

- *"Were you still able to do as much of the works or see your friends and family when you felt this way?"*
- *"When you stopped doing these things what happened to your mood?"*

2. Discuss how the vicious cycle of adversity/low productivity can be broken

- If there is time you can invite participants to suggest ideas of how this cycle can be broken.

Suggested discussion questions:

- *"Does anyone have any ideas of how the vicious cycle of adversity/low productivity can be broken?"*
- *"Has anyone been stuck in this cycle themselves and been able to break it?"*
- *"Or have you seen someone close to you stuck in this cycle?"*

- Summarize the common themes or points to participants' stories. Look for the following points to emphasize:
    - It is hard to do things when your mood is low
    - Many people do not enjoy things as much when their mood is low
    - When you do not do things, like chores, work or pleasant activities your mood doesn't improve (or worsens)
- Tell participants being active breaks the cycle
- Suggested script:

Often many people will think, 'I will start doing things again when I feel better'. Or, they think that one needs to feel energetic first to be active. Actually, the reverse is true: being active makes one feel energetic. So, many people do not start feeling better until they get active. To break this cycle, you need to start doing things again, even though you may not feel like it.

Ask the participants to name activities that they use to enjoy but did not have time or effort to do them anymore. Ask them if they miss these activities and not having these activities have added stress in their life. Make a list of such activities.

Before starting 'Get Going Keep Doing', give a brief summary of the workshop so far:

- Review Managing Stress
- Review Managing Problems (specify any points that were taught while doing review)
- Introduce Get Going Keep Doing (test participants' knowledge by asking questions about Get Going Keep Doing)

1. Briefly introduce the workshop for Get Going Keep Doing

Key points to include:

- Get Going Keep Doing, helps people start doing activities again
- Being active will improve mood.
- We will choose one simple activity participants would like to start doing again

- The activity should be something they are not currently doing or something they would like to do more often
- Give participants time to think about an activity and invite them to raise their hand to share it with the group
- Begin to select participants to share their activity if it is taking too long for people to respond
- Help participants who are unsure of what to do

- *"Is there anything you would like to do that other have already mentioned?"*
- *"Tell me what you used to enjoy doing a year ago?"*

- Only as a last resort, invite everyone to give examples of things the participant might enjoy. Ask the participant to think about these things and come back to them at the end of the discussion and ask them to choose one activity.

Suggested script:

"Thinking about the things you used to do before you were feeling this way, what is one pleasant or enjoyable activity that you could start doing again or do more often?"

Note: The activity chosen can be something the participant completes as part of attending these workshops. For example, talk to someone in the break time, walk to the group with one of the other participants who live nearby, invite one of the other participants for tea after the group. It is recommended that you begin with one activity that is not too big and easier to complete

List of possible activities for practicing Get Going Keep doing

Time to yourself

- Eat a favourite meal or food
- Read a book
- Relax and meditate
- Pray
- Cook
- Listen to music
- Sing or play music

- Dance
- Do some art (e.g., drawing, painting)
- Read magazines or newspapers
- Pick or arrange flowers
- Write a poem, journal or story
- Visit a nice place
- Look at old photos
- Weave or knit
- Go fishing

Connect

- Visit a friend or family (for a meal or an activity)
- Visit mosque or your worship place
- Call or talk to a friend, neighbour, batchmate, colleague or family member
- Invite your neighbour over for coffee or tea or share food with them
- Make a gift for someone
- Play a game with the family or a neighbour

Self-care

- Get out of bed each day at the same time you used to
- Have a bath
- Change your clothes
- Brush your hair Go for a walk alone or with friends or family
    - Try an activity you have not tried before
    - Take a walk
    - Do a household chore e.g., wash dishes, sweep the floor (choose one area), make beds, shop for food or other needs, tidy areas of the house, mend clothes etc

• Child-care activities

• Read mail

• Gardening

• Help children with school work

• Build or repair structures, furniture, part of the house and so on

- Tasks needed for community organization etc.
- Ask participants what they would need to do in order to complete the activity selected (i.e., all the steps involved)
  - E.g., meeting with a friend might mean getting dressed, getting baby ready to take out, and walking to meet her etc. before actually doing the activity. This might be too hard for someone to do who is feel very depressed and an easier activity should be chosen first
- Simple and easier activities might include those that can be done in the home or that do not need a lot of resources or other people.

  Examples:
  - Reading Books,
  - Sports,
  - Listening to music,
  - Singing,
  - Dancing,
  - Playing with a young child,
  - Walking around the neighbourhood,
  - Looking at nature in the back garden,
  - Taking a bath,
  - Brushing one's hair etc.

Prompt Questions:

- *"Close your eyes and imagine when you last did this activity. Can you tell me in as much detail all the things you did and I will write these down? These will be the steps you need to take to complete the activity."*

- *"What are the material things you will need in order to complete the activity?" (E.g., shoes, furniture, people, food etc.)*

TRAINERS' NOTES ON GET GOING KEEP DOING

In case of low mood, lack of energy or stress, (low productive mode) it is important to break the overall task down into smaller and more manageable steps. Remember, this is so the participant does not feel overwhelmed with the task and to make sure they experience some success in completing it. This will encourage self-confidence and begin to improve their mood.

One example which we used during our workshop was that somebody who would like to read books, is not able to find a time to continue reading books. It was a stressful working environment with problems at home. The solution was found in scheduling short sessions of time for reading and sharing the results of the reading with his partner.

Another example with the task, 'cleaning your apartment'. Breaking this task down by choosing small sections of the apartment to clean (for example, cooking area, sleeping area and so on) is more manageable and achievable for the participant.

Help participants schedule in the steps to complete the activity

- Discuss what each participant can do, on what day and at what time (get participants to be as specific as possible)
    - You can write these plans down so you can remember for the review in the next workshop
- As with Managing Problems, discuss with the group how participants can remind themselves to complete the steps over the next week

Remind participants that it might be difficult starting the activity

- Encourage them to keep going with it even if they do not feel like it
- Let them know that their mood might not improve straight away but that it will if they keep doing

For many people it is starting the activity that is the hardest. However, I can assure you that many people find that once they start doing activities it gets easier to keep going.

Managing Stress

1. **Remind participants why this strategy is helpful**
    - It helps the body relax which can help you feel less stressed; remind participants of the tight coil that this strategy is aiming to loosen.
2. **Lead the group in Managing Stress**
3. **Steps to follow:**

1. Participants relax their bodies (move arms and legs, rock head side to side, roll shoulders back)
2. Instruct participants to breath from their stomach (balloon in their belly)
3. Once everyone is comfortable with step 2, begin counting 3 seconds for the in-breath and 3 seconds for the out-breath. Continue for a minute
4. Stop counting and encourage participants to count themselves or keep the rhythm of slow breathing going (if you have a clock, you could encourage participants to follow the ticking of the seconds to keep the rhythm slow)
5. Continue for several minutes

1. Ask participants to say one thing they learnt in today's workshop that has been helpful
2. Remind participants to regularly practise Managing Stress
3. Remind participants to complete their Managing Problems action plan
4. Remind participants to complete their Get Going Keep Doing activity

Chapter 7

WORKSHOP 4 -STRENGTHENING YOUR SOCIAL SUPPORT

Content	Time	Moderator	Venue, participants and tools required
Plenary Session (Session 1) in the Houses			
Review of Workshop 3 Workshop objectives Three Scenarios Understanding networks and their significance	40 minutes	Trainers Supported by facilitators	Larger Group Setting Presentations
Session 2 in Sub Groups			
Identification of network member/partners	10 minutes	Subgroups led by 2 facilitators each	Subgroups of 10-12 Handouts to be used as pointers Each subgroup would need flip charts and markers
Making a network for addressing the problem	20 minutes		
Session3 in the Houses			
Presentation by participants in larger groups	20 minutes	Larger Group Setting	Subgroups Presentations
Ending the workshop Stress management	5 minutes		

Preparing for Workshop 4
• Review Managing Problems slides • Review Vicious cycle of adversity/low productivity • Read Helpful Hints for Managing Problems (Appendix A)

Welcome

Welcome the group back

1. Tell participants the plan for today's workshop:
    - Review of Managing Stress practice
    - Review Managing Problems &Get Going Keep Doing
    - Introduce final strategy to improve/strengthen your supports
    - Practice Managing Stress to end the workshop

Managing Stress Practice Review

Invite participants to share their experiences of practising Managing Stress during the last week

- *How did people go practicing Managing Stress?*
- *What happened when you practiced Managing Stress?*

- *"Does anyone else have any ideas about what (name) could do to overcome this problem?"*
- *"Have others had similar problems? And what did you do?"*

- Be sure to watch the time so ask participants to keep their stories short so everyone can have a turn at sharing

- Respond to and manage any difficulties participants had in completing their activity
    - See Helpful Hints for Get Going Keep Doing below (Appendix A)

- *"What kinds of difficulties did people have completing their Get Going Keep Doing activity over the last week?"*
- *"Of those of you who had difficulties completing your activities would you like to share what happened so we can work through the problems as a group?"*

Managing Problems Review

- Invite participants to share their experience of completing their Managing Problems Action Plan during the week
    - Before asking for experiences, educate participants about home practice
        - *There are 3 possible experiences people will have with any home practice:*
            4. *Successfully completed their action plan*
            5. *Tried to do action plan but it was unsuccessful*
            6. *Unable to do action plan*
        - *All experiences are okay and important to share (especially normalize experiences 2 and 3 above)*
        - *Everyone can learn from other participant's experiences, especially from experiences that were unsuccessful*
    - If possible, review at least 3 participants' action plans in the larger group

- *Did anyone solve all or part of their problem by completing their Action Plan this week?*
- *Of those of you who completed their Action Plans for Managing Problems, would you like to share what happened?*

Be sure to watch the time

- **Respond to and manage any difficulties participants had in completing their Action Plan**
    - See Helpful Hints for Managing Problems (Appendix A)

- *"At some point in this program you will probably all encounter a problem in completing your action plan. Perhaps the action plan was unsuccessful in managing your problem or maybe you were unable to carry out your plan. These experiences are okay and do not mean you have failed in anyway. They are also important learning opportunities for us all.*
- *So did anyone have any problems doing their action plan in the last week?"*
- *"What kinds of difficulties did people have completing their Managing Problems Action Plan over the last week?"*

- *"Of those of you who had difficulties completing your Action Plans, would you like to share what happened so we can work through the problems as a group?"*

Before starting 'Strengthening Social Supports' give a brief summary of the workshop so far:

- Reviewed Managing Stress
- Reviewed Managing Problems (specify any points that were taught while doing review)

Strengthening Social Supports: Education & Case Example

Purpose of 'Strengthening Social Supports':

- Having good support helps people cope better in adversity
- Can help people not become as stressed, depressed etc.
- Can help people better manage practical problems
- Helps people feel they are not alone in the problems they are experiencing

Steps to 'Strengthening Social Supports':

- **Give brief definition of Strengthening Social Supports**

Suggested script:

"Strengthening Social Supports is all about connecting with others to be more supported and able to manage problems better."

Example

Amina of PAS was stuck in a small station in rural Sindh. She did not have many friends and could not share problems she was facing at work with anyone. Recalling the workshop, "Strengthening social support" she realized that many problems seem so much bigger if you try to deal with them on your own. She remembered times when she had problems with her career and she spoke to her colleagues or mentors about these problems and it was lot easier to manage them. She formed the habit of regularly calling her batch mate from other services on WhatsApp. Sometimes she would discuss problems and ask for their help. They were able to give her practical advice. Sometimes they just chatted. She also asked her mother to come to stay with her for a little while. This helped

her in the house. Her mother gives her practical support over a short period of time and she also felt that presence of mother allowed her to have somebody to talk to which made her feel more confident to deal with the stressful issues in her career.

Introduce Strengthening Social Supports as the fourth Psychosocial Skill for civil servants

- Refer to previous discussions of other strategies that included social supports (e.g., a solution for Managing Problems may have included getting support from someone or an organization; Get Going Keep Doing activity may have involved socializing with others)
- **Encourage discussion about what social support is and how it can be helpful**
    - Ask participants to give examples of times when social support has been helpful for them

Suggested prompt questions:

- *"When you think about social support what comes to mind (what do you think of)?"*
- *"Would anyone like to share a time they received support from someone or an organization to deal with a problem? And did it help? How so?"*
- *"What has been people's experience coming to this group and sharing their problems with others? Have people found it helpful? How so?"*
- *"How did (case example's name) say seeking supports helped her in the past?"*

- *"Are there other ways you think strengthening social supports might help people affected by stressful conditions?"*

- *"How do you think it might help you?"*

Key points to include:

- There are many forms of social support:

-Having a friend or family member listen and validate the person's concerns and emotions rather than be dismissive and not show any care

-Getting help to complete a difficult task or providing a way of completing a task (for example, driving them somewhere, borrowing something from them and so on)

- Spending time with others but not necessarily talking about problems (for example, sharing a meal)

- Helping other people (while not forgetting to take care of oneself)

- People feel more confident and hopeful about dealing with problems and adversity when they are supported
- Problems can feel more manageable when people are supported
- Sharing problems with others can help them feel less burdened
- Hearing other people's problems can help people feel they are not alone in their suffering

Consider sharing a proverb that reflects the idea of social support: *-A problem shared is a problem halved - Shared joy is a double joy; shared sorrow is half a sorrow (one is above, --- is eleven)*

- **Discuss obstacles to strengthening social support**
    - Tell the group that it can be difficult to seek out support for different reasons
    - Read a case example that highlights some of these obstacles. In our example, Amina felt embarrassed and apprehensive about sharing career problems with her colleagues. She was concerned that they would see her to be a weak officer and would be disappointed with her if she continues to seek support from them. They would feel that she is not capable of dealing with her problems on our own. She also felt that they would later use this information against her.
    - Ask the group what was Amina's difficulties in strengthening her social support
    - Invite participants to share their personal difficulties in seeking support

Suggested question:

- *"What has made it hard for you to get support from others in the past?"*
- *"What do you think might make it hard for you to strengthen your social supports this week?"*

    - Give examples to help participants identify personal obstacles if needed:
        - Personal feelings: shame, embarrassment, low mood, anxiety or worry
        - Negative expectations: It won't work; There's no point; I'll just burden others

- Isolation: some participants might not have many people they can get support from
- Difficulties trusting others (this is likely to be an obstacle for people who have experienced intimate forms of trauma, such as sexual assault and torture, betrayal, breach of confidentiality.)

Suggested dialogue if a participant is very unsure about strengthening their social supports:

"*Many people feel unsure about talking with others about their problems or asking others for help. One reason is because they are worried, they will burden the other person with their problems or others might not be sympathetic. However, this is often not true. People will often share problems when they know their friend would also tell them about their own problems. Or they might ask for help in return. This might be because that friend is also experiencing similar problems. Rarely will one person only talk about their problems or ask for help. It can also be helpful hearing other people's difficulties so you get a perspective about your own issues especially if you think you are the only one experiencing a problem.*

"*Another reason people do not get support from others is because they have no one they can trust. If you think you do not have anyone you can trust, shall we discuss more together on finding someone that you can trust?"*

Ask participants about obstacles to strengthening social support. What holds them back from asking for others support. Make a list of these issues. Ask the participants in whether in their past experience they felt that some of these concerns were over rated.

Strengthening Social Supports:

- **Tell participants the next half hour will be spent helping them plan to strengthen their social support**

Ask the participants to name possible sources of social support.

Make a list of those.

Ask if all of them would be suitable in all situations or they vary from situation to situation. Ask them how they would plan to use these social supports. Whether they would incorporate this into their daily/weekly schedule.

Ask them whether any social media can be used for social support.

Suggested questions:

- *"Does anyone have an idea of how they would like to strengthen their social support?"*
- *"Is there a social support you had in the past that you could start to strengthen again?"*
- *"Is there someone or an organisation you could get support from?"*

Suggested questions:

" What would be the first step to strengthening your support?"

- **Rehearsing (role playing) what to do:**
    - Participants form pairs and practise what they are going to say to the person or organisation
    - If you do not have time, encourage participants to meet with each other to practise what they are going to say or do this on their own
    - Tell participants the more confident they feel in completing the task, the more likely they will achieve it
    - Role play;
        - Talking about a practical problem and how that makes them feel
        - Talking about being involved in this program
        - Talking about any specific problem
        - Asking to meet with a friend/family member/person
        - Asking for help with a practical problem

- Help participants schedule in the steps to complete the social support activity
    - Discuss what each participant can do, on what day and at what time (get participants to be as specific as possible)
        - The trainer should write these plans down for the review in the next workshop

As with Managing Problems and Get Going Keep Doing, discuss with the group how participants can remind themselves to complete the steps over the next week

Managing Stress

1. **Remind participants why this strategy is helpful**
    - It helps the body to relax which can help you feel less stressed; remind participants of the tight coil that this strategy is aiming to loosen.
2. **Lead the group in Managing Stress**

Steps to follow:

1. Participants relax their bodies (move arms and legs, rock head side to side, roll shoulders back)
2. Instruct participants to breath from their stomach (balloon in their belly)
3. Once everyone is comfortable with step 2, begin counting 3 seconds for the in-breath and 3 seconds for the out-breath. Continue for a minute
4. Stop counting and encourage participants to count themselves or keep the rhythm of slow breathing going (if you have a clock, you could encourage participants to follow the ticking of the seconds to keep the rhythm slow)

Chapter 8

WORKSHOP 5 -STAYING WELL AND LOOKING FORWARD

Content	Time	Moderator	Venue and participants
Plenary Session (Session 1) in the Houses			
Review of Workshop 1- 4 Workshop objectives Staying calm and looking forward What makes you happy and what sad Triangle of peace	30 minutes	Trainers Supported by facilitators	Larger Group Setting Presentations
Session 2 in Sub Groups			
Preparing future plan of action	25 minutes	Subgroups led by 2 facilitators each	Subgroups/Handouts to be used as pointers Each subgroup would need flip charts and markers
Session3 in the Houses			
Presentation of future plan in larger groups	20 minutes	Larger Group Setting	Subgroups Presentations
Ending the workshop	5 minutes		
Stress Management exercise Evaluation and feedback			

Preparing for Workshop 5

- Go through the presentations
- Read Helpful Hints (Appendix A)
- Read the examples used in previous workshops in Appendix B

Welcome

Welcome the group back

- **Congratulate participants for reaching the end of the program**
    - Give a positive message about participants' achievements and efforts
- **Tell participants the plan for today's session:**
    - Review of Managing Stress practice
    - Review participant's practice of Managing Problems, Get Going Keep Doing & Strengthening Social Supports
    - Review the aims of all the strategies of psychosocial skills development workshops
    - Discuss how to stay well and plan for the future

Review of Home Practice Tasks

- **Review all home practice tasks for all strategies**
    - Review the practice of each of these strategies separately- be sure to manage time spent on each

Suggested questions:

"Would people like to share what steps they were able to complete for Managing Problems this week?"

-Ask the same question for each strategy separately

- Be sure to watch the time so ask participants to keep their stories short so everyone can have a turn at sharing

- **Respond to common problems participants experienced and ways to overcome these**

- *"What kinds of difficulties did people have completing their (name a strategy) action plan over the last week?"*
- *"Of those of you who had difficulties completing your activities would you like to share what happened so we can work through the problems as a group?"*

Review

Purpose of the Review:

- Helps participants confirm and strengthen what they have learned (The more participants talk about the strategies discussed, the more likely they will be able to remember them after the group has finished.)
- Opportunity for facilitators to correct any misunderstandings

Steps to 'Review':

- **Tell participants we are going to review Psychosocial skills development strategies**
    - So, they can remember them all when the group has finished
    - So, they feel confident in knowing how to practice each strategy
- **Allow for time to correct any incorrect beliefs about each of the strategies or answer any questions**
    - Be sure you are familiar with the purpose of each strategy and how it is completed so you can identify any incorrect beliefs
    - Examples of common incorrect beliefs like:
        - Managing Stress is only used when you feel scared or stressed
        - Managing Problems helps to solve emotional problems
        - Get Going Keep Doing is only about doing more things around the house

- Strengthening Social Supports is only about telling other people about your problems

Purpose of 'Staying Well' Workshop:

- This workshop provides an opportunity to review of the stress management and problem management tools during the workshop and discuss their applicability to their practical life.

- Participants can look back and feel proud of their achievements
- Opportunity to tell participants what to expect when finishing the group
- Help participants to continue to stay well after Group finishes by preparing the best response to future problems

Steps to 'Staying Well':

- **Begin by again congratulating participants for their efforts and achievements**

Suggested script:

"As you are aware, today is our last workshop and I wanted to start by congratulating you on reaching this stage. You have shown a lot of courage and effort to talk about some difficult topics and face these head on. Are there areas that you think have improved since starting the program?"

- **Review participants original goals for the program**

Suggested script:

"Can anyone remember what they hoped to get out of these workshops at the very beginning?"

"What you wanted to change in your mood, your behaviour, your life etc.?"

- Read out from the notes on participants' goals in Workshop 1
- Discuss goals participants have achieved (whether they are ones they suggested in workshop 1 or not)

Suggested script:

"Have you been able to achieve these goals, either partly or completely?"

"Can you tell me what has changed in your life as a result of these workshops

- **Emphasise the importance of practising strategies even when participants are not having problems**

Key points to include:

- Learning psychosocial skills is like learning a new language- you need to practise it every day if you want to speak it fluently
- The more you practice the strategies, the more likely you will stay well
- If you face a difficult situation in the future, you will have a better chance of managing it well if you have been practicing the strategies regularly
- Participants have all the information to use the strategies on their own
- There is no guarantee you will not face problems in the future

- **Discuss potential future stressors or problems participants might face**

Suggested questions:

- *"What are some difficulties or problems you can imagine facing in the future?"*

"…such as money problems, problems with your physical health, problems with family?" career?

- *"What kinds of problems have you faced in the past that you might have to face again?"*

- Give examples to prompt them if needed
    - anniversary of the death of a loved one
    - family conflicts
    - physical health problems
    - emotional health problems, such as depression or stress
    - droughts or floods in the next workshop
    - community violence or war
    - problems with job or money
    - being forced to leave one's home
    - Political Pressure
    - Difficult Bosses

- Frequent Transfer
- Corrupt Subordinates
- Disagreeing with policy decisions
- Late sitting
- Work life balance
- Time limitations
- Lack of resources

Suggested script:

"*It is not uncommon for participants to experience difficulties in the future. In fact, we will all experience some kind of stress or difficulty in life. However, it is important to respond to these difficulties in helpful ways so they do not become overwhelming."*

- **Help participants identify which strategies they could use for each potential future stressor they might face**
    - Refer to examples of future stressors participants have already identified
    - For example:
        - Feelings of stress, anger, anxiety and physical problems suited to Managing Stress
        - Career issues, unemployment problems suited to Managing Problems
        - Feelings of depression, low motivation or hopelessness, or low productivity suited to Get Going Keep Doing
        - All problems are suited to Strengthening Social Support
    - Also make sure you mention that if problems continue even after they have tried to practice these strategies, they should seek help.

Suggested script:

"What do you think you can do if you experience a very difficult situation or notice negative feelings in the future?"

- **Suggest the group as ongoing support for participants**
    - Suggest that relationships formed in the group can be helpful for participants afterwards
        - Help them remember strategies

- A good source of social support
- Other participants can help watch out for symptoms that someone is not staying well

- **Discussion: How to remember to practice strategies**
  - Discuss what participants can do after the group to remind them to continue practicing
  - You can give each participant a copy of the presentations to act as reminders of the strategies

Looking Forward

Purpose of this 'Looking Forward' workshop:

- Help participants prepare for the future
- Help participants review old personal goals not achieved in these workshops
- Help participants think in what ways they would like to keep improving (i.e., name new goals)

Steps to 'Looking Forward':

1. **Review participants' goals that were *NOT* achieved**
   - Consider whether these goals are realistic
     - Think about whether the goals can be achieved in a short timeframe?
     - Think about whether the goals could have been achieved through this program? Or are they goals that are not suited to these strategies?
       - Many medical/physical problems cannot be helped with these workshops

   Some goals that require another person to change their beliefs or behaviours cannot be achieved if this person does not want to change
2. **Ask participants if they have any new goals, they would like to set for themselves**
   - Help participants identify which strategies would be helpful to achieve all goals (i.e., those not achieved and new ones)
     - *"Which strategy would be best suited to dealing with this problem?"*
     - If you disagree with their response, suggest the strategy you think is better and give reasons for this
   - Consider what steps the participant could take to begin to achieve these goals

Suggested questions:

- *"When can you start completing this (name of strategy) to help achieve your goal?"*
- *"What resources do they need? For example, people you need to talk to, equipment or information?"*
- *"What is the first thing you can do to starting to achieve this goal and when can you do this?"*

Managing Stress

3. Remind participants why this strategy is helpful

- It helps the body to relax which can help you feel less stressed; remind participants of the tight coil that this strategy is aiming to loosen.

4. Lead the group in Managing Stress

Steps to follow:

5. Participants relax their bodies (move arms and legs, rock head side to side, roll shoulders back)
6. Instruct participants to breath from their stomach (balloon in their belly)
7. Once everyone is comfortable with step 2, begin counting 3 seconds for the in-breath and 3 seconds for the out-breath. Continue for a minute
8. Stop counting and encourage participants to count themselves or keep the rhythm of slow breathing going (if you have a clock, you could encourage participants to follow the ticking of the seconds to keep the rhythm slow)

Feedback forms distributed and collected.

APPENDIX A

HELPFUL HINTS & FACILITATORS' NOTES

Helpful Hints for Managing Stress

Participants might have a range of different problems when trying to practise Managing Stress on their own. Below is a list of common problems and possible solutions you can try.

Always discuss how to manage any problems or complaints a participant raises with practising any strategy in your supervision sessions.

Problem	**Solution**
The participant is too concerned about breathing correctly (e.g., keeping to the three seconds in and out, breathing from their stomach).	• Encourage the participant not to be worried about following the instructions exactly. • Help them to understand that the main aim is simply to slow their breathing down in the way that best suits them, even if it means that they are not keeping to the counts of three or even if they are not breathing from their stomach. • Once they have mastered how to slow their breathing down, they can try to use the counting or breathe from their stomach
The participant cannot slow their breathing down when they are at the peak of their anxiety or stress.	• Say that this would be very hard for anyone to do straight away, even a trainer. • Spend some time helping the client to identify early signs that they are beginning to feel anxious or stressed so they can start slow breathing earlier.

	• If this is too difficult, help them to schedule specific times throughout the day to practise slow breathing so they learn how to use it before they get too anxious.
Focusing on breathing makes the participant speed up their breathing and feel more anxious.	• Help them to focus on a ticking clock and breathe to the count of the clock rather than focus only on the breathing (or a musical beat in a song).
They might also experience feelings of light-headedness or dizziness, or feel they are losing control.	• Remind them that these sensations are safe and they are not losing control. • Encourage them to focus just on blowing all the air out (just the breathing out) and letting the in-breath come naturally (or by itself). • Then they can return to focusing on the whole process of breathing (in and out).

FACILITATOR NOTES ON GET GOING KEEP DOING
In situations of low mood, lack of energy or stress, it is important to break the overall task down into smaller and more manageable steps. Remember, this is so the participant does not feel overwhelmed with the task and to make sure they experience some success in completing it. This will encourage self-confidence and begin to improve their mood. For example, 'doing embroidery' might feel overwhelming for a participant. So, you can break this task down and start with just getting all your materials out and putting them in a place where you would feel comfortable to do your embroidery. The participant does not need to even start doing any embroidery yet. Then on another occasion they might just spend 10 minutes on the embroidery and build up from there.

Another example with the task: ‘cleaning your apartment’. Breaking this task down by choosing small sections of the apartment to clean (for example, cooking area, sleeping area and so on) is more manageable and achievable for the participant.

Helpful Hints for Get Going Keep Doing

Participants might have a range of different problems when trying to carry out their Action Plan for Get Going Keep Doing.

During supervision always discuss how to manage any problems or complaints a participant raises with practising any strategy.

Problem	**Solution**
The participant did not feel like doing the activity when it came time to do it,	This is probably the most common difficulty that participants will have. First let participants know that this is a very common problem for people to have when they first start Get Going Keep Doing. Then do the following, • Show them the inactivity cycle poster • Remind them that they will probably never feel like doing the activity while they feel depressed, but this is what keeps the inactivity cycle going • Remind them that they have to start doing some activity in order for their mood to improve. Once they do this, they will start to feel like doing these things again but this takes time

	• Review the activities chosen in the workshops ○ Ask the participant what was difficult about starting such an activity. Listen for clues that tell you it is too big an activity or that it wasn't broken down into small enough steps • You can either break this activity down into smaller steps to help them get started • Or you can choose an easier activity they can do • **NOTE**: The pleasant activity can be something that is completed during the group (e.g., talk to someone in the break time)
The participant forgot to carry out their plan or they were unable to for other reasons (e.g., they became busy, they got work, other problems came up)	This is probably the second most common difficulty that participants will have. Invite the group to suggest ideas for remembering to do Action Plans. • What did participants who did complete their Action Plans do to remind themselves? • What has worked in the past if they have had to remember to do something? • What might they suggest to a friend who needs to remember to do something?

	If other things distracted the participant from doing their Action Plan, tell them the following in a gentle but firm way: • This is normal and happens to many participants • Distractions will often come up • Remind them that in Workshop 1 they discussed the reasons for and challenges to joining the workshops and they decided to do their best to engage • In order to improve the will, have to do their best to practise as much as possible between workshops • Discuss ways they might be able to make practising the strategies important in their daily life
The participant was unable to talk to someone because they did not know what to say or felt nervous	Help the participant decide exactly what they want to say to the person. Invite the group to help them decide what to say if they are unsure. Then have the participant rehearse this with you or another participant. You may have them do this several times until they feel confident.
Participants complain that their mood has not improved	This is very normal. Participants should not expect their mood to change dramatically in one week. Tell participants that feelings often take time to change. However, they will eventually change with Get Going and Keep Doing

	It is important that you encourage participants to not give up because this will certainly cause their mood to stay the same or worsen

FACILITATOR NOTES ON MANAGING PROBLEMS

Step 1: Listing problems

In the first assessment, you asked each individual to name two concerns. The first step of Managing Problems involves reviewing these concerns, asking if the participant has other concerns, and deciding whether these are solvable or unsolvable problems.

Beware of participants who feel very hopeless! They may think all their problems cannot be solved so you may have to tell them why you think a problem is actually solvable.

Unsolvable problems are those that you cannot change or have any influence or control over, such as living in a slum or having an untreatable physical illness or disability. However, sometimes there are parts of an unsolvable problem that can be changed, such as how the participant views the problem.

- E.g., someone with cancer may not be able to change their illness but there might be things they can do to help with their pain, or problems relating to accessing medical treatments. Your role is to explore with participants whether there are any parts of the problem that can be changed or influenced.

Step 2: Choose a problem

The second step of Managing Problems is to **choose** which problem the participant would like to focus on.

The participant should choose an *easy or small problem first*. It does not have to be the same problem the participant mentioned in the first assessment. Choosing a small problem will give the participant the opportunity to experience early success in the program.

However, you should try to help participants use 'Managing Problems' to tackle a bigger or more difficult problem as you progress with the programme. This is because it may be more challenging for them to properly use 'Managing Problems' without your support after completing the workshops. However, as with other decisions, you should discuss this with your supervisor – as this may not be appropriate decision to make with some participants who feel very hopeless or due to the group setting.

Step 3: Define the problem

Next, you will help participants to **define** the problem as specifically as you can.

There are a few reasons for this:

- More specific problems are easier to solve (because it is easier to think of solutions that will help solve the problem)
- The person can better judge whether their problem has been solved or influenced
- More specifically defined problems do not seem so large and overwhelming for the participant (e.g., compare "problems with my marriage" to "being irritable with my husband when he gets home from work")

Problems that are best suited to Managing Problems are those that are practical and that can be changed or reduced to some degree. A participant might say that poverty is a problem they want to change. This problem is too big and vague. You need to help the participant make it more specific and practical. Getting more information about the problem is a good way of doing this.

Suggested questions to help define the problem:

- *When is this a problem for you? In what situations does this problem happen?*
- *If I were to watch you when this problem happened, what would I see, what would you look like, what would you be doing or not doing?*
- *How would your life be different if you did not experience this problem?*
- *If you did not have this problem, how would you or I know? What would be different in the way you felt, behaved etc.?*

This step can be the most challenging for a facilitator. It is also very important to do this well, as it affects how you will teach the rest of the strategy. Therefore, we encourage you to prepare, between workshops 1 and 2, how you might define some of the problems participants have identified at the first assessment. It is useful to discuss this during supervision. For many problems, a participant might not choose the problem that you have practiced defining but at least you have had some practice defining problems as specifically as you can.

Step 4: Possible Ways of Managing the Problem

Once the problem is defined, encourage the participant to think of as many solutions as possible to solve or manage, all or parts of this problem. Also help participants to think about their personal strengths, resources and support they might be able to use.

1) <u>This step is *not* about giving advice:</u>

Many participants will need some help thinking of possible solutions, particularly if they are feeling hopeless. The temptation for you will be to tell participants different solutions, especially if you are feeling impatient because you are concerned about time.

However, since these workshops act like a training program for participants, it is important that you guide the participant by suggesting general ideas that can help them generate more specific solutions. This will help empower participants so they are not dependent on you to manage problems in the future., a participant is feeling overwhelmingly stressed about a problem with her children. The facilitator encouraged her to think about seeking support from with someone she trusts. It is a preferred method of encouraging the participant to think of people she can get support from instead of telling her to talk with a specific person, such as her mother, about the problem. The aim of this step is to help the participants come up with their own ideas.

2) <u>Be aware of personal values:</u>

This is also a time when you need to be careful that you are not allowing your personal values to interfere. For instance, you may disagree with the values of the possible solutions participants are considering (for example, talking with a specific religious leader r, cheating to complete a work-related

task, refusing to help someone), or you might want to suggest a solution that is based on your value system and not the participant's.

It is very important that during the programme you put aside your personal values and help the participant to make decisions based on their personal values and beliefs. Be reassured that this is difficult to do for facilitators! However, it is very important for you to respect participants and not argue with their personal values.

When you find yourself disagreeing with a participant's solutions it is okay to talk about this in supervision.

3) Solutions that fix the entire problem

At this stage, it is also important that the participant does not become too concerned about only coming up with solutions that will completely fix the problem. This is often when many participants get stuck when they try to deal with an issue by themselves. The aim at this stage is to think of any solution, no matter how effective such solution is in solving the entire problem or even just part of it.

Remind participants they are not deciding if the solutions are good or bad in this step. Participants are only required to think of as many solutions as possible regardless of how good they are. You might even use humour and offer silly suggestions to show this point.

Feelings of hopelessness:

Participants who are depressed or who are feeling excessively hopeless may have a lot of difficulty thinking of possible solutions. This is because they often think nothing will get better and they have a lot of doubt about their abilities to change their situation. You can use a number of questions to encourage responses from the participant, including:

- Asking them to think of solutions that might work for a friend in a similar situation, but who does not feel depressed.
- Asking them what they have tried in the past (regardless of whether it has worked or not)

- Give broad or vague ideas – e.g. *"Some people have found talking to others can be helpful. Does this sound like a solution you could use? Who could you talk to? What could you say or ask that might help solve part of the problem?"*

Step 5: Decide and choose

Once you have exhausted all the possible solutions with participants, this is when you help them **evaluate** each solution. This means considering how effective and helpful each solution might be. You will help the participant choose only those solutions that are helpful in managing the problem.

Short- and long-term consequences:

In evaluating solutions, think about both the short- and long-term consequences of different ideas. For instance, choosing to not go out (isolate oneself) to deal with difficult memories of a loved one who has died might help with their emotions in the short-term. However, this is an unhelpful long-term solution as it can cause other problems, such as depression.

Unhelpful solutions:

When the participant chooses a solution that is clearly unhelpful, you can be more direct with them. An unhelpful solution would be one that causes significant problems for their physical and/or emotional wellbeing, for their friends and family members, or for their work and/or social life. examples are quitting CTP or your career.

Other examples of unhelpful solutions:

- Becoming physically aggressive
- Using drugs
- Carrying out illegal or very dangerous activities

Achievable solutions:

You should help participants consider how achievable it is to carry out each solution. While theoretically a solution might be very effective, if the participant cannot complete it due to lack of resources, it is not a good solution.

Step 6: Action plan

Spend a good amount of time helping participants design an **action plan** to carry out the solution.

This includes:

- breaking the solution into small steps
    - E.g., finding work might involve getting information about what work is available, learning about what is needed for different jobs, reviewing and, for some jobs, updating letters of recommendation
    - *What would be the first step to carrying out this solution?*
    - *Close your eyes and imagine as vividly as you can, that you are completing this solution now. Tell me in as much detail everything you do in order to carry it out.*
- Helping participants choose a specific day and time to carry out each task
    - suggesting reminders to help make sure participants complete the desired tasks (this can be a group discussion as other participants may have some good ideas) E.g., using alerts on a mobile phone, coinciding tasks with community activities, meal times, or having a friend or family member remind them, are all good ways of helping the participant complete the tasks

If a solution involves talking to someone else and the participant does not feel confident about this, role play (or practise) this interaction with the participant. This can be a good way of helping them practise what they would say if their plan is to ask for something or talk to someone. It can improve their confidence and the chances of them carrying out the plan.

Step 7: Review

In the next workshop, you will spend time **reviewing** how things went in completing the planned tasks. Discuss and manage any difficulties that arose in completing the tasks so participants can spend the following week trying to carry out the desired tasks again. If participants managed to complete the tasks,

you may talk about what next steps they need to carry out to continue managing the problem if applicable.

Reviewing is also important in increasing the participant's self-confidence as well as showing them that you believe completing these tasks is important and that you care about whether the participant can get them done. This helps build the relationship and keeps participants responsible for making efforts to practice the strategies outside of the group sessions.

It is important for facilitators to know that not all problems will be solved through Managing Problems. If a participant's problem has not been solved it might be due to several reasons (e.g., the problem is not solvable, the problem is too big, Managing Problems is not the right strategy for this problem).

Helpful Hints for Managing Problems

Participants might have a challenge when trying to carry out their Action Plan for Managing Problems.

During supervision, always discuss how to manage issues a participant raises with practicing any strategy.

Problem	**Solution**
The participant forgot to carry out their plan or they were unable to for other reasons (e.g., they became busy, they got work, other problems came up)	This is probably the most common difficulty that participants will have. Invite the group to suggest ideas for remembering to do Action Plans. • What did participants who completed their Action Plans do to remind themselves? • What has worked in the past if they have had to remember to do something? • What might they suggest to a friend who needs to remember to do something?

	If other things distracted the participant from doing their Action Plan, tell them the following in a gentle but firm way: • This is normal and happens to many participants • Distractions will often come up • Remind them that in Workshop 1 they discussed the good and less good things about joining the workshops and they decided to do their best to engage in these workshops • In order to improve they will have to do their best to practise as much as possible between workshops • Discuss ways they might be able to make practising these strategies important in their daily life
The participant was unable to talk to someone because they did not know what to say or felt nervous	Help the participant decide exactly what they want to say to the person. Invite the group to help them decide what to say if they are unsure. Then have the participant rehearse this with you or another participant. You may have them do this several times until they feel confident.
The participant's problem did not change or worsened after they carried out their Action Plan	In this situation, first let them know that sometimes this can happen but it might not be because they did anything wrong or because Managing Problems does not work Then do the following,

	• Get as much information about what the participant did (their Action Plan) and what happened
	  ○ You might be able to identify what went wrong from listening to details
	  ○ You might find out that the problem they are wanting to solve is not solvable and they need to choose another problem (e.g., if the solution to the problem relies on another person changing their behaviour, such as drinking)
	• Invite the participant to first guess what they think went wrong
	• Then invite other participants to suggest what might have gone wrong
	• Decide whether the problem is still solvable or unsolvable
	• If still solvable, go back to step 3 and make sure the problem has been defined as specifically as possible
	• Ask the group to think of as many possible solutions to the problem
	• Ask the participant and the group to choose the best solution
	• Have everyone help the group to develop a new Action Plan)
	• Help the participant decide when they will carry it out

	Sometimes Managing Problems is not the best strategy to address the problem. It can be helpful to wait and see if any of the other strategies help to manage the problem.
The chosen problem was too big	Big problems are hard to manage! It is important to help participants choose a problem that is manageable. Sometimes this means breaking down the problem into smaller parts and just choosing one of these parts to work on. Big problems that should be broken down further include: • Time management can be broken down into, for example, scheduling time, regular lunch breaks, and not bringing work home • Relationship with husband may be broken down to reducing arguing with husband, planning for quality time, etc. • My child's behaviour can be broken down to reducing the child's hitting, reducing the child's yelling, etc. See Facilitators' Notes for Step 2 (above) for more information

Helpful Hints for Strengthening Social Supports

Participants might have a range of different problems when trying to carry out their Action Plan for Strengthening Social Supports.

Always discuss how to manage any problems or complaints a participant raises with practising any strategy in your supervision sessions.

Problem	**Solution**

The person or organisation the participant tried to seek support from was not available or not helpful	Sometimes this will happen. It is important that participants do not feel hopeless about this and that they do not give up on seeking support.
	
	• If availability is an issue: Try to get as much information from the participant about why the social supports were not available
	  ○ You might decide together that if the participant keeps trying at different times the person might be available
	• If helpfulness is an issue: Try to get as much information from the participant about why the social supports were not helpful
	  ○ Was it because the participant did not communicate clearly what they wanted? If so, rehearse a better way of saying what they need
	  ○ Was it because the support person was unable at that time to give them support? If so, the participant might be able to try again at a different time
	  ○ Was it because the support person is not able to provide that kind of support? If so, decide on someone else the participant can seek support from. Also, this person might be able to offer a different kind of support.

	(e.g., someone might not be able to give support about emotional problems but can be very helpful with practical problems) • From the information you have gathered decide with the participant (and group) what the new action plan is for strengthening social support
The participant forgot to carry out their plan or they were unable to for other reasons (e.g., they became busy, they got work, other problems came up)	This is a common difficulty that participants will have. Invite the group to suggest ideas for remembering to do Action Plans. • What did participants who did complete their Action Plans do to remind themselves? • What has worked in the past if they have had to remember to do something? • What might they suggest to a friend who needs to remember to do something? If other things distracted the participant from doing their Action Plan, tell them the following in a gentle but firm way: • This is normal and happens to many participants • Distractions will often come up • In order to improve the will, have to do their best to practise as much as possible between workshops

	• Discuss ways they might be able to make practising the strategies of the workshops important in their daily life
The participant was unable to talk to someone because they did not know what to say or felt nervous	Help the participant decide exactly what they want to say to the person. Invite the group to help them decide what to say if they are unsure. Then have the participant rehearse this with you or another participant. You may have them do this several times until they feel confident.

Appendix B

WHAT IS STRESS?

Definition of stress from a discussion with trainee civil servants

- Uncomfortable feelings
- Unpleasant feelings
- Psychological changes
- Physical changes
- Generic response to conditions beyond routine.
- Vicious cycle
- Loss of composure
- Not capable of dealing with the challenges
- Brings out the worst in your personality type

Effects of stress

- Loss of face
- Damage to your ego
- Suspended in reality
- Unable to differentiate between mundane and policy issues
- Loss of belief in one's own capabilities
- Pre occupation with minor issues
- Feeling out of place
- Lack of clear decision making

LIST OF PROBLEMS CAUSING STRESS IN CIVIL SERVANTS

Divided into Solvable (s) and unsolvable(u) based upon actual workshops conducted at CSA

a) Long working hours (u)
b) PT – particularly it is an issue when there is smog (u)
c) Work life balance (s)
d) Sleep issues/deprived (s)
e) Time Management (s)
f) Monotonous routine (s)
g) Balance between official and social commitments (s)
h) Unhealthy meals in mess (s)

List of Problems causing stress in Civil Servants

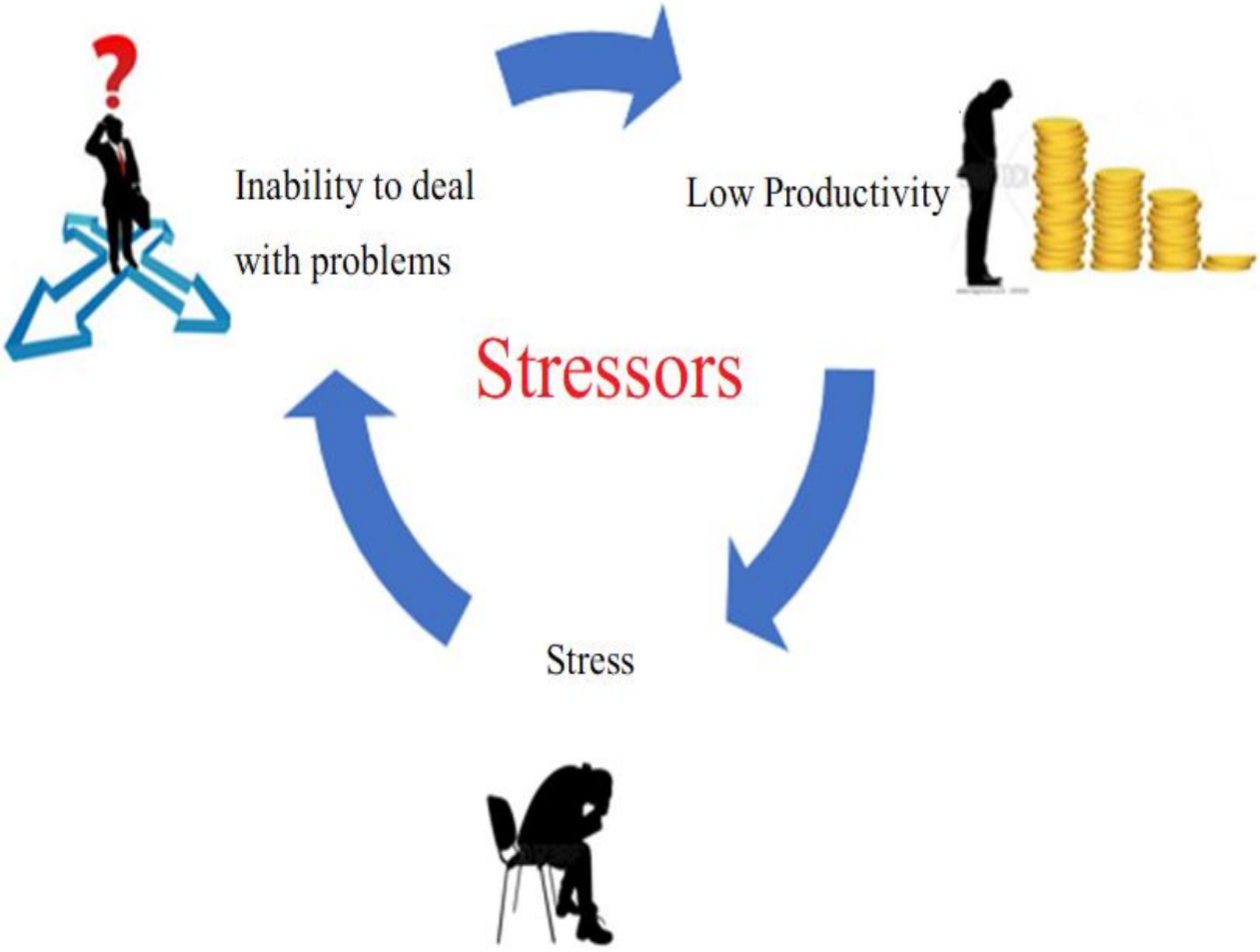
Bas**ed upon actual workshops conducted at CSA**

- Morning PT
- Class after lunch
- Can't sleep early
- Long academic sessions
- Home sickness
- Over thinking
- Smog
- Breakup
- Compromising on principles
- Work life imbalance
- Politicization of bureaucracy
- Depression of friend
- Time Management
- Scarcity of time
- Financial management in personal life
- Hair fall
- Change of life style
- Adaptability issues
- Unreasonable expectations
- Peer Pressure
- Parents and families Pressure
- Association with a global community
- Association with dramatic experience

- A shortage of resources vs expectations
- Hostage to others
- Hostage to fortune
- Not being able to follow your own dreams
- Differences in the reality and the dream of the civil services viz-a-viz salary and power
- Competition with other powerful institution
- Political pressure
- Not being able to achieve your professional dream
- Identity crises
- Loss in dream world (when I was ---)
- Unrealistic targets
- Result of genetic pre disposition
- Absence of a coping mechanism
- Feeling of hopelessness within the system
- Challenging group dynamics
- Challenging external factors in ability to manage situation

Appendix C

ADVERSITY CYCLE AND STRATEGIES TO ADDRESS IT

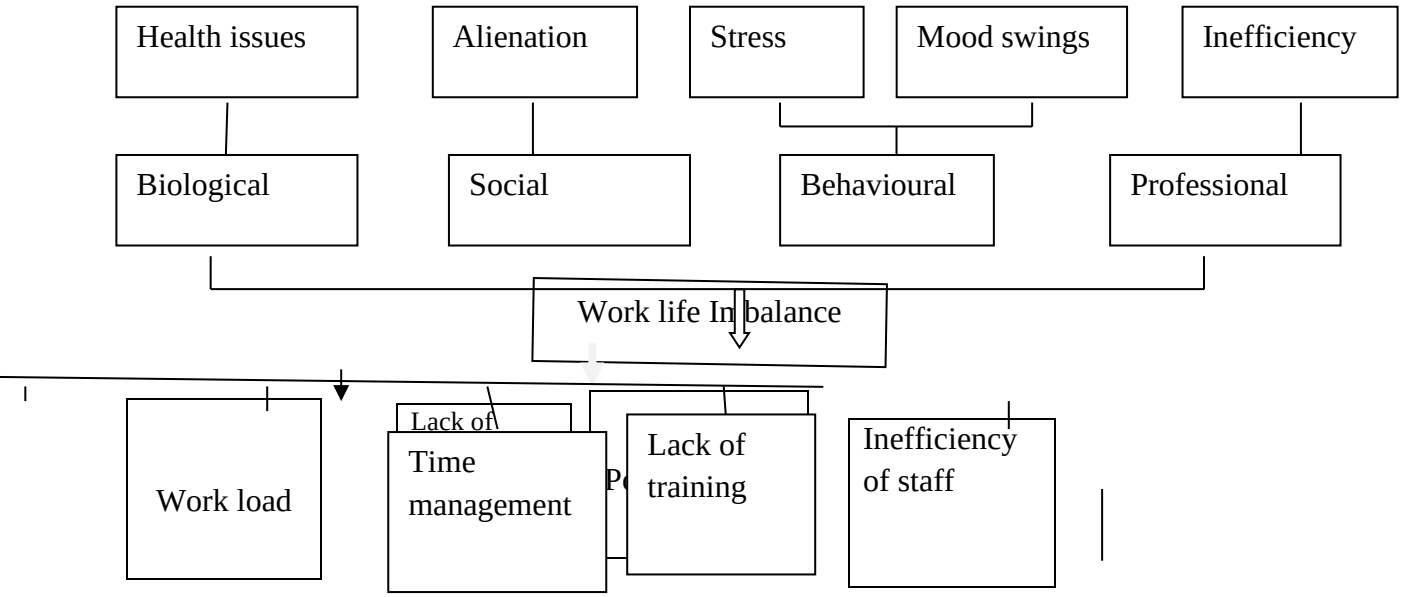


Appendix D

PROBLEM TREE EXAMPLES

Taken from the actual Workshops conducted at CSA

Example-1

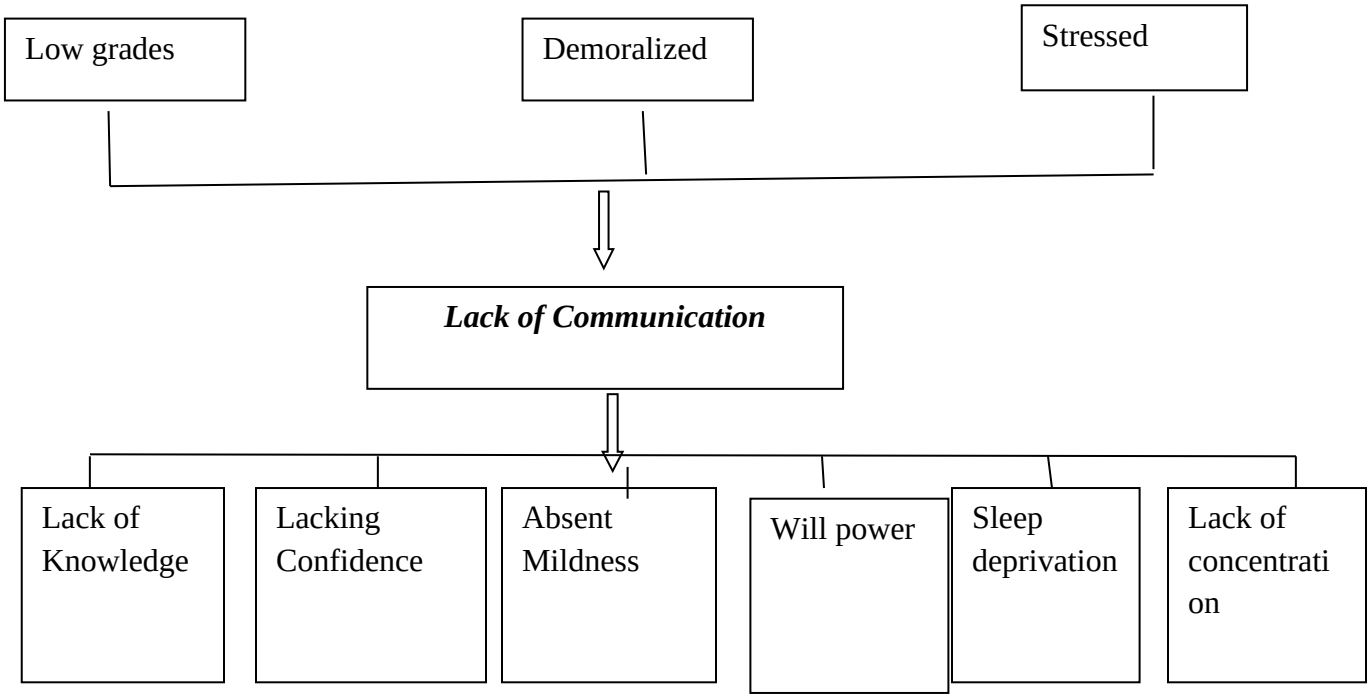


Action-Plan

i. Work delegation
ii. Prioritisation
iii. Goal Oriented Planning
iv. Training Progress/Incentives for staff
v. Agenda setting / priority setting / set a time table
vi. Master ship /skill building

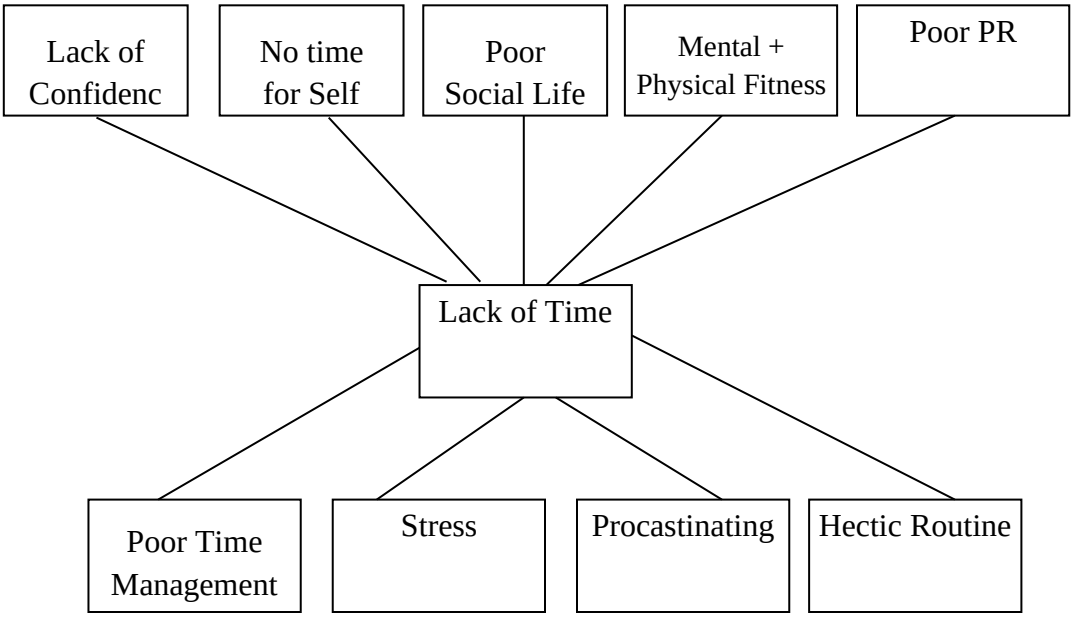
Problem Tree

Example-2



Problem Tree

Example-3

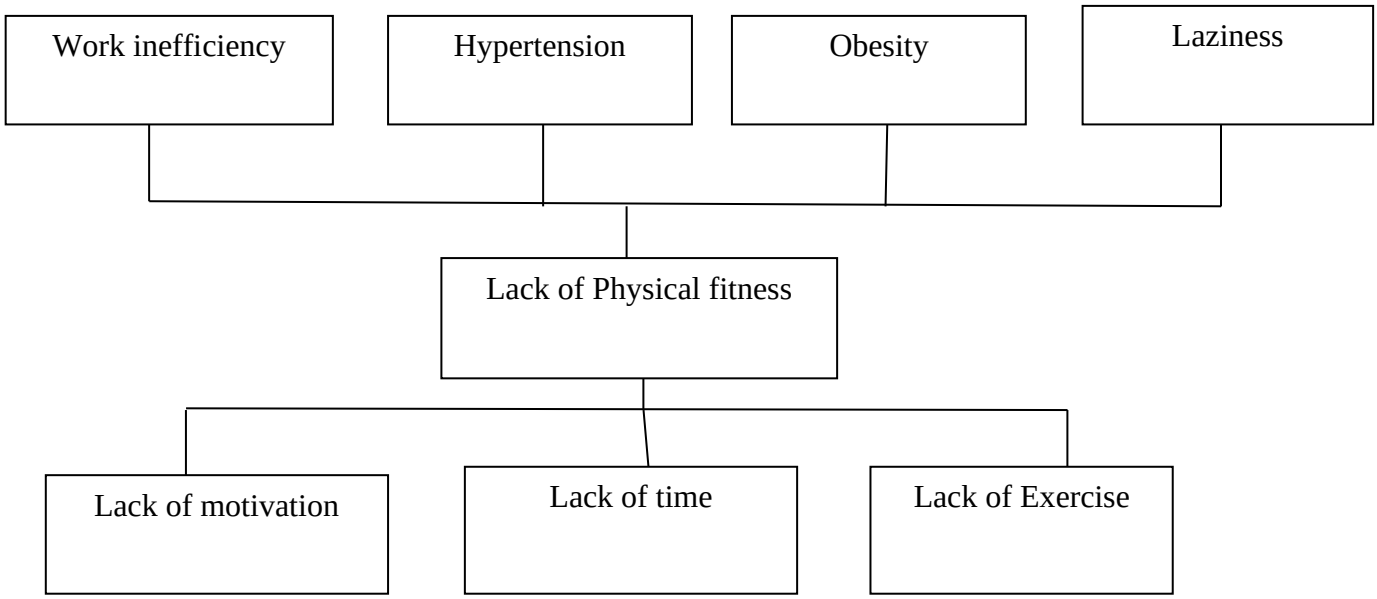


Action Plan

- Improve Time Management
- For Stress management -Meditation
- For Procrastination -Proactive approach
- For Hectic Routine Discuss with Boss

Problem Tree

Exercise No. 4



Action Plan

Start gym/ Exercise

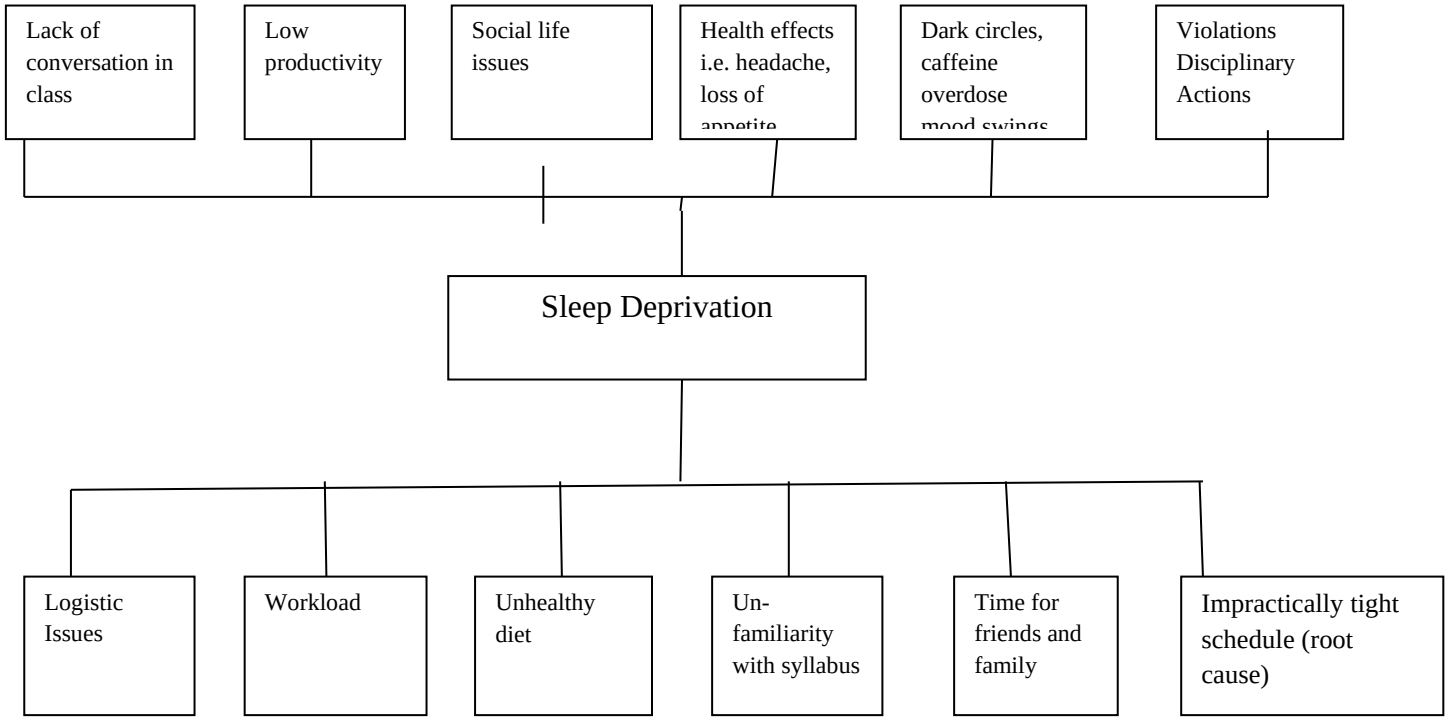
Create Time

Listen to up lifting music

Watch Movies

Problem Tree

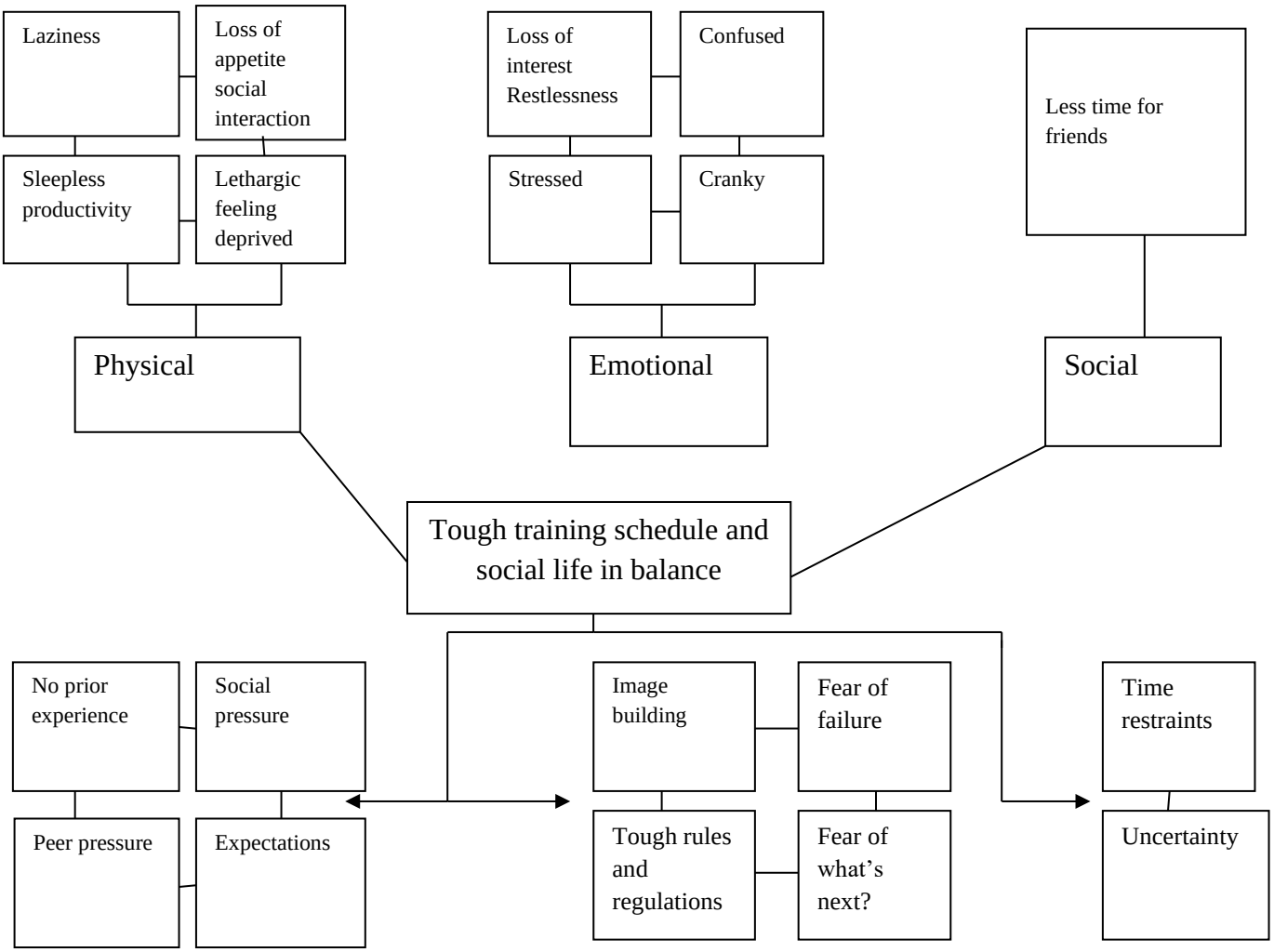
Exercise No. 5



Action Plan

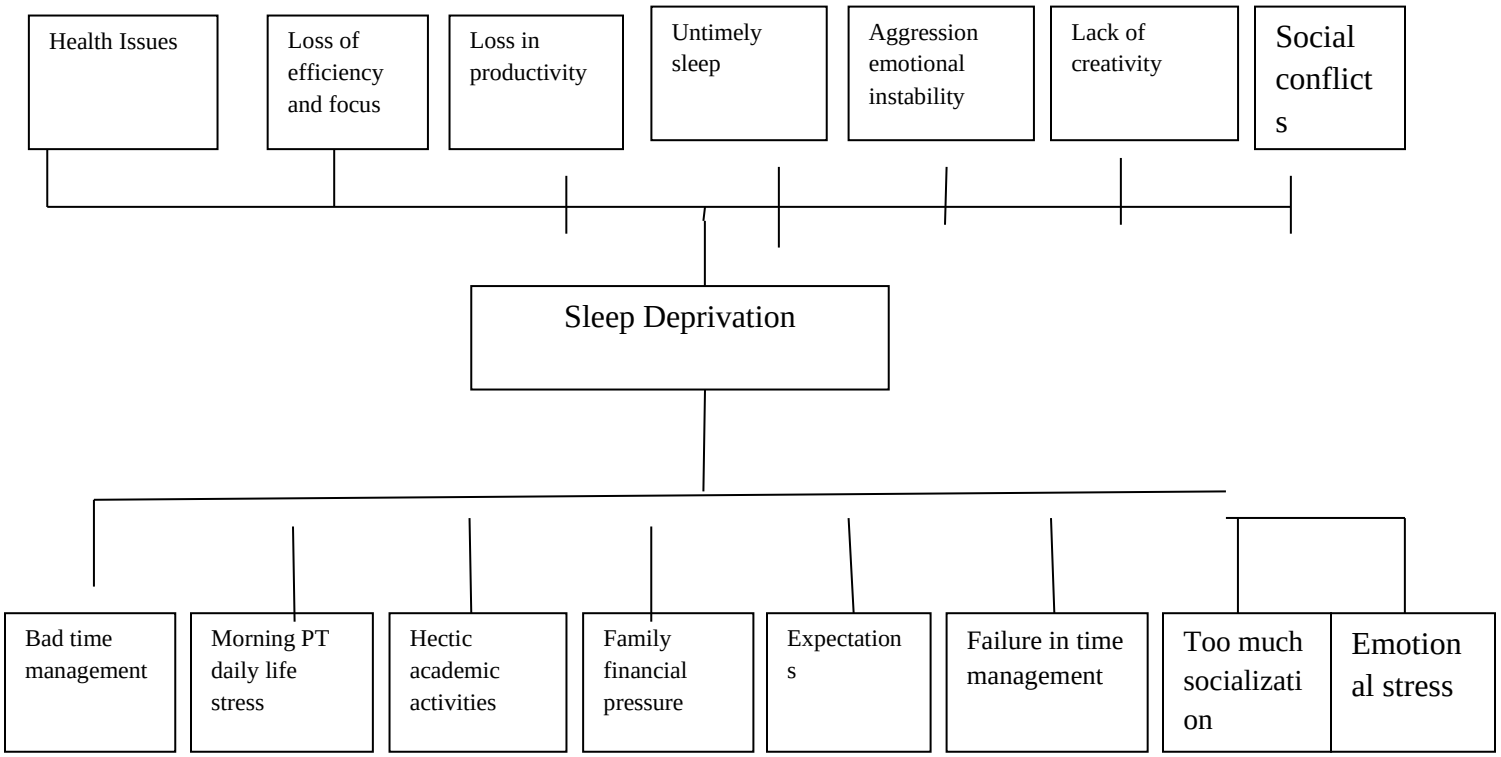
i. Time Management
ii. Requesting authorities to reschedule
iii. Reschedule PT Sessions
iv. Activities confined to office hrs
v. Spending less time with friends
vi. Reducing time and number of lectures
vii. Getting our stress levels checked
viii. Better utilization of weekends
ix. Break after lunch, power nap

Example 6


Laziness
Loss of appetite social interaction
Sleepless productivity
Lethargic feeling deprived
Physical
Loss of interest Restlessness
Confused
Stressed
Cranky
Emotional
Less time for friends
Social
Tough training schedule and social life in balance
No prior experience
Social pressure
Peer pressure
Expectations
Image building
Fear of failure
Tough rules and regulations
Fear of what's next?
Time restraints
Uncertainty

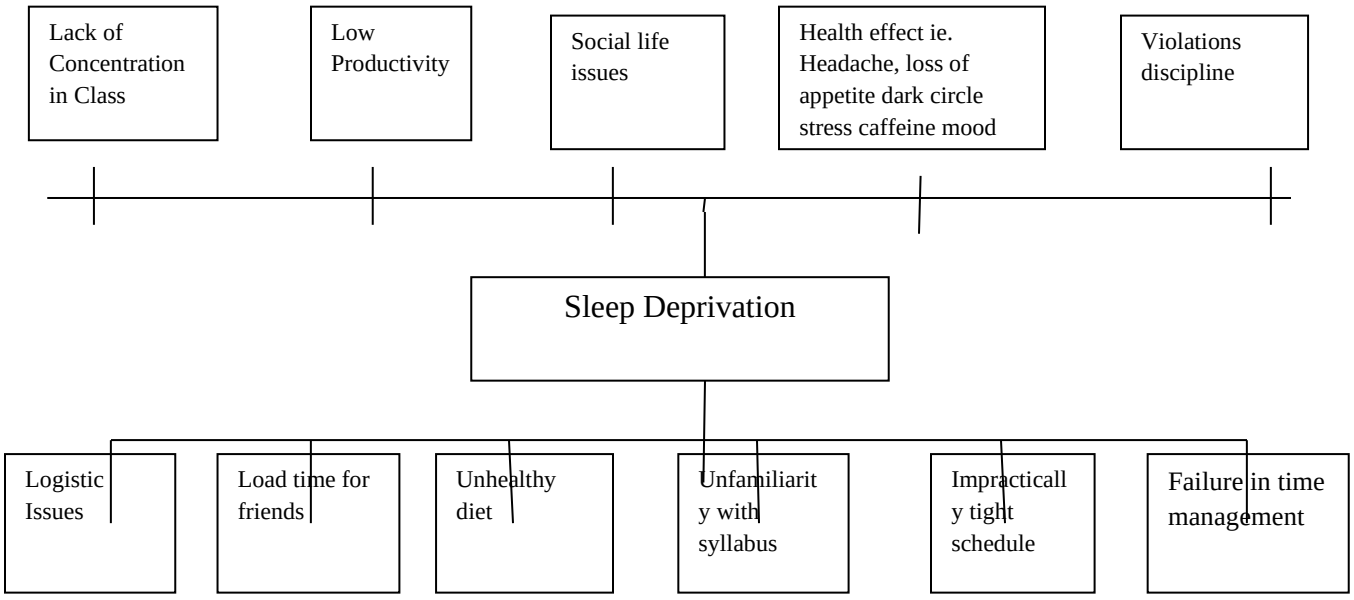
Problem Tree

Exercise No. 7



Problem Tree

Exercise No. 8



CONVERSION OF PROBLEM TREE INTO OBJECTIVES TREE

Problem Tree ⇨ **Objective Tree**

Effects of the Focal Problem ⇨ **Outputs/Results**

Effects ⇨ **Outputs**

Causes of the Focal Problem ⇨ **Overall Objectives**

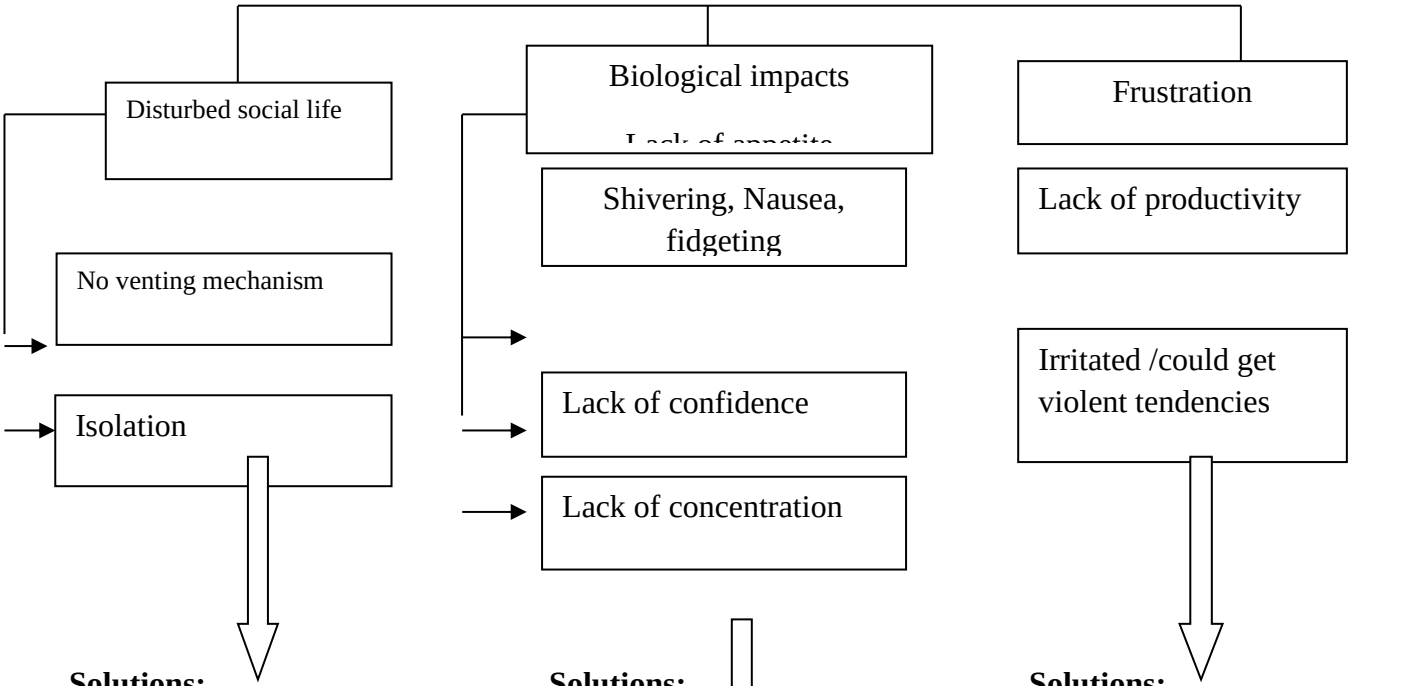
Cause ⇨ **Objectives**

Making an action plan from Objective's tree

Example

Overall Objectives: Lack of inter-personal skills

Purpose: How to deal with inter-personal skills issues?



Solutions:

- Talk to friends or loved ones more of them often
- Writing a diary etc.
- Greater recreational activities
- More effective ice breaking activities

Solutions:

- Awareness
- Psychiatrists/psychologist consultation
- Creating an environment where no one gets judged
- Having a strict diet chart and other tools
- Use humour as a tool to boost confidence

Solutions:

- Meditation
- Strengthening stress busters
- Physical exercise
- Plan your life time manageme

APPENDIX E

EXAMPLES OF SOCIAL SUPPORT

Taken from workshops conducted at CSA

Source	Mode of support
Colleagues (CSA)	Relaxing/ Schedule making
	Time Management tips
Roommate	Group study
	Improved sleep
	Division of Work
Family	Emotional support
	Home cooked food
Faculty	Counselling
	Practical solution
	Logistics
Doctor	Medicines
Mess Committee	Diet
	Avenue to vent out frustration
Seniors:	suggestions for coping

Examples of Social Support

1. Whom do you see as social support?
   Parents, Siblings, Friends
2. What sort of social support do you seek?
   Emotional, Financial Tangible
3. Ways of seeking support?
   Choosing the social support givers carefully
   Mediation Divert attention from stress
4. Experience of sharing problems with others?
   Element of non-seriousness
   Tell already practiced tactics

WHAT DO YOU EXPECT FROM SOMEONE PROVIDING SOCIAL SUPPORT

Objectiveness

- Effective communication with Boss
- Seek help from mentor/senior
- Improvement of commitment level.

Respect

- Healthy listening
- Understanding the personality of boss and treating them accordingly.

Time Management

- Daily Routine
- Effective ways of saving time
- Multi-tasking
- Analysis of daily routine

Health issues

- Professional help
- Regular check up

Appendix F

SOME ANSWERS TO QUESTIONS ASKED IN WORKSHOP 5

What makes you happy

1. Food
2. Sleep
3. Plantation/Forest
4. Music
5. Pets
6. Travelling
7. Playing sports
8. Dance

What makes you unhappy

1. Noise
2. Pollution
3. Fighting/conflicts
4. Stress
5. Sickness
6. Sense of competition
7. No Interment Access
8. Not getting salary on time

Preparation for Future

1. Optimistic approach

Appendix G

WHAT WORKS FOR YOU

Informal Feedback from participants of the Workshop

Workshop No.1

- Breathing Exercise
- Problem identification

Workshop No.2

- Managing the problem
- Identifying causes and effects and
- Their solutions
- Dividing issues into solvable and unsolvable

Workshop No.3

- Acceptance

Positive/optimistic attitude

- When life gives you lemons, make lemonade

Workshop No.4

- Solving the issues by getting social support from
- Family
- Friends
- Teachers
- Seniors

Appendix H

PRESENTATIONS

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Human Development Research Foundation
Improving lives through Research

PSYCHOSOCIAL SKILLS DEVELOPMENT FOR TRAINEE CIVIL SERVANTS

WORKSHOP-1

My life my career
Leading Change in Times of Uncertainty

Civil Services Academy, Lahore

Workshops Framework

Objectives and structure of workshop-1

- Understanding adversity
- Understanding stress
- Dealing with stress
- Group activities

Establishing Norms

Respect

- Respecting each other

Arrive

- Arriving and finishing on time
- Staying in the training room during training session

Commit ment

- Commitment to being an active participant (including in role-plays
- Not interrupting each other

e phon

- Turn off or put away mobile phones

Encoura ging

- Being encouraging and thoughtful when providing feedback to each other

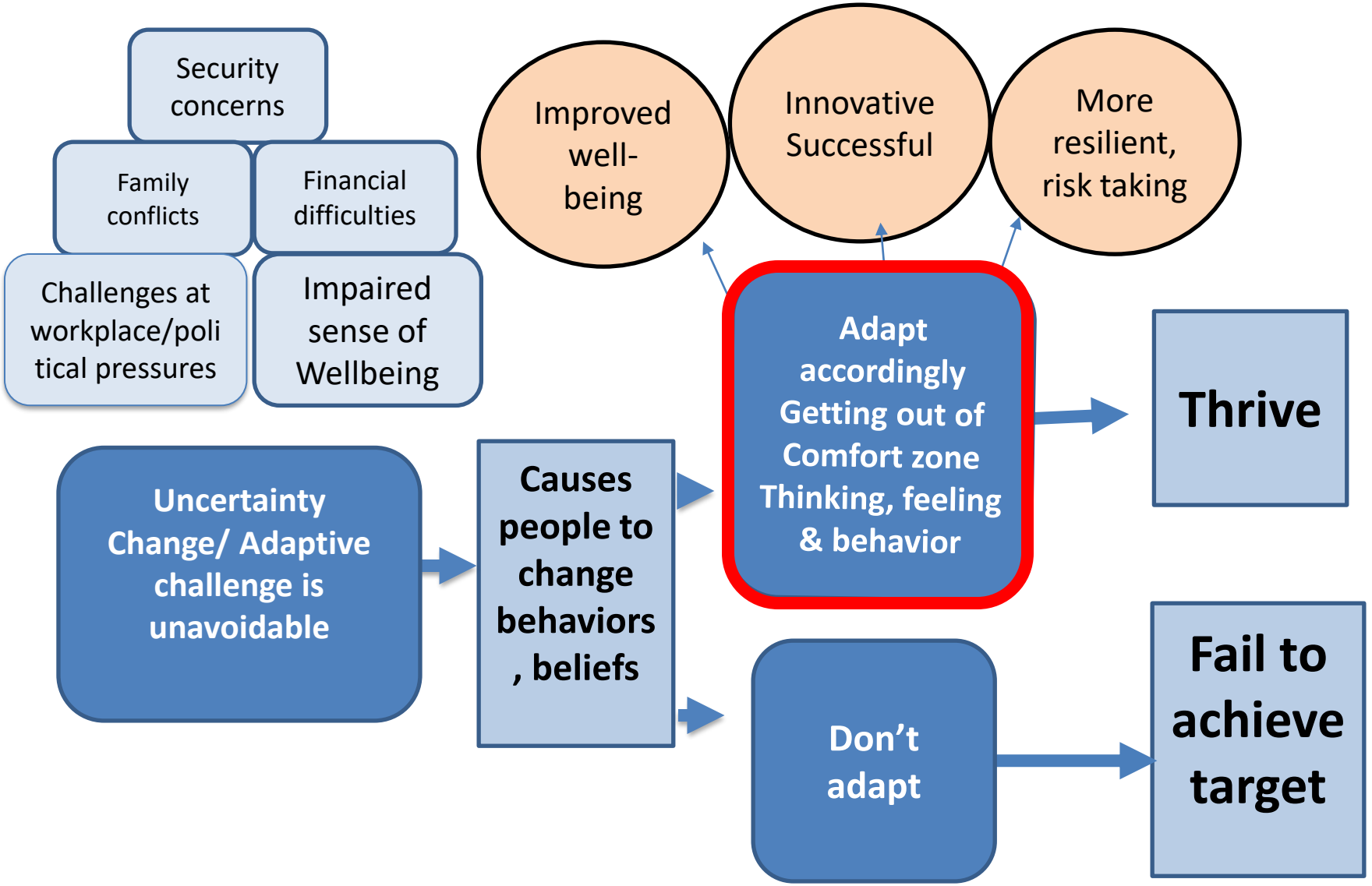
Listen & Ask

- Listen with full attention
- Ask questions- there are no silly ones!

Trainee – trainer relationship

- Mentor–junior
- Coach-athlete
- Teacher-student
- Doctor-patient

What is adversity ?



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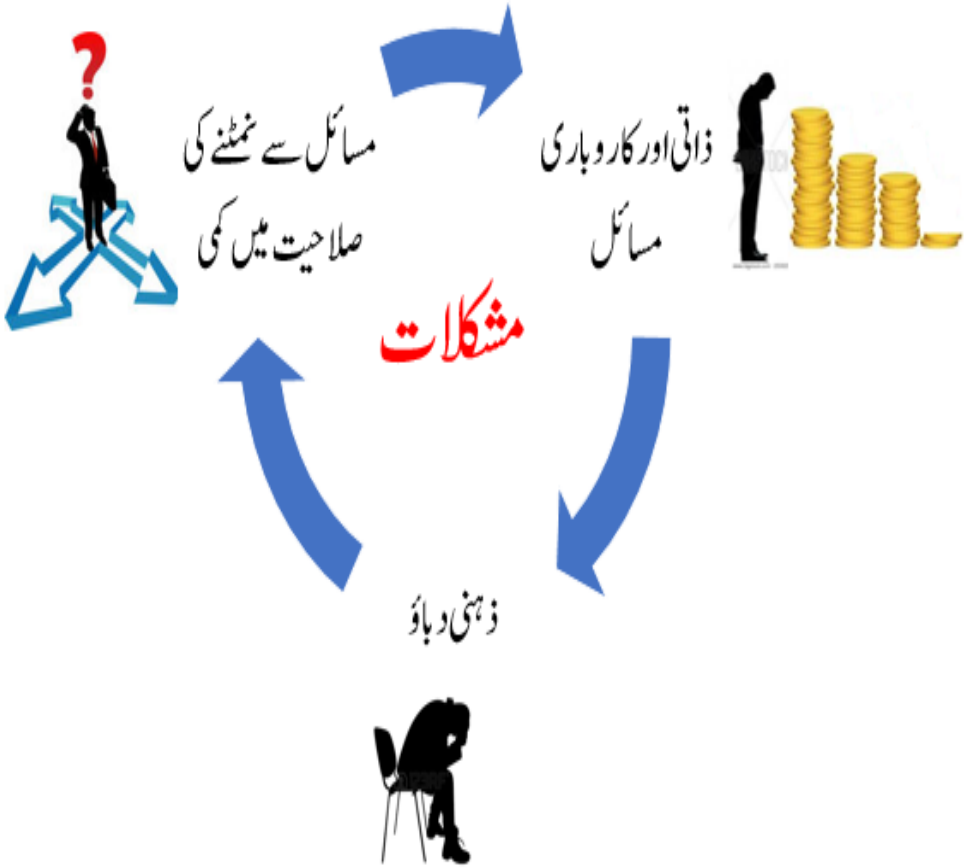


Stigma of Mental illness/stress

- Prevents acknowledgment and treatment
- Civil service structure promote stigmatization
- Studies show that public knowledge about mental health illnesses has recently increased, but considerable stigmatization of individuals with mental health illnesses remains. For example, mental illness is ranked near the bottom of other illnesses in terms of public acceptance (Hinshaw 2007).
- According to the US Surgeon General report, stigma is the main barrier to mental health care: "It deters the public from seeking, and wanting to pay for, care.
- **Stigma can be related to causes such as shame, guilt, self-image, and concerns for social discrimination**

Stress good or bad

- An artist needs a certain amount of turmoil and confusion," Joni Mitchell
- Eustress and Distress
- Nothing unusual
- Tchaikovsky -I assert that life is beautiful in spite of everything! In a word, there are many thorns, but the roses are there too.
- Churchill's black dog

Why Psychosocial Skills Development

Advantages

- What can you personally get out of this programme?
- What might improve in your life ?
- What do you think you might be able to do that you cannot do now?
  - Balance between family and career
  - Better at job related tasks (e.g., decision making, completing work on time, better problem management)
  - Self-care
- If your problems reduce, how might this be good for other areas in your life? e.g., your relationships, your work, your other duties

Why Psychosocial Development

Challenges /Perceived Disadvantages

- What are some of the problems for you in joining the programme?
- What will you have to give up or lose if you join the workshops?
- Will it reduce your time for your other studies, sports or family and friends?
- Will the programme be used to profile you or make a pen picture which can affect your future career?

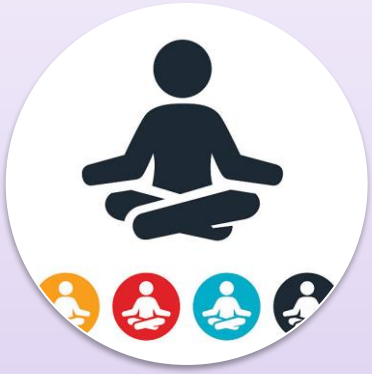
What is stress ?

- **How to define stress? Is stress always bad?**
- **How stress affects our body**
  - **E.g., headaches, pain in the body, stomachaches, tingling, dizziness, racing heart, difficulties breathing (think of a pressure cooker)**
- **Sometimes people experience physical problems and this can increase their stress.**
- **Regardless of whether the physical problems are or are not caused by stress, learning ways to reduce stress may also help alleviate the physical problem.**

Purpose of ‘Managing Stress’ Workshop

- How adversity causes stress
- How stress affects the body
- To introduce a basic strategy to manage stress through calming the body

Steps to Managing Stress



relax body (shake out arms, legs, relax the neck)

breathe from the stomach

Slow down your breathing

(3 seconds to breath in

3 seconds to breath out)

Practice regularly

What will we do in the breakup sessions ?

Discussions on

- **Challenges faced by civil servants**
- **How to manage stress**

Thank You

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PSYCHOSOCIAL SKILLS DEVELOPMENT FOR TRAINEE CIVIL SERVANTS

WORKSHOP-1

Group activities

My life my career

Leading Change in Times of Uncertainty

Civil Services Academy, Lahore

Reminders for facilitators

- When providing feedback, first give a positive comment then comment on what could have done differently or included
- Consider each other's feelings (eg nervous, embarrassed etc.)
- Not laughing at other's mistakes
- There are no wrong answers
- Respect participants

Establishing Norms

Respect

- Respecting each other

Arrive

- Arriving and finishing on time
- Staying in the training room during training session

Commitment

- Commitment to being an active participant (including in role-plays
- Not interrupting each other

Mobile phones

- Turn off or put away mobile phones

Encouraging

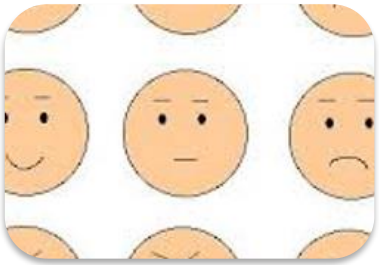
- Being encouraging and thoughtful when providing feedback to each other

Listen & Ask

- Listen with full attention
- Ask questions- there are no silly ones!

Basic Helping Skills

Confidentiality



Non-verbal skills

Validating

Putting aside your personal values

Praising openness

Communicating concern

Giving advice

- Divide into smaller groups and assign one or two questions each
- Designate note takers
- Designate moderators if necessary
- Use multimedia if necessary

Why should we do such workshops?

Do civil servants need it?

Are there other ways of teaching these skills?

Time frame: 10 minutes

- What do you think are the main challenges faced by civil servants of Pakistan?
- How do you see these challenges affecting overall performance of Civil Servants (leadership and management capacities, physical and mental health)
- Does anyone among you have any personal stories or friends from civil servants experiencing such kinds of challenges?

Time frame: 10 minutes

Managing Stress

- Recall examples of times they felt stressed and what happened
- How do you deal with stressful conditions?
- Have you tried out any other methods in the past?
- Which have been successful? Why?
- Which have been unsuccessful? Why?

Time frame: 10 minutes

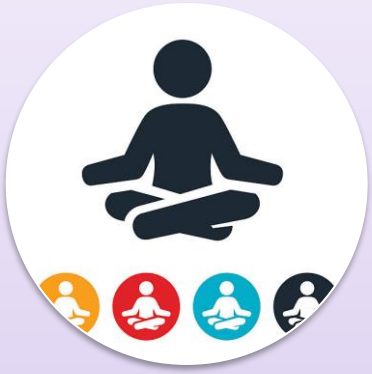
Breathing exercises(5 min)

- Relax your body a little bit. Shake out your arms and legs and let them go floppy and loose. Roll your shoulders back and gently move your head from side to side.
- (You can also imagine that you are at a place which is very peaceful, surrounded by greenery and where they feel happy and safe)
- Placing your hands on your stomach (belly), imagine you have a balloon in your stomach, and when you breathe in you are going to blow that balloon up, so your stomach will expand. And when you breathe out, the air in the balloon will also go out, so your stomach will flatten. Watch me first. I am going to exhale first to get all the air out of my stomach.
- (Alternative example: You must have seen a new born baby, when it inhales the air, its stomach expands like a balloon); look at me, I will first of all I will breath out all the air from my stomach (Breathe through your stomach; try to demonstrate how air will be inhaled and exhaled from the stomach. Do it at least 5 five times over with your breaths.)

Breathing exercises-II

- Okay, so now you try to breathe from your stomach with me. Remember, we start by breathing out until all the air is out, and then breathe in. If you can, try and breathe in through your nose and out through your mouth.
- (Practice this exercise with the participants for at least two minutes.)
- Great! Now the second step is to slow the rate of your breathing down. So we are going to take three seconds to breathe in and three seconds to breathe out. I will count for you; 1,2,3,4…
- Now, breathe in; 1, 2, 3...and breathe out, 1, 2, and 3. Do you notice how slowly I count? (Repeat this for approximately two minutes.)
- That's great. Now when you practice on your own, don't be too concerned about trying to keep exactly to three seconds. Just try your best to slow your breathing down, remembering that when you are stressed you will breathe fast.
- Okay, so you try on your own for the next few minutes.
- Allow the participants to practice trying to slow down their breathing on their own for at least two minutes. Try to count their breaths in and out so you can judge whether they are doing it too quickly. Afterwards, spend some time talking about any difficulties they had.
- "Okay, so how was it doing it on your own? Was it more difficult trying to keep your breathing to a slower rate?"

Steps to Managing Stress



relax body (shake out arms, legs, relax the neck)

breathe from the stomach

Slow down your breathing

(3 seconds to breath in

3 seconds to breath out)

Practice regularly

Discussion 5 min

- Ask the group what they found good about Managing Stress
- Ask them what they found difficult about doing Managing Stress
- Discussion/Referral for any difficulties participants had

Discussion

- One thing you have learned in today's workshop that has been helpful
  - Any missing point ?
- Regularly practice Managing Stress
  - Which day and time ?
  - Friends or a family members can remind to do the breathing exercise
  - Any group member can also remind everyone (through a call or message)
  - A Whatsapp group including all the participants can be created (in which the coach can remind everyone or participants can remind to one other)

Ideas for Follow up

- Discussions at the mess etc
- Whatsapp groups ?

Thank you

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PSYCHOSOCIAL SKILLS DEVELOPMENT FOR TRAINEE CIVIL SERVANTS

WORKSHOP-2

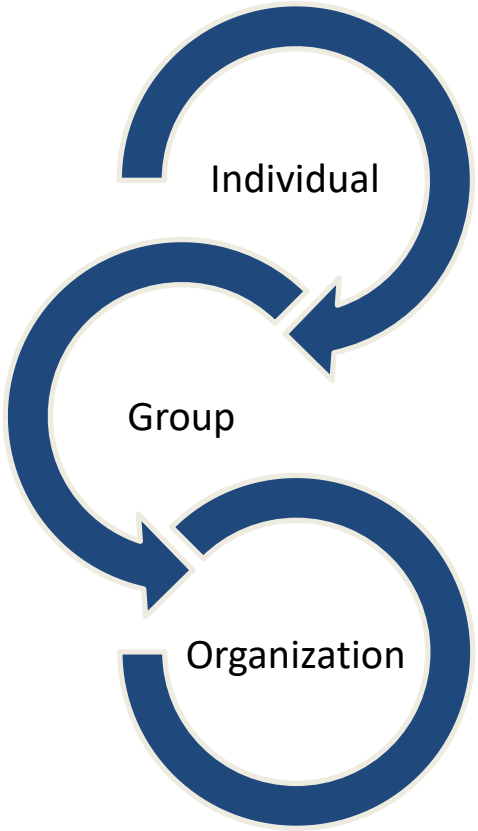
Managing Problems

My life my career

Leading Change in Times of Uncertainty

Civil Services Academy, Lahore

Psychosocial Skills for Civil Servants- programme strategies



Workshop Framework

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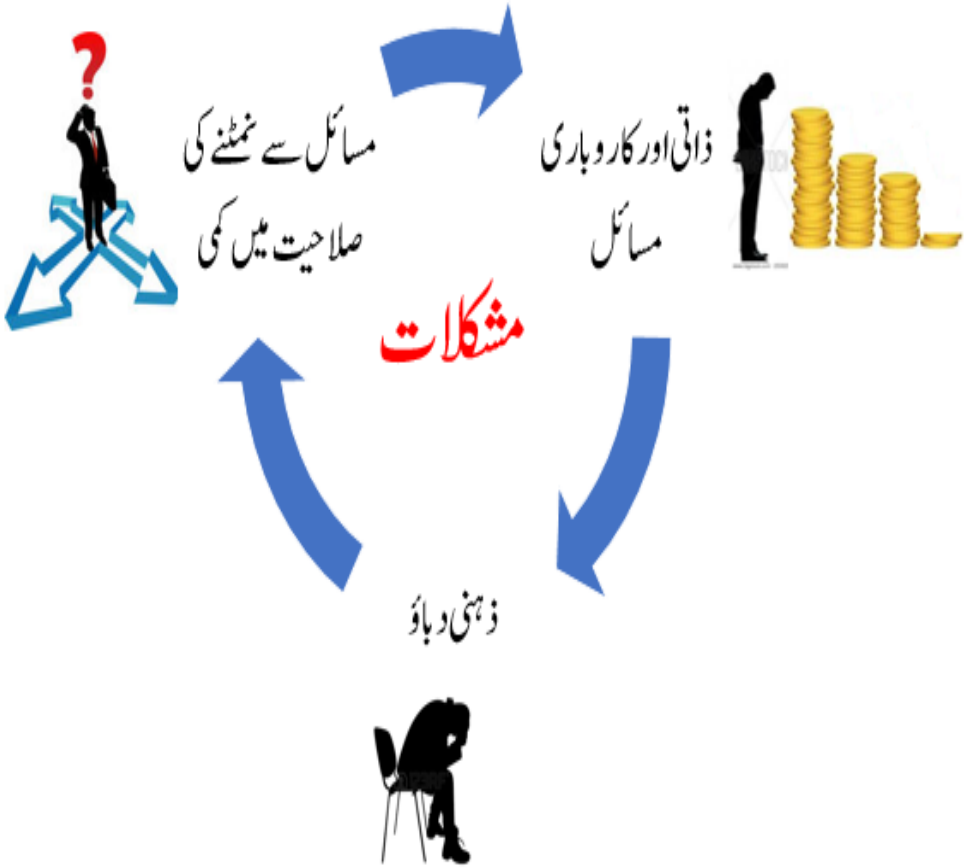


Workshop 1 -Issues discussed

- Why do we need these workshops?
- What are the challenges faced by civil servants?
- How do these challenges affect the performance of civil servants?
- Other ways to teach these skills?

Discussion on workshop 1

- What did you find good about Workshop 1 Managing Stress
- What did you find difficult about doing Managing Stress
- Different people experience different types of problems while doing breathing exercise.
- There are different ways of managing stress.

Summary of discussions

- Sources of stress
  - Problems in career
  - Problems due to political or economic instability
  - Law and order issues
  - Lack of professional training
  - Conflict with superiors, colleagues or subordinates or stakeholders
  - Work life imbalance
  - Raising children and care giving

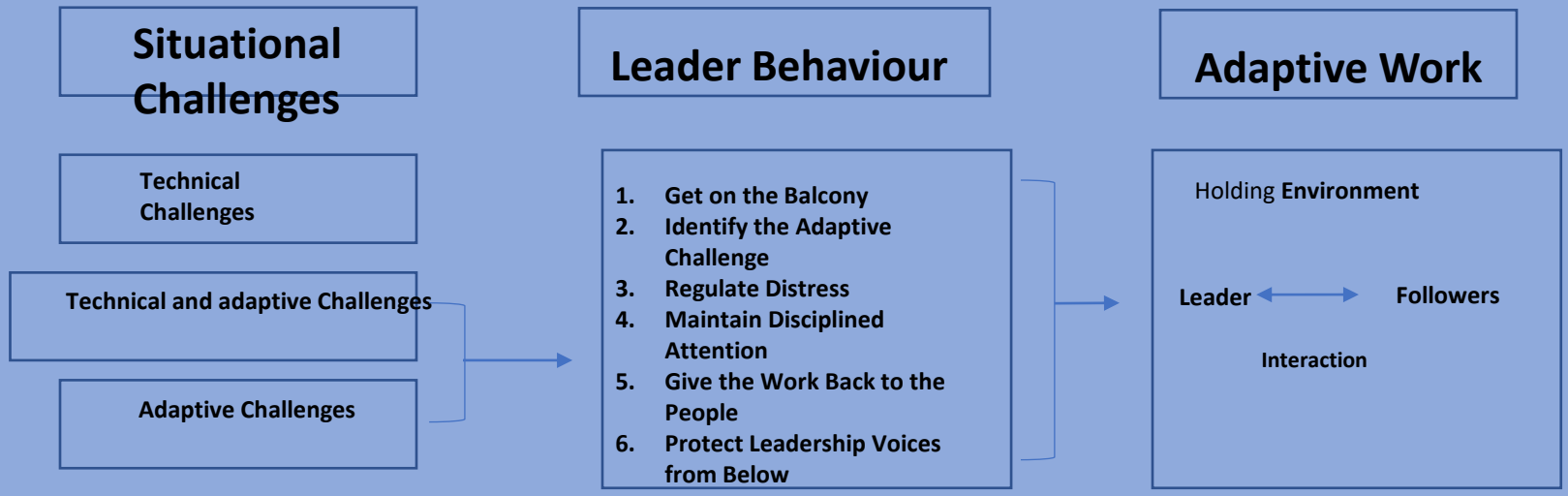
Objectives of workshop 2

- Define what is problem and what is need
- Types of problems
- Learn tools and methods necessary for fixing a problem(solvable problems)
- Using problem tree
- Using Objectives tree
- Making action plans

Defining need and problem

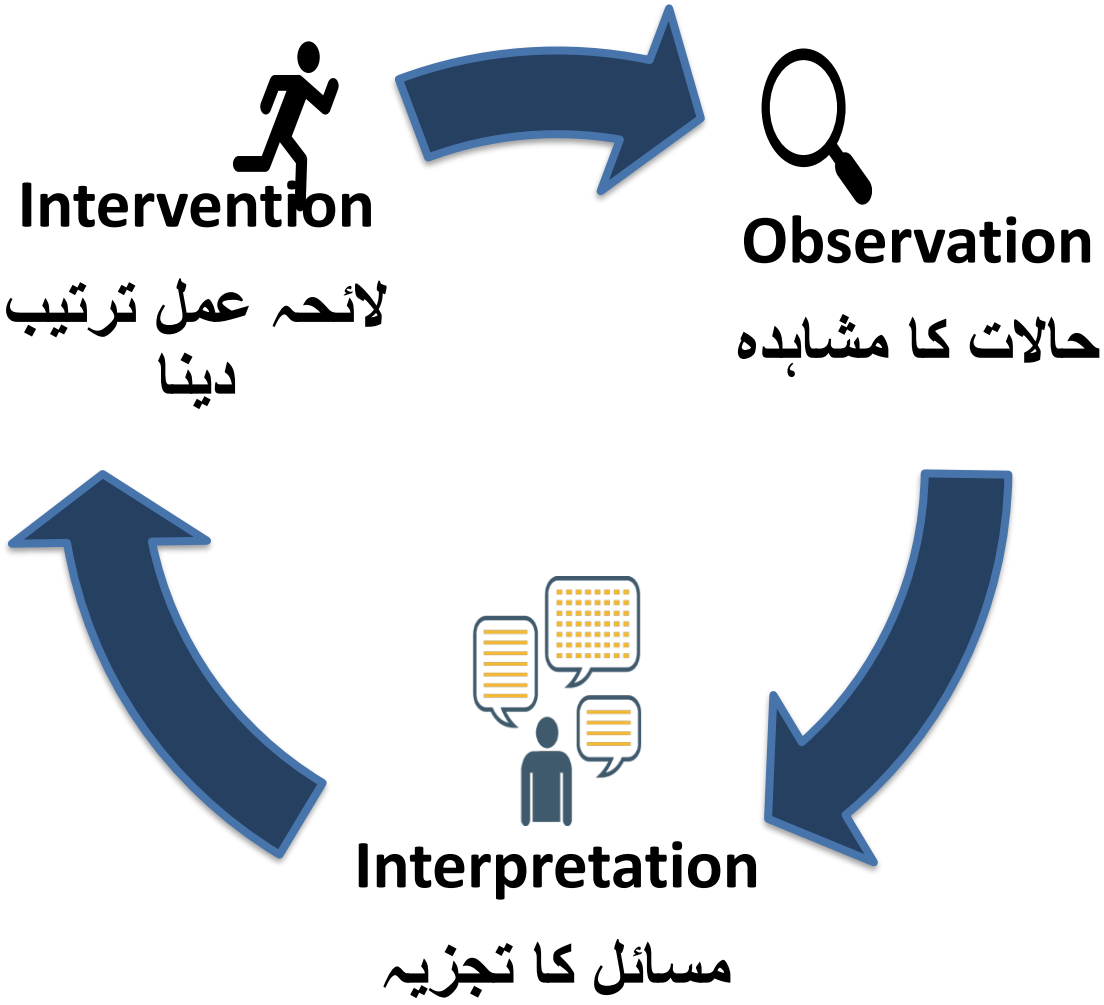
- What is need
- What is a problem
- Two major types of problems
    - Solvable
    - Unsolvable

Adaptive Leadership Model



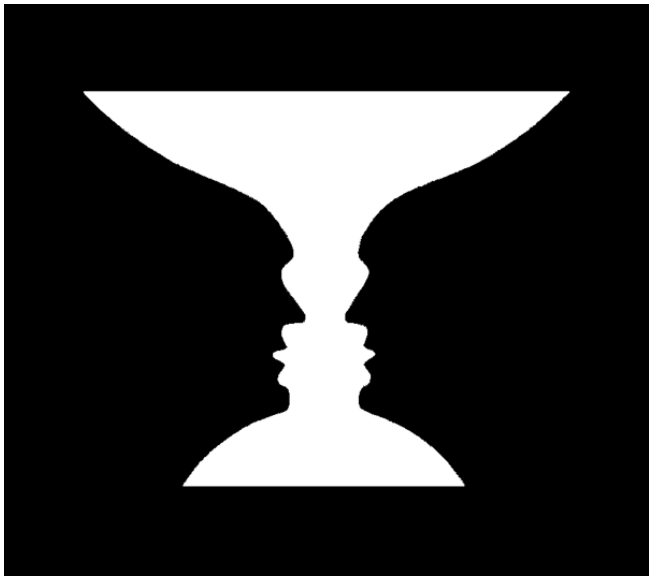
* Heifetz R, Grashow A, Linsky M. The Practice of Adaptive Leadership: Tools and Tactics for Change your Organization and the World. Boston, MA: Harvard Business Review Press; 2009

Observe, interpret and intervene cycle



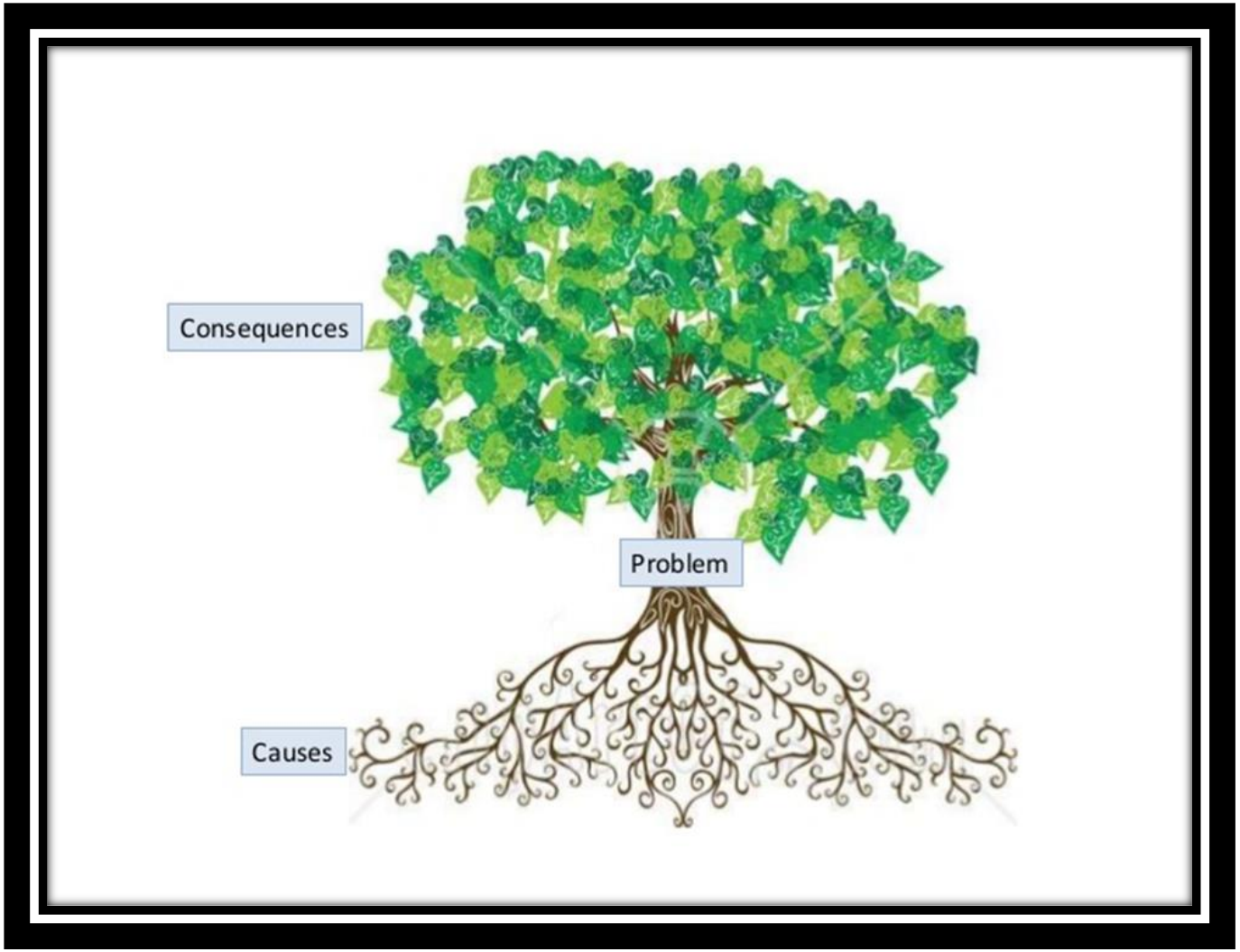
Challenge: Defining a problem?

Deep observation: floor + balcony

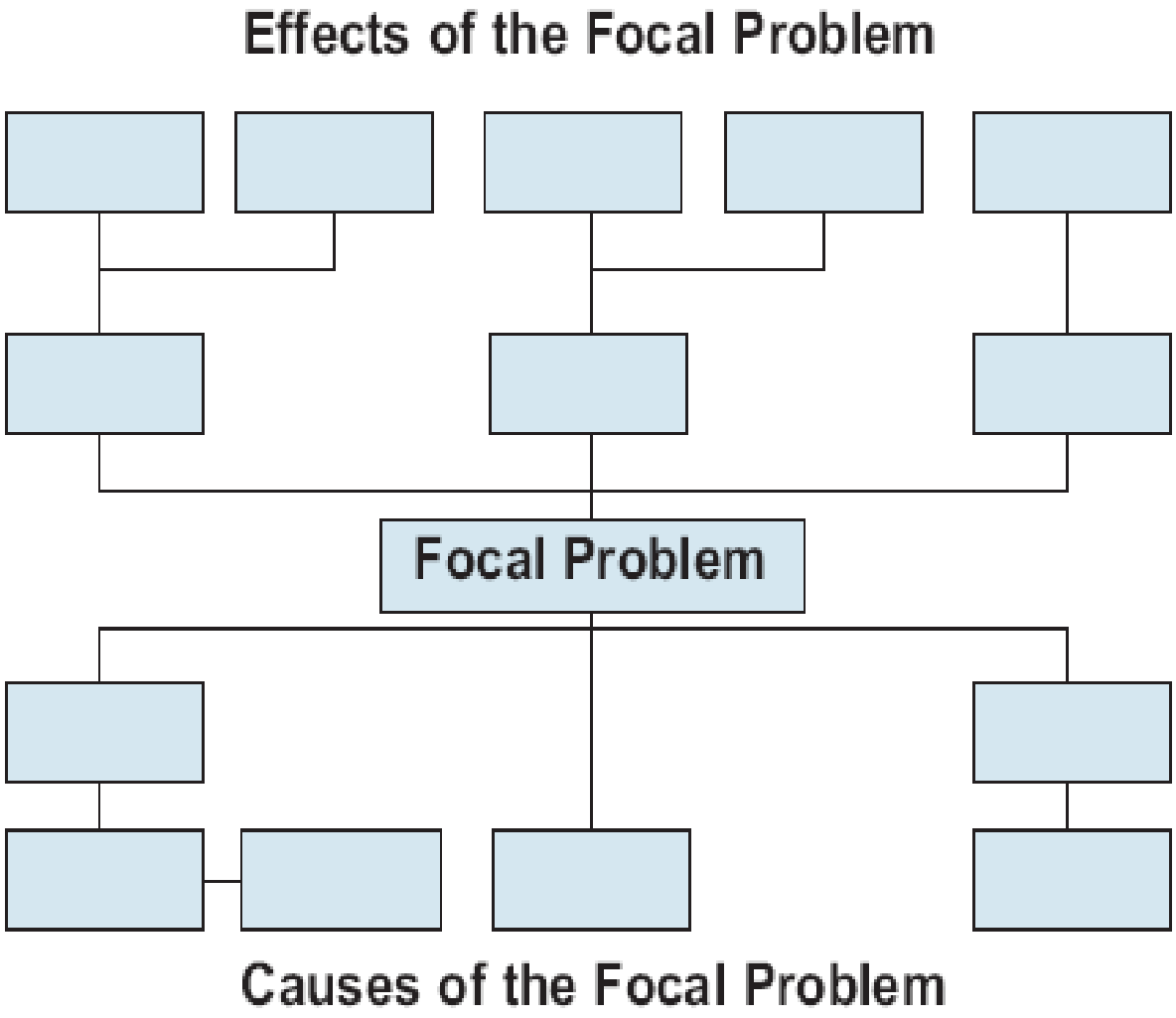


Balcony view

Problem Tree Analysis



Problem Tree

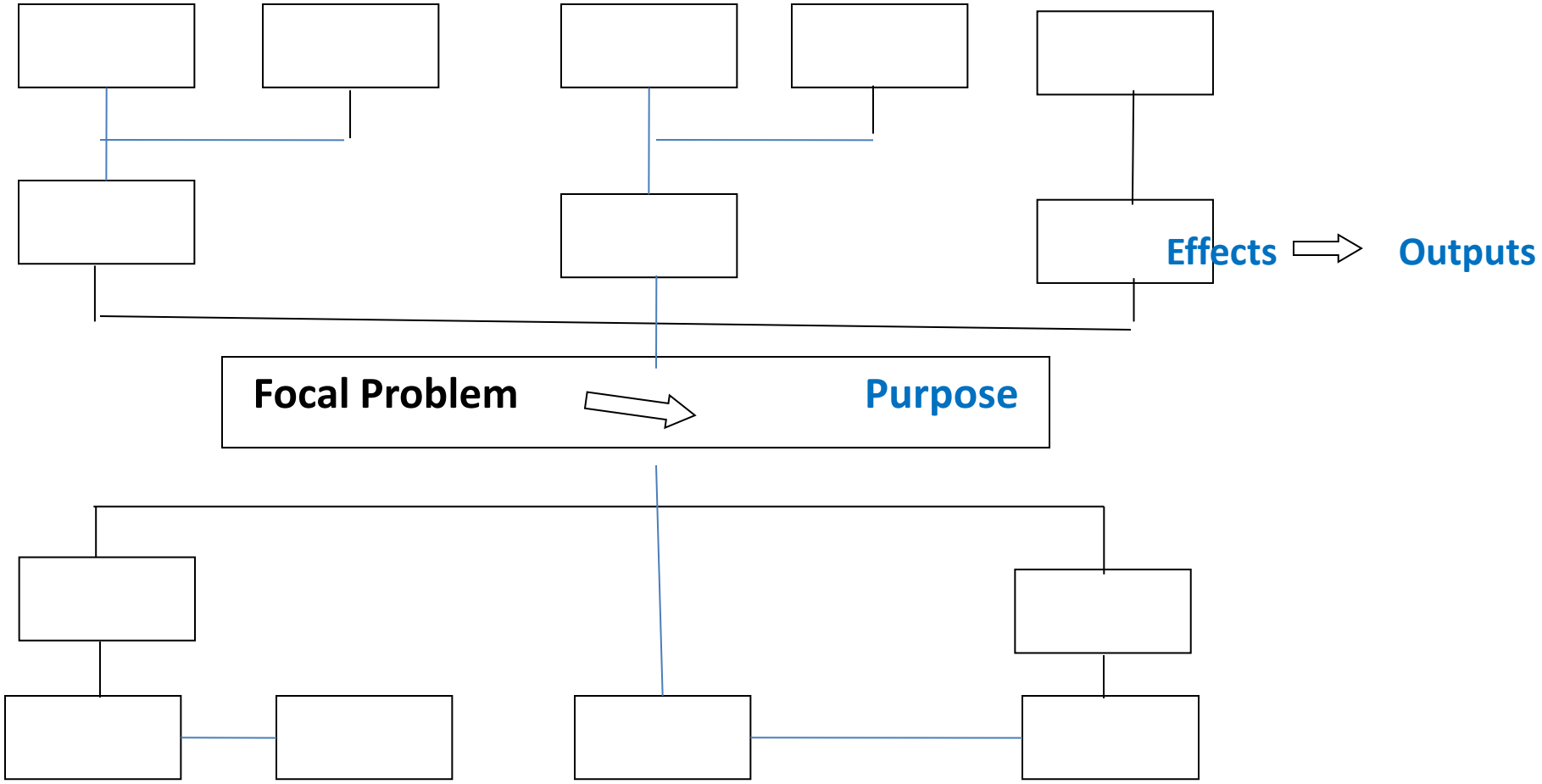


EFFECT

CAUSE

Problem Tree ⇨ Objective Tree

Effects of the Focal Problem ⇨ Outputs/Results



Causes of the Focal Problem ⇨ Overall Objectives

Cause ⇨ Objectives

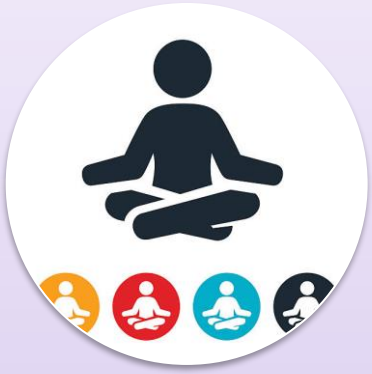
Relationship between problem and objective tree

Problem tree	Objective tree
• Effects	Overall objectives
• Focal problem	Project Purpose
• Causes	Results/Outputs

End of Workshop 2

In group activities, we will select one problem, conduct its analysis and review it.

Managing Stress



relax body (shake out arms, legs, relax the neck)

breathe from the stomach

Slow down your breathing

(3 seconds to breath in

3 seconds to breath out)

Practice regularly

Thank you

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PSYCHOSOCIAL SKILLS DEVELOPMENT FOR TRAINEE CIVIL SERVANTS

WORKSHOP-2

Group activities

My life my career

Leading Change in Times of Uncertainty

Civil Services Academy, Lahore

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- There are no wrong answers
- Respect participants

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Listen & Ask

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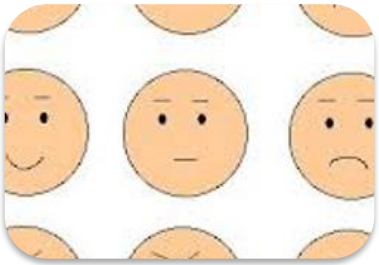
Confidentiality



Non-verbal skills

Validating

Putting aside your personal values

Praising openness

Communicating concern

Giving advice

- Designate note takers
- Designate moderators if necessary
- Use multimedia if necessary

Managing Problems

- List down all the problems
- Select problems that you face in your personal or professional life
- Divide problems in two categories i.e.

    1) problems in your control and

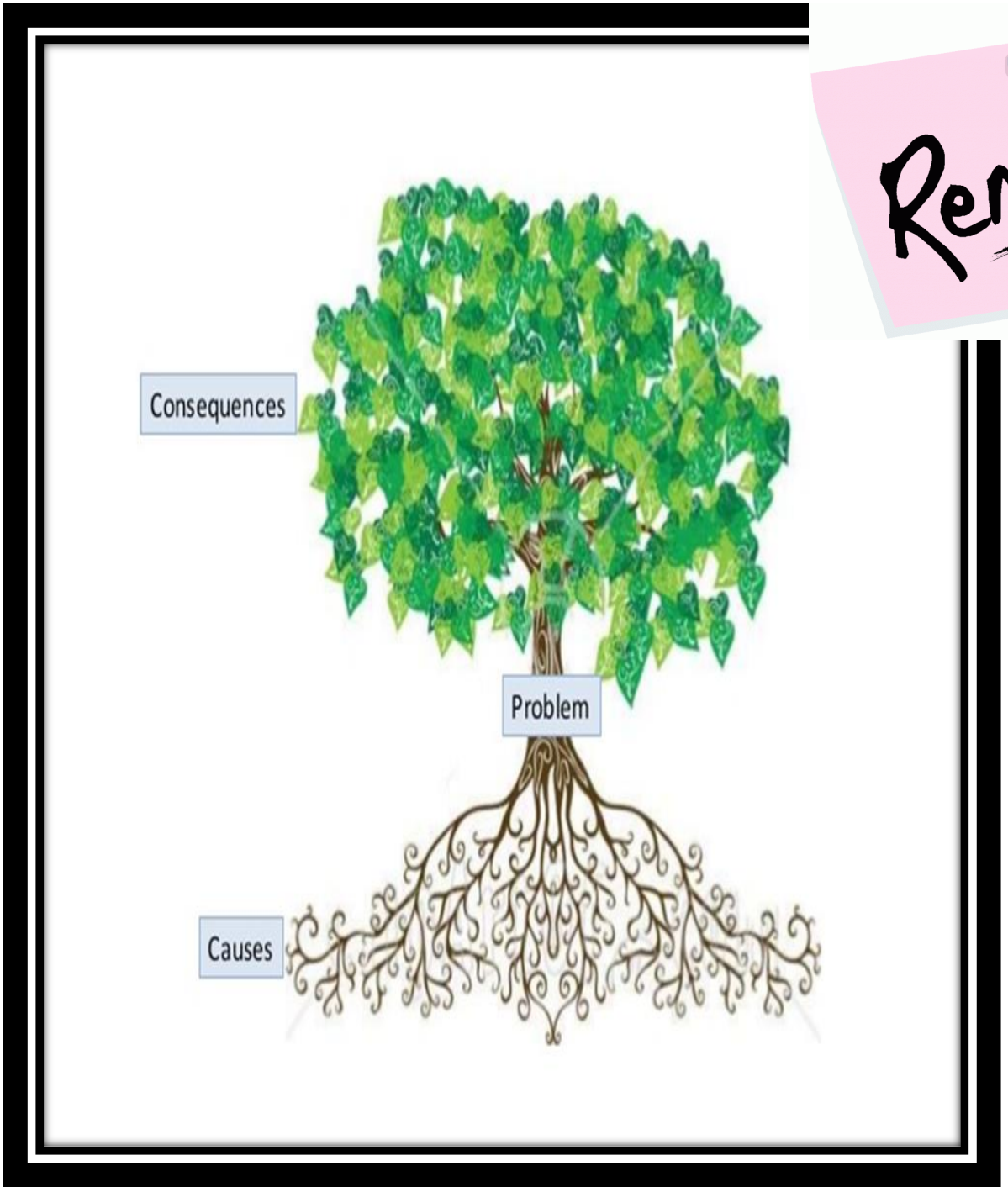
    2) problems out of control

5 minutes

Managing Problems

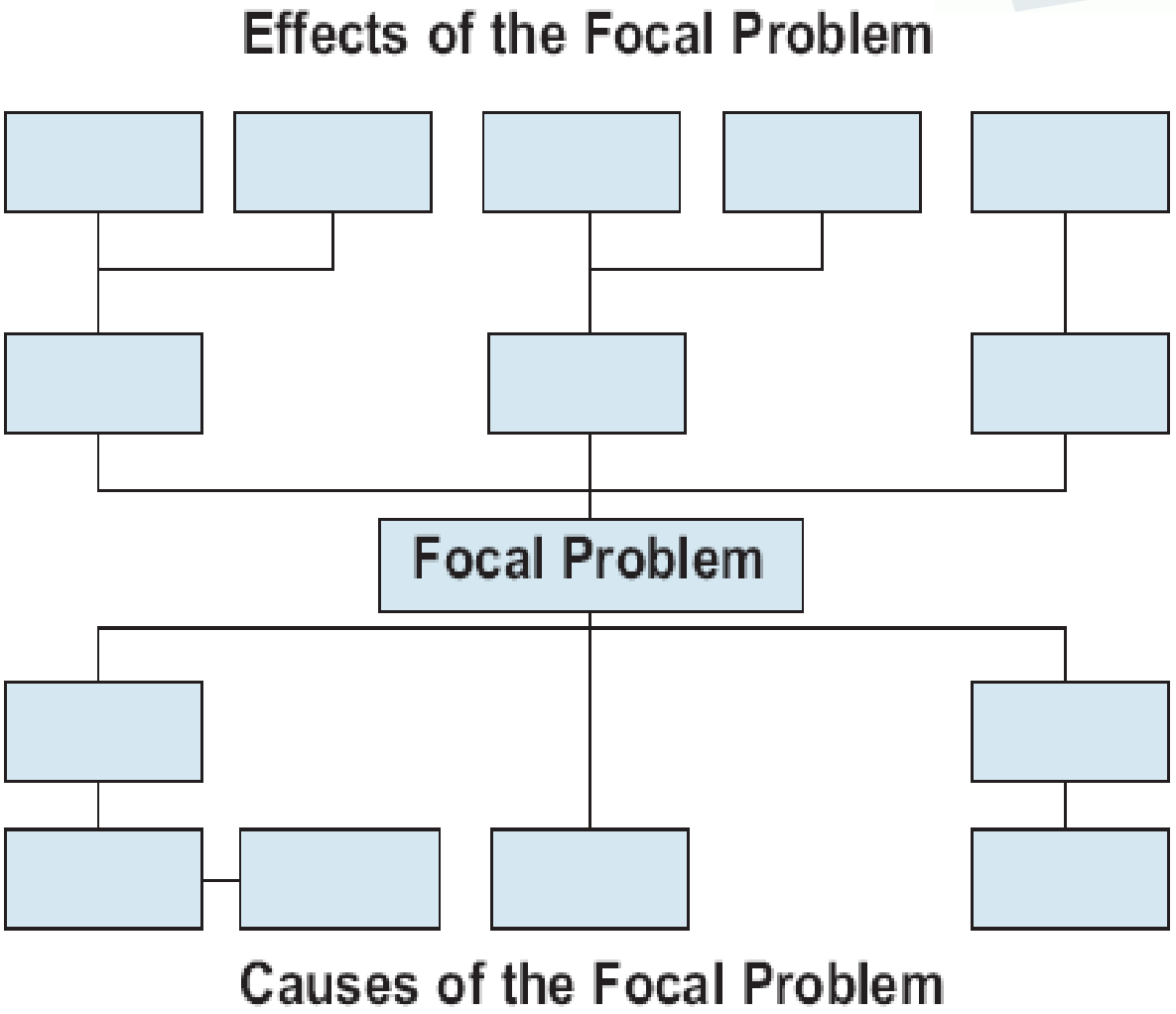
- Select one major problem
- Conduct problem tree analysis

10 minutes


Consequences
Problem
Causes


Reminder!

Problem Tree



CAUSE

Relationship between problem &objective tree

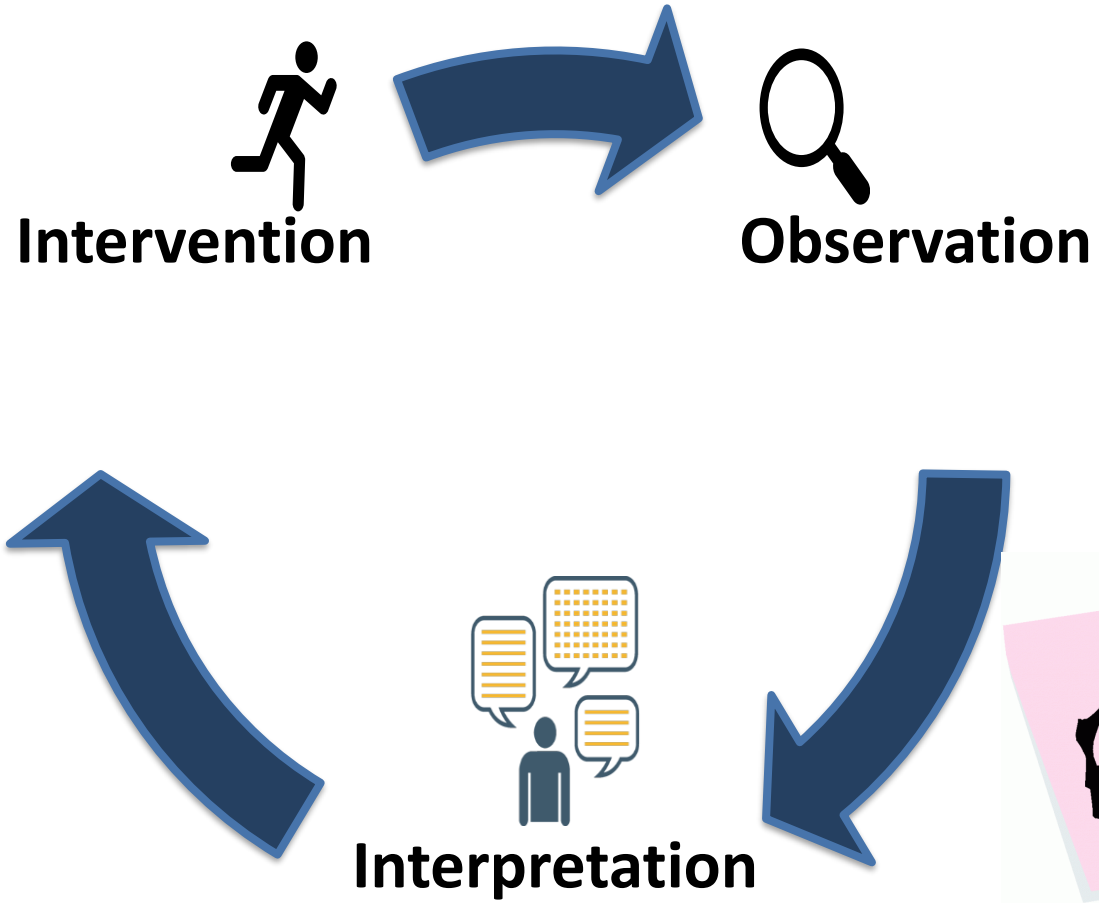
Problem tree	Objective tree
• Effects	Overall objectives
• Focal problem Purpose	Project
• Causes	Results/Outputs

Objective Tree

- Observe Problem tree analysis through cause and effect analysis
- Prepare objective tree by converting root causes into outputs (TIP – Turn it upside down)

5 minutes

Preparing action plan through Observe, interpret and intervene cycle



Tips

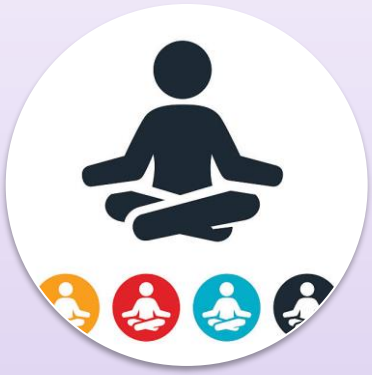
- Select one problem .
- Try to talk about one problem only at a time.
- Divide the problem into smaller problems if necessary.
- Select parts of the problems which can be solved.
- Leave out the parts or causes out of control
- Ask yourself what is the problem, what happened when it occurred, what do I do/not do when this problem occur.

Action plans

- Think: What are you going to do about this problem?
- Prepare a list of all possible solutions
- Select one best suited solution
- Discuss the pros and cons of the solution
- Think about all the resources you will need to execute this solution
- When and how would you execute? Strategize and plan out. Prepare action plan.

10 minutes

Steps to Managing Stress



relax body (shake out arms, legs, relax the neck)

breathe from the stomach

Slow down your breathing

(3 seconds to breath in

3 seconds to breath out)

Practice regularly

Thank You

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PSYCHOSOCIAL SKILLS DEVELOPMENT FOR TRAINEE CIVIL SERVANTS

WORKSHOP-3

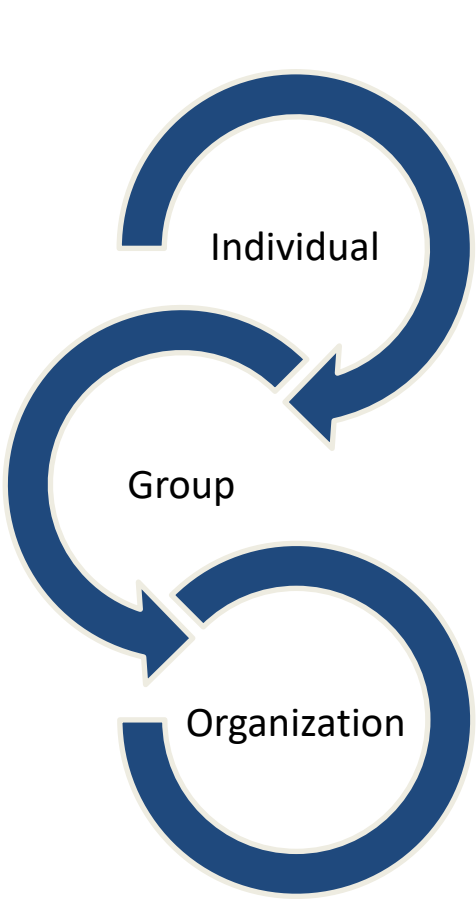
GET GOING KEEP DOING

My life my career

Leading Change in Times of Uncertainty

Civil Services Academy, Lahore

Psychosocial Skill Development for Civil Servants-strategies

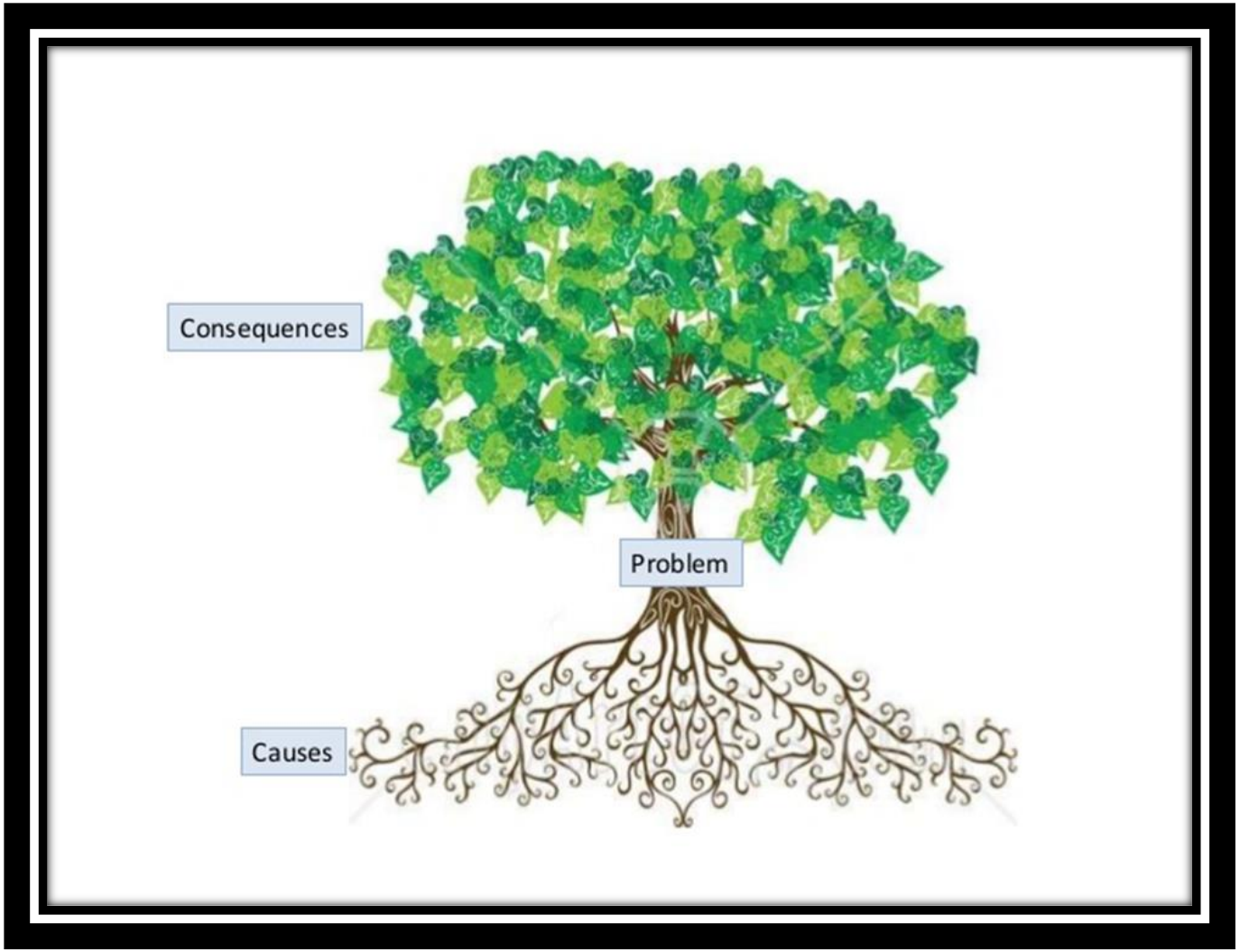


Workshops Framework

Review of Workshop 1 and 2
Presentations by probationers

- Causes of Stress
- Managing Stress
- Defining Problem: Observation, Interpretation and Intervention
- Problems Tree Analysis
- Action plan from Workshop 2

Problem Tree Analysis



Relationship between problem and objective tree

Problem tree	Objective tree
• Effects	Overall objectives
• Focal problem	Project Purpose
• Causes	Results/Outputs

Workshop 3: Objectives

- How to defeat failures
- Live and move forward in the face of adversity
- Cope with the stress and disillusionments

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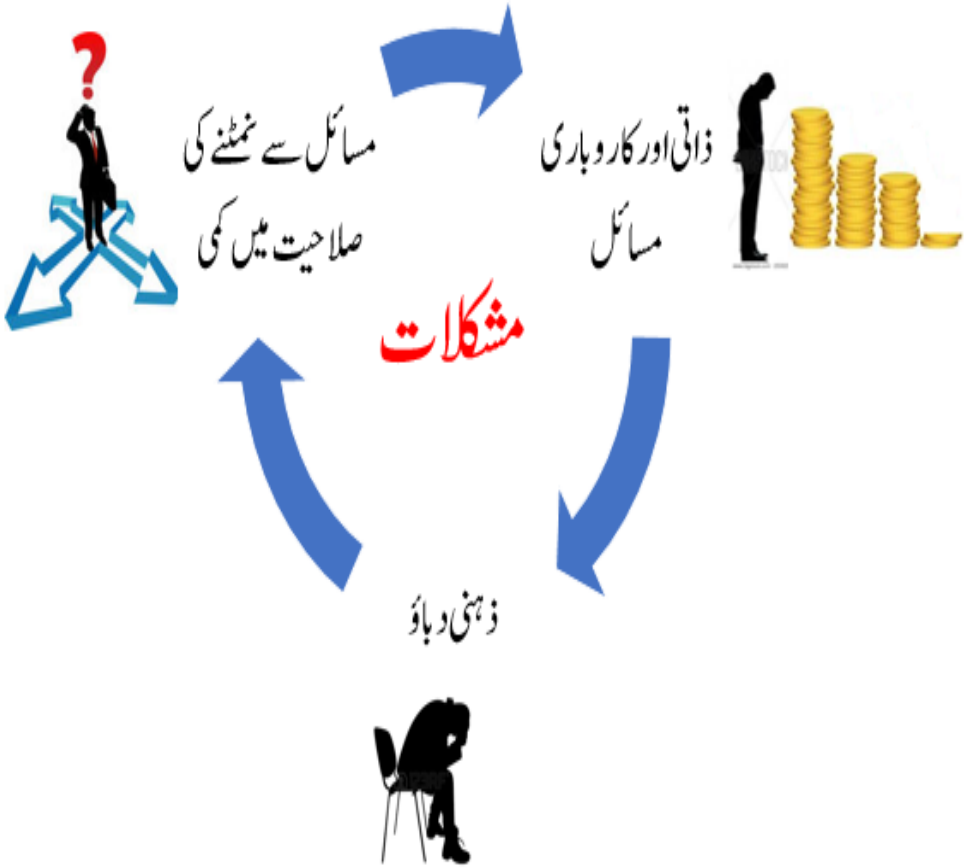


Three possible scenarios

- There are 3 possible experience you will have

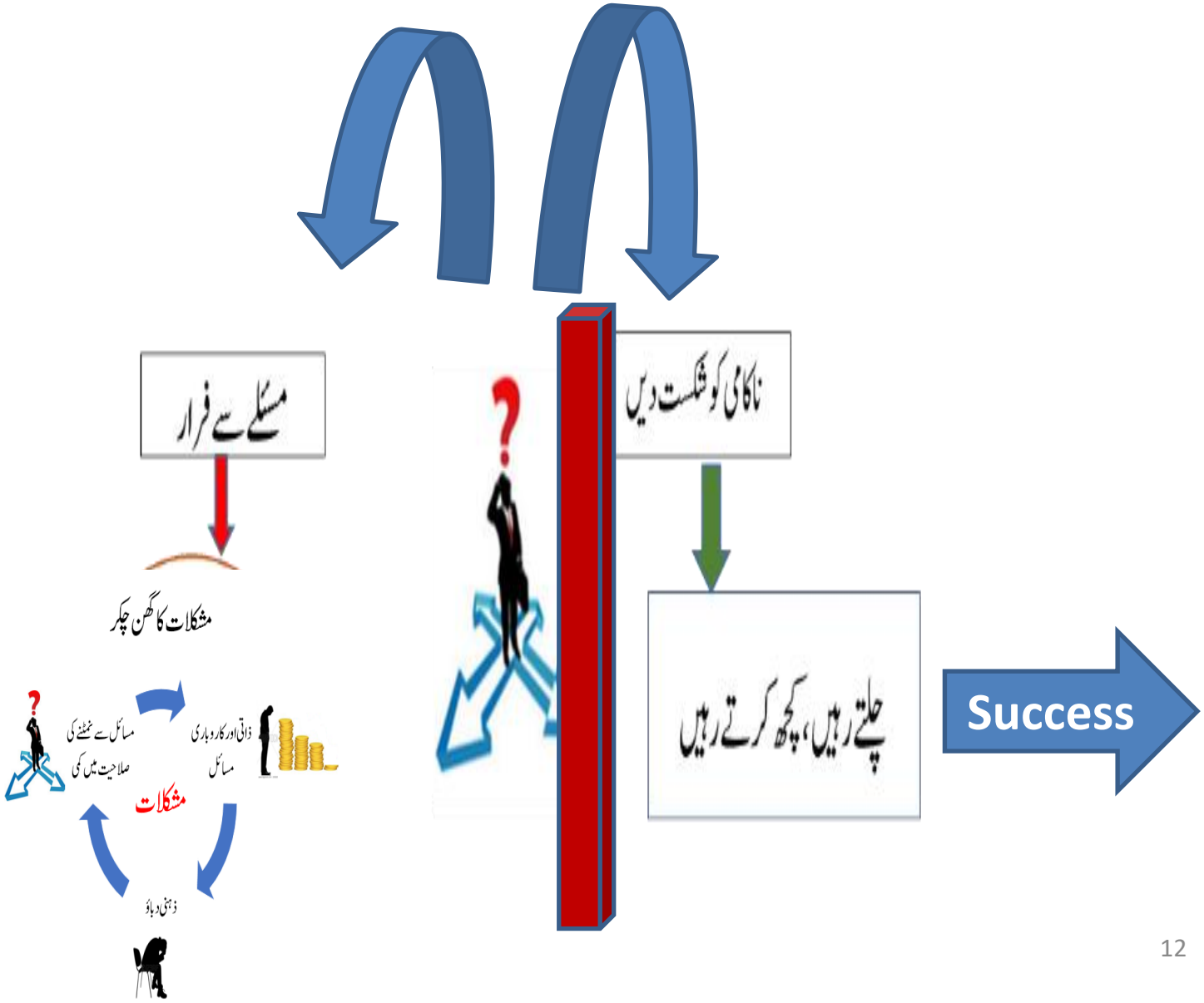
Successfully completed action plan	Tried to do action plan but unsuccessful	Unable to do action plan
		

This workshop deals with scenario 2 and 3

Get Going Keep Doing

- No single best solution of your problem
- Every effort is a kind of experiment
- Problem may be simple, complicated, complex or chaotic
- Some times you do not get anticipated results which might overwhelm your physical and mental abilities and put you under stress

Challenge of adversity: Fight or Flight



Moving from obstacle thinking to opportunity thinking

Improved
Problems
Management

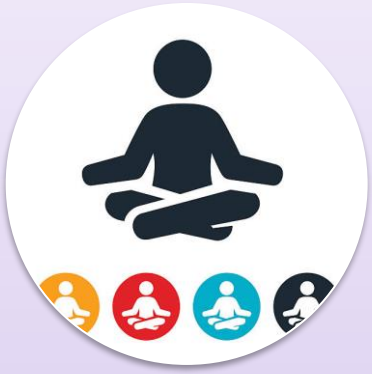
Get going
keep doing

Dealing
with Stress

Keep doing get going

- List activities you enjoy
- Do you give them up at times of stress
- Breakup sessions for discussion

Managing Stress



relax body (shake out arms, legs, relax the neck)

breathe from the stomach

Slow down your breathing

(3 seconds to breath in

3 seconds to breath out)

Practice regularly

Thank You

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PSYCHOSOCIAL SKILLS DEVELOPMENT FOR TRAINEE CIVIL SERVANTS

WORKSHOP-3 Group activities

Get Going Keep Doing

My life my career

Leading Change in Times of Uncertainty

Civil Services Academy, Lahore

Reminders for facilitators

- When providing feedback, first give a positive comment then comment on what could have done differently or included
- Consider each other's feelings (eg nervous, embarrassed etc.)
- Not laughing at other's mistakes
- There are no wrong answers
- Respect participants

Establishing Norms

Respect

- Respecting each other

Arrive

- Arriving and finishing on time
- Staying in the training room during training session

Commitment

- Commitment to being an active participant (including in role-plays
- Not interrupting each other

Mobiles

- Turn off or put away mobile phones

Encouraging

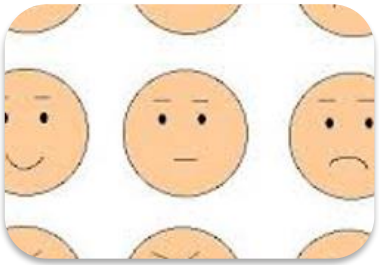
- Being encouraging and thoughtful when providing feedback to each other

Listen & Ask

- Listen with full attention
- Ask questions- there are no silly ones!

Basic Helping Skills

Confidentiality



Non-verbal skills

Validating

Putting aside your personal values

Praising openness

Communicating concern

Giving advice

- Divide into smaller groups and assign one or two questions each
- Designate note takers
- Designate moderators if necessary
- Use multimedia if necessary
- Bring out the problem and objective trees from last workshop and give to the respective groups

Discussion

- Review your problem tree from workshop 2 ?
- Why did you select this problem?
- Is it solvable or not solvable?
- What sort of challenges did you face in the recent past?
- Can you use this tree on them ? Try one

10 Minutes

Discussion

- Review your group's objective tree from workshop 2
- What possible solutions were available to you and what type of decisions did you make?
- What elements were in your control and what were not in your control
- What have been your results in relation to the decision you made
- Which of the three scenarios did you face?
- What is your future strategy?
- What will you prefer to do if experience same situation again

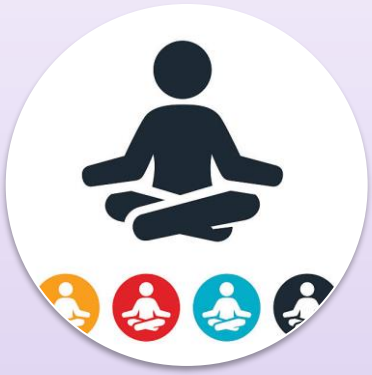
10 Minutes

Discussion

- What did you find good about the workshops so far ?
- During the week did you practice the strategies?
- Did you find them useful?
- Did you have any difficulties?
- List the activities you enjoy ?
- What was source of stress for you last week ?
- Did you continue your pleasurable activities or did you give them up ?

10 minutes

Managing Stress 5 Minutes



relax body (shake out arms, legs, relax the neck)

breathe from the stomach

Slow down your breathing

(3 seconds to breath in

3 seconds to breath out)

Practice regularly

Breathing exercises

- Before we start, I want you to relax your body a little bit. Shake out your arms and legs and let them go floppy and loose. Roll your shoulders back and gently move your head from side to side.
- (You can also ask the participants to imagine that they are at a place which is very peaceful, surrounded by greenery and where they feel happy and safe so that they can take breaths in a better and focused way.)

Breathing exercises II

- Place your hands on your stomach (belly), Imagine you have a balloon in your stomach, and when you breathe in you are going to blow that balloon up, so your stomach will expand. And when you breathe out, the air in the balloon will also go out, so your stomach will flatten.
- Watch me first. I am going to exhale first to get all the air out of my stomach. (Demonstrate breathing from the stomach – try and exaggerate the pushing out and in of your stomach. Do this for at least five breaths.)
- (Alternative example: You must have seen a new born baby, when it inhales the air, its stomach expands like a balloon); look at me, I will first of all I will breath out all the air from my stomach (Breathe through your stomach; try to demonstrate how air will be inhaled and exhaled from the stomach. Do it at least 5 five times over with your breaths.)

Breathing exercises-III

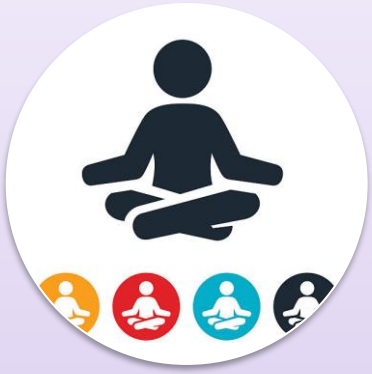
- Okay, so now you try to breathe from your stomach with me. Remember, we start by breathing out until all the air is out, and then breathe in. If you can, try and breathe in through your nose and out through your mouth.

  (Practice this exercise with the participants for at least two minutes.)
- Great! Now the second step is to slow the rate of your breathing down. So we are going to take three seconds to breathe in and three seconds to breathe out. I will count for you; 1,2,3,4…

Breathing exercises-IV

- Now, breathe in; 1, 2, 3...and breathe out, 1, 2, and 3. Do you notice how slowly I count? (Repeat this for approx two minutes.)
- That's great. Now when you practice on your own, don't be too concerned about trying to keep exactly to three seconds. Just try your best to slow your breathing down, remembering that when you are stressed you will breathe fast.
- Okay, so you try on your own for the next few minutes.
- Allow the participants to practice trying to slow down their breathing on their own for at least two minutes. Try to count their breaths in and out so you can judge whether they are doing it too quickly. Afterwards, spend some time talking about any difficulties they had.
- "Okay, so how was it doing it on your own? Was it more difficult trying to keep your breathing to a slower rate?"

Managing Stress



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Practice regularly

Thank You

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PSYCHOSOCIAL SKILLS DEVELOPMENT FOR TRAINEE CIVIL SERVANTS

WORKSHOP-4

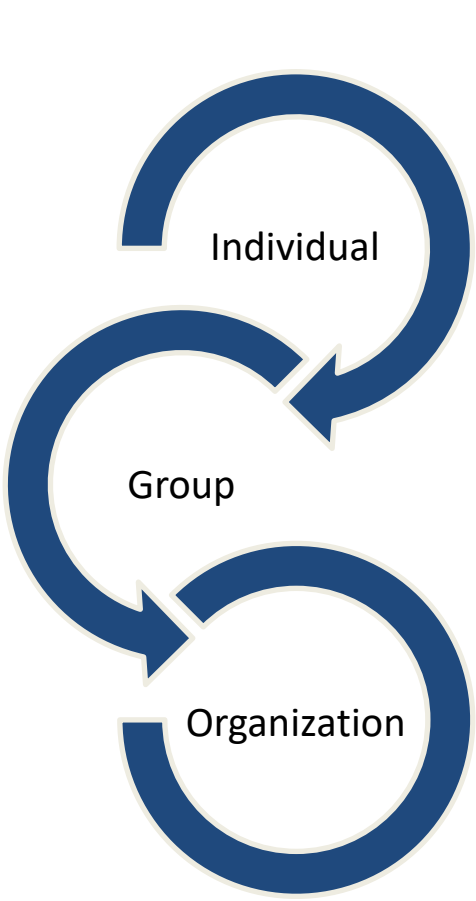
STRENGTHENING SOCIAL NETWORKS

My life my career

Leading Change in Times of Uncertainty

Civil Services Academy, Lahore

Psychosocial Skill Development for Civil Servants-strategies



Workshops Framework

Review of Workshop 1 and 2
Presentations by probationers

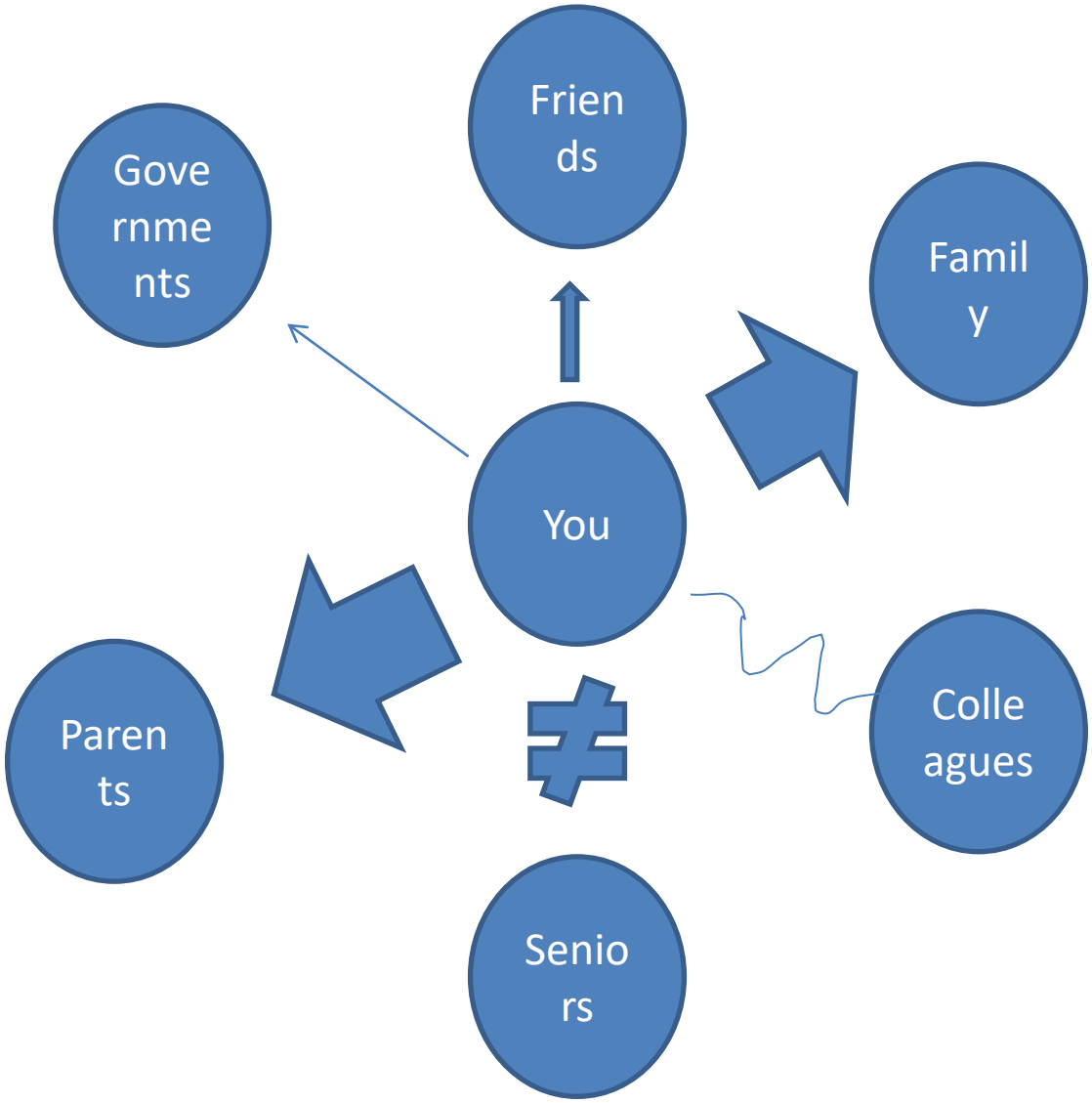
- Causes of Stress
- Managing Stress
- Defining Problem: Observation, Interpretation and Intervention
- Problems Tree Analysis
- Action plan from Workshop 2
- Workshop 3 activities

Objectives of workshop-4

- Moving from individual efforts to collective efforts
- Seeking alternate strategies from other stakeholders
- Making use of collective wisdom
- Using participatory approach
- Moving from conventional solutions (2+2) to more innovative and adaptive solutions

Who else can support you in solving the problem

List all stakeholders who either have stake in the problem or can be helpful in addressing the problem


Friends
Governments
Family
You
Parents
Colleagues
Seniors

Strengthening your social support

- Its all about connecting with others to be more supported and able to manage problem better
- Having good support helps people cope better in adversity
- Can help people not become as stressed, depressed etc.
- Can help people better manage practical problem
- Help people they are not alone in the problem they are experiencing

Advantages of Social Support Network

Stress can be ***better managed when your social support network is as strong as it can be.*** Here are the reasons why you should strive harder in strengthening your relationship with each identified member of your social support network:

- Sense of Security
- Source of Strength
- Feeling of Belongingness

Types of social support

Types of Social Support	
Emotional	Expressions of empathy, love, trust and caring
Instrumental	Tangible aid and service
Informational	Advice, suggestions, and information
Appraisal	Information that is useful for self-evaluation

Examples of Strengthening Support Network

EMOTIONAL SUPPORT	PRACTICAL SUPPORT
• Having a friend or family member listen the your concerns rather than be dismissive and not show any care • Spending time with others but not necessarily talking about problems (i.e. sharing a meal) • Connecting with an organization that is providing appropriate information and support to you • Helping other People (while not forgetting to take care of oneself)	• Getting help from others for example, learning new methods and tools to handle terrorism • Strategies of conflict transformation and peace • Helping other colleagues to manage stressful and difficult situations

‘Strengthening support network’

Who can be part of social support network

Its role

How can it help in keep doing get going

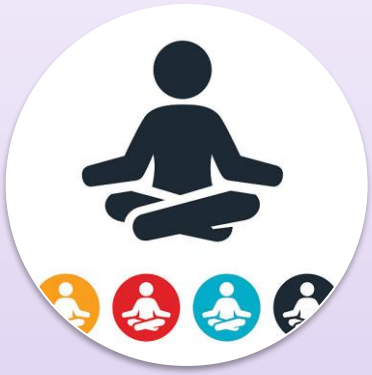
Differentiate between your self and your career

Sharing and caring

Consider civil servants who

- Do not share problems with others,
- Do not want to burden others,
- Believe that seeking support is a sign of weakness,
- With limited resources- live far from town/Pakistan , lack of transport, few people around them they trust isolated etc., and
- Have difficulties trusting others.

Managing Stress



relax body (shake out arms, legs, relax the neck)

breathe from the stomach

Slow down your breathing

(3 seconds to breath in

3 seconds to breath out)

Practice regularly

Thank You

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PSYCHOSOCIAL SKILLS DEVELOPMENT FOR TRAINEE CIVIL SERVANTS

WORKSHOP-4

Group activities

My life my career

Leading Change in Times of Uncertainty

Civil Services Academy, Lahore

Reminders for facilitators

- When providing feedback, first give a positive comment then comment on what could have done differently or included
- Consider each other's feelings (eg nervous, embarrassed etc.)
- Not laughing at other's mistakes
- There are no wrong answers
- Respect participants

Establishing Norms

Respect

- Respecting each other

Arrive

- Arriving and finishing on time
- Staying in the training room during training session

Commit ment

- Commitment to being an active participant (including in role-plays
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- Turn off or put away mobile phones

Encoura ging

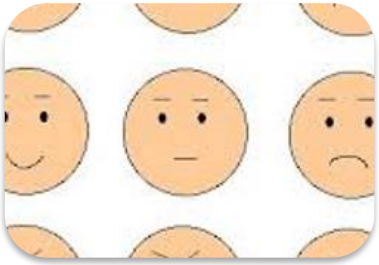
- Being encouraging and thoughtful when providing feedback to each other

Listen & Ask

- Listen with full attention
- Ask questions- there are no silly ones!

Basic Helping Skills

Confidentiality



Non-verbal skills

Validating

Putting aside your personal values

Praising openness

Communicating concern

Giving advice

- Designate note takers
- Designate moderators if necessary
- Use multimedia if necessary
- Bring out the problem and objective trees and give to the respective groups

Discussion

- When you think about social support what comes your mind?
- Review your problem tree/action plan from workshop 2 ?
- Whom you received social support?
- What sort of support did they provide you in addressing the problem you facedWrite down as many ways of seeking support you can think of
- Be as specific as possible in your examples (e.g. avoid writing “get support from friends”, rather specify the type of support you could get)

10 minutes

Key points

- Strengthening social support can mean different things to different people. Different forms of support include:
  - having a friend or family member listen and validate the person's concerns and emotions, rather than be dismissive and not show any care;
  - connecting with a mentor providing needed and appropriate information and support;
  - getting help to complete a difficult task or providing a way of completing a task (e.g. driving them somewhere, borrowing something from them, etc.);
  - Spending time with others but not necessarily talking about problems (e.g. sharing a meal);
  - Helping other people (while not forgetting to take care of oneself).

Obstacles to strengthening social support

- What has been your experience of coming to this group and sharing problem with others? Have you found it helpful? Individual opinions sought
- How do you think it might help you?
- What has made it hard for you get support from others in the past?
- What do you think might make it hard for you to strengthen social support this week? Later in life ?

10 Minutes

Possible Difficulties

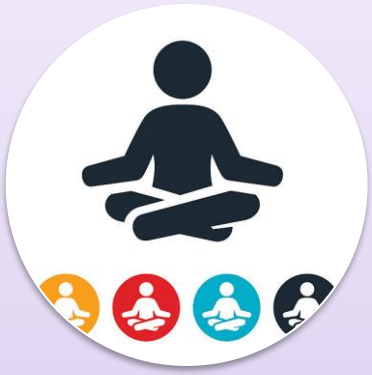
- Personal feelings: shame, embarrassed, low mood, anxiety and worry
- Negative expectation: it wont work, there is no point, It will burden others
- Isolation
- Difficulties in trusting others

Group discussion

- Action plan for strengthening social support?
- Is there a social support you had in the past that you could start to strengthen again?
- Is there some one or an organization you could get support from?

5 Minutes

Managing Stress(5 min)



relax body (shake out arms, legs, relax the neck)

breathe from the stomach

Slow down your breathing

(3 seconds to breath in

3 seconds to breath out)

Practice regularly

Breathing exercises I

- Before we start, I want you to relax your body a little bit. Shake out your arms and legs and let them go floppy and loose. Roll your shoulders back and gently move your head from side to side.
- (You can also ask the participants to imagine that they are at a place which is very peaceful, surrounded by greenery and where they feel happy and safe so that they can take breaths in a better and focused way.)

Breathing exercises II

- Placing your hands on your stomach (belly), I want you to imagine you have a balloon in your stomach, and when you breathe in you are going to blow that balloon up, so your stomach will expand. And when you breathe out, the air in the balloon will also go out, so your stomach will flatten. Watch me first. I am going to exhale first to get all the air out of my stomach. (Demonstrate breathing from the stomach – try and exaggerate the pushing out and in of your stomach. Do this for at least five breaths.)
- (Alternative example: You must have seen a new born baby, when it inhales the air, its stomach expands like a balloon); look at me, I will first of all I will breath out all the air from my stomach (Breathe through your stomach; try to demonstrate how air will be inhaled and exhaled from the stomach. Do it at least 5 five times over with your breaths.)

Breathing exercises-III

- Okay, so now you try to breathe from your stomach with me. Remember, we start by breathing out until all the air is out, and then breathe in. If you can, try and breathe in through your nose and out through your mouth.

  (Practice this exercise with the participants for at least two minutes.)
- Great! Now the second step is to slow the rate of your breathing down. So we are going to take three seconds to breathe in and three seconds to breathe out. I will count for you; 1,2,3,4…

Breathing exercises-IV

- Now, breathe in; 1, 2, 3...and breathe out, 1, 2, and 3. Do you notice how slowly I count? (Repeat this for approx two minutes.)
- That's great. Now when you practice on your own, don't be too concerned about trying to keep exactly to three seconds. Just try your best to slow your breathing down, remembering that when you are stressed you will breathe fast.
- Okay, so you try on your own for the next few minutes.
- Allow the participants to practice trying to slow down their breathing on their own for at least two minutes. Try to count their breaths in and out so you can judge whether they are doing it too quickly. Afterwards, spend some time talking about any difficulties they had.
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Thank you

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PSYCHOSOCIAL SKILLS DEVELOPMENT FOR TRAINEE CIVIL SERVANTS

WORKSHOP-5

STAYING CALM & LOOKING FORWARD

My life my career

Leading Change in Times of Uncertainty

Civil Services Academy, Lahore

Review of Workshop 1, 2, 3 & 4

- Causes of Stress
- Managing Stress
- Defining Problem: Observation, Interpretation and Intervention
- Problems Tree Analysis/Worksheet
- Get going keep doing
- Strengthening social network

Review

- What did you find good about the workshops?
- Since the last workshop did you practice the strategies?
- Did you find them useful?
- Did you have any difficulties?

Objectives of workshop-5

- Look back and feel proud of achievements
- What to expect when finishing the group
- Continue to stay well by preparing the best response to future problems
- Help participants learn how to remain calm in the face of adversity
- How to help each other and mobilize support in the event of critical circumstances
- Prepare plan of action for future

Workshops Framework

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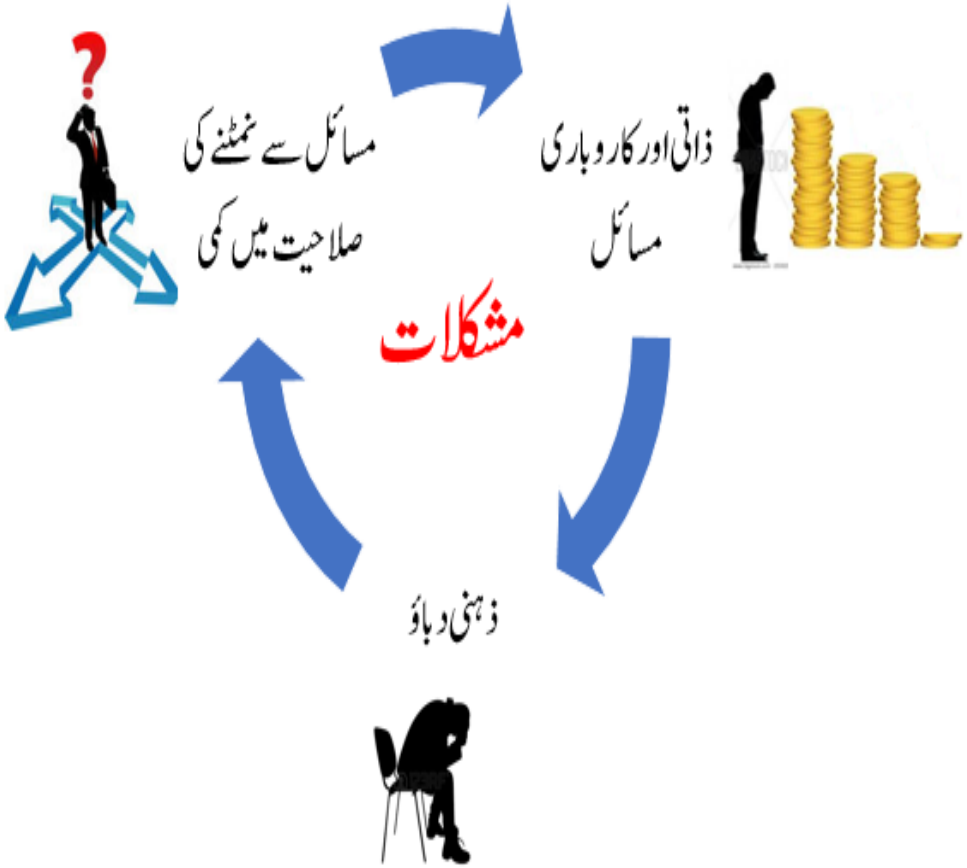


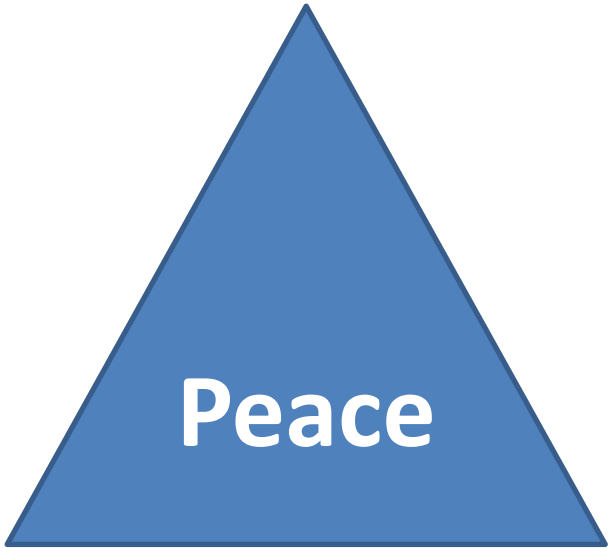
PSYCHOSOCIAL SKILLS DEVELOPMENT strategies

Staying Calm & Looking Forward

- Instead of working to exhaustion, take care of yourself and stay calm.
- If you keep on consuming all of your energies, you will eventually burnout.
- Taking care of yourself will help you to remain adherent to your goal.
- Eg. spending a few hours with your family, going out for a walk, enjoying your favorite food or company of your friends

Triangle of peace

Good Health



Problem management

Job satisfaction

Steps to Staying Well

- Positive review of achievements
- Review of the original goals for the program
- Importance of practicing strategies even in the absence of a problem
- Discussing potential future stressors and problems
- Identification of the strategies for each potential future stressors
- Suggesting ongoing support
- How to remember to practice these strategies

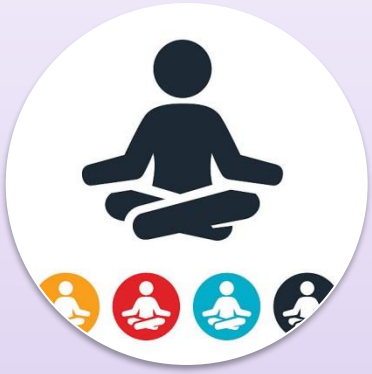
Discussion

- One thing you have learned in these workshops that has been helpful
  - Any missing point ?
- Regularly practice Managing Stress
  - Which day and time ?
  - Friends or a family members can remind to do it
  - Any group member can also remind everyone (through a call or message)
  - A Whatsapp group including all the participants can be created (in which the coach can remind everyone or participants can remind to one other) ?

Discussion II

- Preparation for the future
- Review old personal goals not achieved in the duration of the workshops
- Thinking the ways to keep improving (name new goals)

Managing Stress



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breathe from the stomach

Slow down your breathing

(3 seconds to breath in

3 seconds to breath out)

Practice regularly

Thank You

PSYCHOSOCIAL SKILLS DEVELOPMENT FOR TRAINEE CIVIL SERVANTS

WORKSHOP-5

Group activities

My life my career

Leading Change in Times of Uncertainty

Civil Services Academy, Lahore

Reminders for facilitators

- When providing feedback, first give a positive comment then comment on what could have done differently or included
- Consider each other's feelings (eg nervous, embarrassed etc.)
- Not laughing at other's mistakes
- There are no wrong answers
- Respect participants

Establishing Norms

Respect

- Respecting each other

Arrive

- Arriving and finishing on time
- Staying in the training room during training session

Commit ment

- Commitment to being an active participant (including in role-plays
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- Turn off or put away mobile phones

Encoura ging

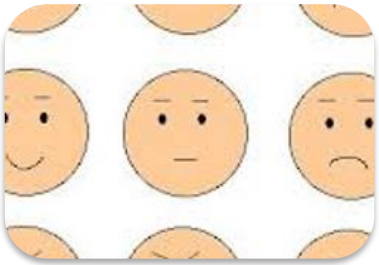
- Being encouraging and thoughtful when providing feedback to each other

Listen & Ask

- Listen with full attention
- Ask questions- there are no silly ones!

Basic Helping Skills

Confidentiality



Non-verbal skills

Validating

Putting aside your personal values

Praising openness

Communicating concern

Giving advice

PSYCHOSOCIAL SKILLS DEVELOPMENT strategies

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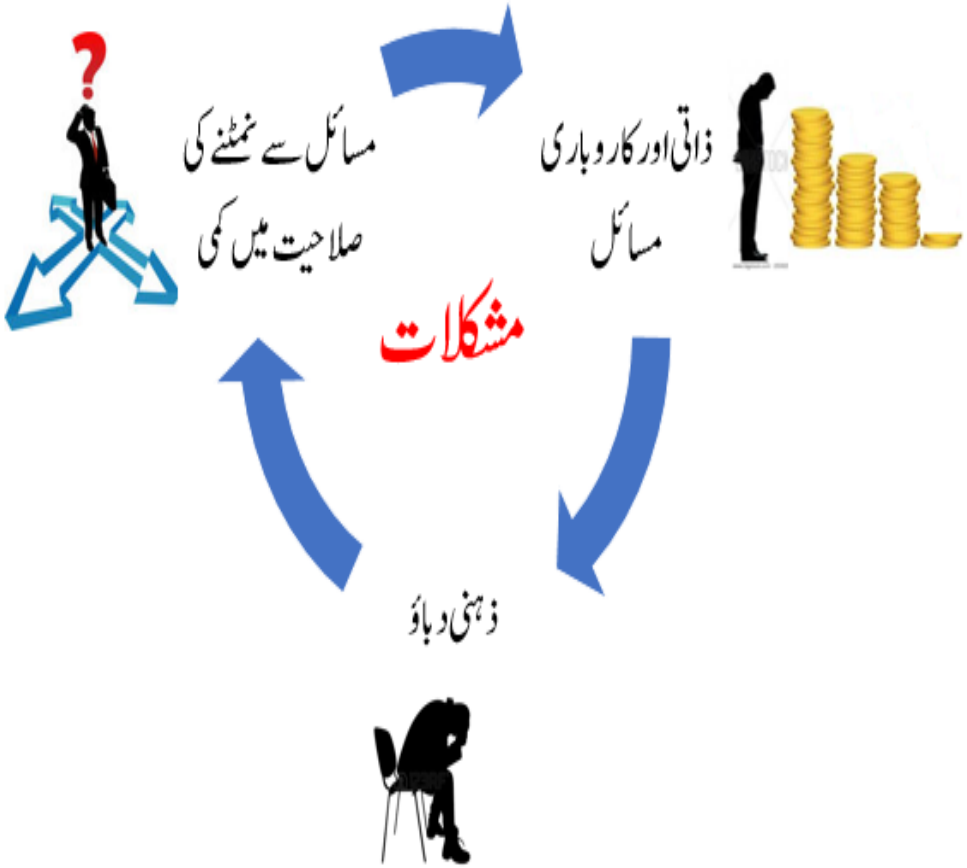


- Designate note takers
- Designate moderators if necessary
- Use multimedia if necessary
- Bring out the problem and objective trees and give to the respective groups

Discussion points

List down the things which:

a) Make you happy

b) Make you unhappy

How can these activities impact your well-being, decisi
power and passion for work?

What are the activities you can do to better care for yourself? (to take care of their physical health and for staying calm)

- Talk to someone, going out for a walk, or spending time with friends,

How can these activities impact your well-being, decision making power and passion for work?

10 Minutes

Discussion

- Each subgroup will discuss and prepare a presentation on what they have learnt and how they practiced the workshops
  - Workshop 1 - What is Psychosocial Skills management for civil servants and Managing stress
  - Workshop 2 - Managing problems
  - Workshop 3 - Get Going Keep Doing
  - Workshop 4 - Strengthening support network

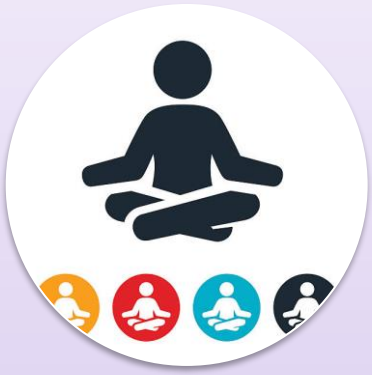
15 Minutes

Discussion

- Review old personal goals not achieved in the duration of the workshops
- Preparation for the future
- Thinking the ways to keep improving (name new goals) and continue practicing

10 minutes

Managing Stress 5 Minutes



relax body (shake out arms, legs, relax the neck)

breathe from the stomach

Slow down your breathing

(3 seconds to breath in

3 seconds to breath out)

Practice regularly

End with ideas for Follow up

- Discussions at the mess etc
- Whatsapp groups ?

5 minutes

Thank you

Appendix 6

Training of trainers' manual

Psychosocial skills development for Trainee Civil Servants

My Life, My Career

Training of trainers Manual

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Introduction

Psychosocial Skills Development for Trainee civil servants is a brief training program for trainee civil servants in order to enable to better cope with a range of challenges they might face in the course of their careers.

This is the training of Trainers Manual. The purpose is to train the trainers in the delivery of the workshops. Before reading this manual, you should be familiar with the manual which describes the intervention in detail.

How to Use This Manual

This manual is a guide for master trainers to train trainers/facilitators who will train Trainee civil servants. This manual can be used to conduct a two-day training session followed by a pre and post workshop session. This would allow a reiteration of the lesions and not put too much demand on the schedule of the trainers.

The trainers/facilitators will both receive the same training but the trainers will conduct the first and third sessions of each workshop whereas the facilitators support them in these sessions and conduct the second session comprising of activities and discussions in the smaller groups. These roles are interchangeable.

The facilitators can later become full trainers after practice.

Trainers/facilitators should have an understanding of the nature of the job of the civil servants as well as the cultural and physical atmosphere in which they are working. They can be either from the civil service themselves or have experience of delivering trainings to civil servants. Regular instructors of the training institutes are well suited for this training.

Training of trainer's sessions are spread over two days. A proposed schedule has been developed for each day to help you cover all the content required for training the potential trainers/facilitators.

The training could be further supported through WhatsApp groups created for this purpose. Unlike the trainees, the trainers agreed to form a WhatsApp group. This is because although there was no natural affinity or friendship between the groups, there was no competition either.

Flexibility

This manual is highly structured, but there ***is*** room for flexibility.

- The manual is clear about what information that is **important** to be communicated to `trainers/facilitators `.
- The method by which you choose to communicate information is entirely your decision. The manual provides a variety of training methods and encourages greater use of active methods rather than lecturing.
- It is *not* recommended that you change the order of sessions.

- It is *not* recommended that you change the length of the training.
- You may alter sections of this manual to better suit the cultural and professional background of trainers/facilitators (such as examples).
- The use of presentation slides is recommended whereas the use of videos is not as it might lead to distraction and not taking the training seriously. A video would also create the impression that not enough hard and original work has been done in the preparation of the training workshop. The trainees need to be made aware that they the trainers have something of special value to impart which they have worked hard upon. Videos appeared to be time fillers for them.

Preparation Checklist

To help the training run more smoothly it is useful to be well prepared. Use the following checklist:

1. Preparing Yourself

Be familiar with the following,

☐ Psychosocial Skills development for Trainee civil servants Manual

☐ This training manual and PowerPoint slides

☐ The activities and games from this training manual. Choose activities in advance and know the message they are trying to give to trainers/facilitators.

☐ Who will be the trainers/facilitators (e.g., their level of experience, skill and knowledge, how they will be using the strategies taught)

Although there are likely to be some psychologists in the group, it would be more appropriate to let the faculty members and civil servants to take the lead as they are in a better position to relate with the trainee civil servants and they would be taken more seriously by the participants. The professional psychologists would not be taken seriously as the civil servants consider themselves to be a higher calibre and class. Also, that would create an impression that their being treated as psychologically challenged people which they are not.

☐ Who your trainers/facilitators future trainees will be (read available reports on the Trainee civil servants in terms of their problems and resources, and their cultural background, get briefing from CSA [1]

[1] In the case of CSA, the study participants will be newly inducted civil servants undergoing induction training at Civil Services Academy, Lahore, Pakistan. The civil servants are citizens of Pakistan, both males and females, aged between 21 to 30 years and have at least 14 years of education. They have passed the Civil Superior Services (CSS) examination held in 2018, a country-wide competitive examination and have been assigned to one of the federal level cadres but who have yet to carry out their official duties. Some of them (about 60% have work experience elsewhere, while about one third are straight from the universities. This is relevant particularly to enable us to use relevant examples. The

2. Preparing Materials

Have you got enough copies of the following materials for trainers/facilitators and one copy for yourself?

☐ Psychosocial Skills development for Trainee civil servants Manual with Presentations

☐ Feedback Form

☐ Pens/Pencils

☐ Spare paper or notepads

Have you got the following materials ready for yourself?

☐ This manual

☐ Accompanying PowerPoint slides

☐ Large pieces of paper for making flipcharts

☐ Whiteboard markers

3. Preparing the Venue

We consider that it is appropriate to use the same training venue where the regular CTP sessions are conducted. The Civil Services Academy was found to have appropriate facilities. However, we also felt that it would not be appropriate to use the classroom settings for the TOT workshops. We should use the library or similar setting in which all the participants could have eye contact and hold free discussion.

It is also appropriate to take the group outside the classroom for breathing exercises. This would relax the group. However, it is important to keep in mind that this might take some additional time and create scheduling difficulties. It would take time to gather them back for the next session.

Be sure you know your venue as best you can before you start training. Check the following,

☐ Is there sufficient space for the number of trainers/facilitators participating, including breaking into pairs/small groups for role-plays?

☐ Is there a comfortable environment (e.g., lighting, temperature, seating that can be moved easily, quiet and offers privacy)?

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most pertinent examples are from the early careers of civil servants. We also need to take examples from different occupational groups having different careers paths in order to make sure everyone can relate to the examples.

☐ Do the computer and multimedia projector facilities work?

☐ Are there adequate bathroom facilities and where are these?

☐ Are there adequate refreshments and how will these be served?

☐ Is there a flip chart and markers to use for activities session?

Tips for Conducting Training

Your role as a master trainer is to improve the knowledge and skill of trainers/facilitators in Psychosocial Skills development for Trainee civil servants as well as their confidence in their role. The following tips can help you achieve these aims.

1. Number of trainers

Providing training can be a demanding job. Try to keep to a trainer-to- trainers/facilitators ratio of 1:8.

It is better to have two trainers for a group of about sixteen. A smaller group does not allow for more vibrant discussion. And two trainers allow the trainers to have a break or to help each other in making the same points in a different way. This keeps the interest of the group alive and the presence of two trainers from different backgrounds allows the possibility of introducing the subject from different points of view.

Having more than one master trainer means you can share the role. While one person is leading the other master trainer can monitor time, energy levels of trainers/facilitators etc. This allows you to modify the training according to their needs. For example, if the trainers/facilitators look disengaged you can introduce an energizer game or take a break.

2. Training Methods

The best way for most people to learn something new is through practice. So, this manual emphasizes using active training methods (e.g., role-plays, activities, videos etc.) and minimizes long periods of lecturing. As a general guide you should not spend more than 30 minutes lecturing at one time.

When teaching, avoid using technical terms, such as *empathy*, *active listening*, *psycho education*, and *CBT* (*cognitive-behavioural therapy*) etc. (unless you are giving training to psychologists). If trainers/facilitators do not understand these words they might feel confused or lack confidence in their role and they do not need to know these terms to be effective.

Encourage trainers/facilitators to ask questions at any time to clarify doubts and discuss additional thoughts.

3. Encouraging Participation

The following tips will help encourage `trainers/facilitators ` participation:

- Use their names
- Acknowledge everyone is an expert and everyone learns from each other
- Be aware of shy as well as dominating participants– allow opportunities for shier trainers/facilitators to contribute (e.g., invite people to contribute, use small group discussions regularly) Give feedback sensitively – provide positive feedback (i.e., what went well) before correcting mistakes

4. Keeping to Schedule

Keeping to a time schedule can be challenging. Time estimates for each activity have been suggested. In practice, the time spent on each activity will largely depend on the group (e.g., size, how talkative they are, how quickly they learn concepts). Having a colleague keep time while you are training can be a good way of ensuring you keep to schedule.

Tips for Conducting Role-Plays

There are 2 types of role-plays you can conduct in the training. It is suggested that where possible you practice all types for each strategy.

1. Live demonstration role-plays (where trainers play the role of `trainers/facilitators ` play the role of Trainee civil servants, and trainers/facilitators learn how to deliver a particular section of training)

2. Active role-plays, (Trainers/facilitators form small groups to role play a skill/section of training)

When directing trainers/facilitators to act as Trainee civil servants, encourage them to:

- Try to imagine being ta Trainee civil servant, and to relate to their situation and problems
- Do not provide answers too easily. Do not be too difficult as a Trainee civil servant- this can be frustrating, interfere with their learning and potentially impact on the confidence of the trainer and facilitator.
- Giving feedback to trainers/facilitators: Encourage to start with telling them 1-3 things you liked and one thing that could be improved

Options to consider for (trainer) demonstration role-plays:

- Present the same role-play twice- first, demonstrating poor use of the skills and common trainer errors (e.g., giving advice to the trainee civil servant) and then a better demonstration of the skills. E.g., give direct advice to a Trainee civil servant in Managing Problems to show how this can feel undermining or disempowering for a trainee civil servant compared to helping the trainee civil servant come up with their own solutions.

Training schedule

Day 1

Topic	Session Time	Activities	Materials
Introductions Background	1 hour	Discussion	Presentation Whiteboard/ Flip Charts and markers
Basic Helping Skills	20 minutes	Role-plays Discussion Quiz set-up	Presentation Whiteboard/ Flip Charts and markers
Group management skills	20 minutes	Discussion Role-plays	Presentation Whiteboard/ Flip Charts and markers
Tea Break	20 minutes		
Managing Stress	1 hour	Activity Role-plays Discussion	Presentation Whiteboard/ Flip Charts and markers
Managing Problems	2 hours	Discussion Role-plays Quiz	Presentation Whiteboard/ Flip Charts and markers
Lunch Break			
Get Going, Keep Doing	1 hours	Discussion Role-plays Quiz	Presentation Whiteboard/ Flip Charts and markers
Strengthening Support Network	1 hours	Discussion Role-plays Quiz	Presentation Whiteboard/ Flip Charts and markers

Day 2

Topic	Session Time	Activities	Materials
Review and Workshop 5	1 hour 30 minutes	Discussion Role-plays Quiz	Presentation Whiteboard/ Flip Charts and markers
Tea Break	20 minutes		
Role-plays & feedback Workshop 1 and 2	2 hours 30 minutes	Discussion Role-plays	Presentation Whiteboard/ Flip Charts and markers
Lunch Break			
Role-plays & feedback Workshop 2 and 3	2 hours 30 minutes	Discussion Role-plays	Presentation Whiteboard/ Flip Charts and markers
Supervision	1 hour	Discussion	Presentation Whiteboard/ Flip Charts and markers
Trainers' self-Care	30 Minutes	Discussion	Presentation Whiteboard/ Flip Charts and markers

Day 1 First session

Master Trainers begin the workshop by warmly welcoming everyone.

Acknowledge any efforts made in attending the workshop- i.e., taking time away from other work responsibilities, and other commitments. Acknowledge that by attending this workshop trainers/facilitators are making an important commitment towards improving the well-being, decision making and leadership skills of the civil service.

- This is the first part of the training of trainer's process. After these two days workshops, following steps will be conducted A training session just before the workshop to review the learning and retention of the concepts as well as brief on the particular workshop being conducted that day.
- Ongoing training of presenters and facilitators in the actual session by master trainers. We will let the presenters and facilitators lead the workshops with the master trainers staying in the background.
- Post workshop sessions conducted with the participation of all the presenters and facilitators to gather feedback, preparing for next sessions and dissemination of the lessons learned.

Logistics

If necessary, inform trainers/facilitators on necessary logistical information, including where to find bathrooms, arrangements for tea and meal breaks etc.

Briefly review schedule for the training and ensure everyone can commit to this. Make any necessary adjustments to the schedule at this point.

Introductions

Trainers introduce themselves first - including, their background, and/or anything about themselves (e.g., favourite food, hobbies, family etc.).

Begin to break down hierarchies early on in training to enhance participants` confidence and engagement: Acknowledge everyone's expertise and experience and the value of this in this training. let them know that *you* will be learning a lot from *them* over the next days.

Ask trainers/facilitators to introduce themselves and say something about themselves (e.g., something that makes them unique, nature of their business, a hobby, or personality characteristic).

Psychosocial Skills Development Workshops: An overview

Discussion 10 minutes

Discuss why Psychosocial Skills Development Workshop was developed

Main points to emphasize:

- Psychosocial Skills Development Workshops for Trainee civil servants is a training program for trainee civil servants of Pakistan, who are working in stressful conditions. The program aims to improve the psychosocial well-being, problem-solving skills, decision making skills, and resilience of trainee civil servants through evidence-based strategies.

- The purpose of this training program is to enable trainee civil servants to function better in their professional and personal lives by helping them cope with the psychological stress of working in highly uncertain and risky environments.
- The training program for Trainee civil servants consist of five workshops, which will include evidence-based strategies of stress management, problem solving, developing experimental mind set (behavioural activation), strengthening support network and self-care.
- This training workshop is spread over 2 days to train you people as trainers/facilitators to enable you to deliver this training to the Trainee civil servants in Pakistan.
- The training does not include any monetary incentive.
- The training does not provide any solutions rather the training will provide strategies and tools to help trainee civil servants deal with their problems
- The training does not cover problems that are out of the civil servants' control such as terrorism, security issues and financial issues, but it provides strategies and tools to tackle stressors and challenges that arise due to these circumstances.
- This is a research based and evidence-based training program.
- We will not share its findings with the faculty. These workshops are not meant to do psychological profiling or assessment.
- The trainers will not attempt any kind of judgment about the psychological health of the trainees. The purpose is not diagnostic or evaluation but providing tools for improving psychosocial skills.
- The training program is not for those who are affected by illness. Rather it is more of preventive in nature. The purpose is to create awareness for psychosocial issues and to provide support to certain people who are on the borderline.
- The training workshops do not necessarily address serious psychological issues for which individual therapy/medication might be required.
- The probationers who feel that they need individual psychological therapy would be recommended to a penal of experts.
- These workshops are not about the stress caused by CTP. While the stress caused by training programs can be used as an example, the workshops primarily focus on providing certain tools for psychosocial skills development during the training course as well as after it in order to deal with stressful conditions likely to be faced in their life and career.

Adversity
15 minutes

What is Adversity?

Show slide on adversity. Explain adversity (any stressful/difficult situation such as workplace stress, death of loved one, internal displacement, conflicts/war, security concerns/blasts)

Ask participants what do they think about stress?

Activity:

Discuss the need for Psychosocial Skills Development Workshop for Trainee civil servants - e.g., the problems which civil servants face in their careers. Trainers/facilitators can give examples from own life.

Possible questions to start the discussion:

- What do you think are the main challenges faced by civil servants in Pakistan? For example, political pressures, financial difficulties, work life balance etc.
- How do you see these challenges affecting civil servants and their performance?
- Does anyone have any personal stories or friends from civil service of experiencing these kinds of challenges that you feel comfortable sharing? If so, please do not use their names.

It may be helpful to write these down on the board or flip chart.

Lead into explanation of the two aims of the Workshops

1. Help reduce stress in civil servants working in challenging situation and improve their well-being, and psychosocial skills.
2. Empower trainee civil servants to be their own trainers/facilitators

Explain how these Workshops will achieve these aims by teaching the 5 strategies.

Outline the sessions- Review each of the strategies and their general purpose.

Introduction to Training Manual

Orient trainers/facilitators to the materials for the training including the training manual They Trainers/facilitators will need to bring them each day.

The manual has three main parts.

1. The first section describes:
    - What are the Psychosocial Skills development Workshops; and
    - Basic helping skills
    - Group management skills.

The second section contains the main content of the five training workshops Each workshop has 3 sessions. For the first part of the session the presentations are to be used. The second part of the session consists of the sub groups for discussions. Handouts are prepared for these sessions. Formal presentations are not necessary.

2. The Third section includes appendices like
    - Problem checklist;

- Case examples for workshops
- Presentations

Show and review training schedule.

The workshop was conducted in a three-session format.

The first session also termed the plenary session consisted of presentations made to a group of about fifty trainee civil servants. In this setting presentation of the key concepts of the particular session of the workshop will be made by a presenter(trainer). The other three or four Co-trainers (facilitators) will be present in the session also and intervened in accordance with the requirements.

These sessions will be held in Houses. Houses are used for conducting group wise lectures during the other courses of the CTP. In these lecture halls about 50-80 peoples can sit. They are named after great leaders of Pakistan and Pakistan movement. The five halls were named Sir Syed House, Jinnah House, Iqbal House, Johar House and Liaqat House.

Power Point presentations will be used to convey the main concepts. These presentations in contain all the material from the manual adapted in accordance with the needs of the civil servants as well as the charts and graphs.

For the second session, participants are divided into smaller groups of 10 to 12 each where participants will sit around table and there will be no presentation. Points are written on a flipchart and given to the facilitators to enable them to ask the question. They will be given time limit to be allowed for discussions for each set of questions. The main points of the discussions will be noted down by one of the participants. However, at times the Co-trainers can display certain slides on the screen so that the participants remain focused point. This practice varies from trainer to trainer and subject to subject.

Finally, for the third session the trainee civil servants will be again brought into larger setting in houses and asked to discuss the gist of their discussions with their colleagues by making presentations.

Training Rules and Expectations

Discussion	**10 minutes**

Examples of rules/expectations:

- Confidentiality
- Respecting each other (including a wish not to disclose something)
- Treating everyone as an expert – everyone's opinions, ideas and questions are respected
- Commitment to being an active participant (including in role-plays)
- Not interrupting each other
- Being encouraging and thoughtful when providing feedback to each other
- Open to making mistakes or being corrected by others
- Arriving and finishing on time

- Staying in the training room during training session (you can discuss how to manage emergency situations- e.g., let the trainer know you need to leave).
- Trainers to keep to schedule and allow ample time for breaks
- Turn off or put away mobile phones
- Listen with full attention
- Ask questions- there are no silly ones!
- Although this is a time to learn it is also important that we enjoy ourselves

Briefly discuss the "rules" to role-plays. In addition to the above, these might include;

- Being sensible- while the role-plays are not formal tests, they should be taken seriously
- Trying not to be deliberately difficult when acting as trainee civil servants
- Taking time out if individuals are feeling too closely connected with role play stories
- When providing feedback, consider giving a positive comment first (what the "trainer" did well) then commenting on what the "trainer" could have done differently or included (this will be modelled constantly by you as a trainer)
- Consider each other's feelings (e.g., nervous, embarrassed etc.) when providing feedback
- Not laughing at other's mistakes

Next, discuss Trainers/facilitators' expectations i.e., what is hoped they will get from this training.

Optional Activity: Ask Trainers/facilitators to write down (in their notepads) specific goals they hope to achieve by the end of the training. These can be reviewed towards the end of the course.

Points to emphasise:

1. Trainers/facilitators need to stick as closely to the manual as possible-and try not to add personal interpretations. We can only say that these workshops work if we know that everyone is delivering the same workshops! The manual and presentations given will include suggested dialogues to help trainers/facilitators for this purpose. You don't need to stick to them word for word.
2. If a trainer wants to do something with the trainee civil servants that is not part of the workshops, they *must always* discuss talk with the master trainers first. Some variations of a strategy might be appropriate while others will not be acceptable.
3. Some degree of flexibility is okay in the dialogues- e.g., using your own words to make it sound more natural, using civil servants` examples when introducing a strategy
4. To help trainers/facilitators feel confident, competency assessments will be completed after training, role-plays will be used in supervision and sometimes an observer will sit in your training sessions to see how you are going

Basic Helping Skills (BHS)

Discussion

Discuss what the core basic helping skills (BHS) are.

Options for leading discussion:

- Define each of the BHS from the manual.

Role-Play

Practicing BHS

Aim: Improve familiarity and confidence in using all BHS

Time Frames: 2 minutes to form pairs and give instructions; 5 minutes for each conversation (swap once); 10 minutes for discussion (see next session)

Instructions:

- One trainer practices BHS as they talk with the "trainer" about problems they are currently experiencing (real or made-up)
- There is no expectation for the 'trainer' to apply any strategies or solve problems
- Swap roles
- Discuss and give feedback

Helpful hint for giving feedback: Encourage trainers/facilitators start with telling the 1-2 things they liked about the other trainer and one thing that could be improved

Possible BHS to change or not use:

- Posture (turned away from person, slouching, stiff/rigid)

- Eye contact (staring, lack of eye contact, distracted/eyes looking around the room)

- Tone of voice (quiet, abrasive/harsh)

- Directive / advice giving

- Dismissive of feelings/reactions (e.g., 'I know how you must feel'; 'At least…. didn't happen to you)

- Trying to wrap up the conversation, hurry the person along

Discuss what it felt like and any personal examples individuals would like to share.

Discussion **10 minutes**

Discuss why basic helping skills are so important.

For example:

- Builds rapport and trust in the relationship,

- Helps participants feel more comfortable, especially when talking about more personal and business-related information.

- Improves the chances of the civil servants engaging in the Psychosocial Skills Development Workshop.

When it is difficult to practice Basic Helping Skills

Group discussion about when it is difficult to show trainee civil servants BHS.

Aim: Increase awareness of difficulties showing BHS in order to prevent this from impacting on the intervention delivery

Time Frames: 10 minutes as a larger group

Participants: All trainers/facilitators

Discussion points to consider:

- Tell trainers/facilitators that it is normal to experience difficulties in showing empathy for trainee civil servants

- We should try to show BHS even when it is difficult or we don't feel genuine about it.

- It might be difficult to feel empathy for certain type of trainee civil servants. (e.g., particular personalities, age groups or etc.)

- Sometimes there are days trainers/facilitators have difficulties expressing BHS (e.g., because they are feeling tired, stressed, have personal issues on their mind etc.)

- The balance between being kind and caring while also being firm (e.g., about completing practice tasks)

- Regardless of how easy or difficult it is to express BHS to trainee civil servants, they should all receive the same amount of BHS

- Responding to reluctant trainee civil servants

The trainee civil servant-trainer relationship

Discussion

Discuss the trainee civil servant-trainer and facilitator relationship:

Write any key discussion points on a poster

Themes to cover:

- The role of a trainer and facilitator (including how they are different from friends and family and using metaphors
  - Coach-athlete
  - Teacher-student
  - Doctor-patient
  - Mentor-Junior

Group Management Skills

Discussion

Keeping to time without cutting short valuable group discussion
• Reminding trainee civil servants about time schedules throughout the program is helpful • Break times can be used to return to group discussions that you need to cut short • Sometimes you might decide that a group discussion is very important to continue with and so you decide to shorten another section of the group. Always talk with your master trainer about these decisions to make sure you have not skipped important information.

1) Managing dominant participants
• A dominant participant might be someone who talks a lot in the discussion, doesn't let other participants share their stories, talks over the top of others or rejects other participants' opinions. They might think they already know about the subject maybe even more than the trainer. Be sure to always use your basic helping skills when managing dominant participants • When a participant is being dominant, you use skills to manage them in front of the group and also on their own. • In front of the group, you can thank the person for their contribution and then invite others to share.   ○ *"Thank you (name). What you are saying is very interesting but I'd also like to hear from others in the group. Has anyone else had a similar or different experience?"* • If a participant is causing problems in the group and not responding to your management you should speak to them on their own during a break or at the end of a session. Explain to them that it is important that everyone has a turn to talk or have their problems managed in the group. Be careful not to start with saying something negative to the person as they may not listen to your suggestion.

- *"You have been very engaged in the programme which is good. But it is very important that everyone in the group has an opportunity to speak. And I have noticed this is not happening at the moment. So, I will ask you to watch that you are respecting everyone in the group, not talking over the top of others and giving everyone a chance to talk. This might mean waiting and letting someone else talk first when there is a discussion. Does this sound okay to you?"*

- There might be reasons why the person is being dominant in the group (e.g., they do not like other participants from different backgrounds, they believe they need the most help in the group, the group believes they should be dominant or speak for others because of their previous education). It would be helpful to understand what these reasons are and help the participant and the group to manage them.

2) Encouraging discussion with a quiet group

- The case example will be helpful for encouraging group discussion. But you might ask the group to talk about the case example if they are not talking about personal problems.
- Sharing other examples, you are familiar with (e.g., from the career of senior civil servant, or from previous groups you have led) can also help participants feel more comfortable joining discussions. Be sure not to include real people's names or stories that might easily identify who they are (this will break confidentiality)
- Talking individually to participants to help them participate in the group can also be helpful

"I have noticed you are very quiet in the group. Is there anything I can do to help you engage more in the discussions?"

3) Managing group discussions that go off-topic or discuss unhelpful strategies or those outside of the scope of the workshops (e.g., Capacity development of civil service, improvements in CTP)

- You will need to be firm when re-directing group discussions. But also, be sure to use your basic helping skills!
  - *"I can see this is an interesting discussion but we have moved away from the focus. Let's come back and we can discuss this topic during the break."*

4) What to do if a participant drops out, attends late or irregularly etc.

- Be sure to speak with participants who are not engaging in the programme. They might be regularly showing up late or leaving early or missing sessions.
- Find out what the reason is for their disconnection
- You can review the discussion on Advantages and Disadvantages of joining the group and also their individual goals. This discussion might motivate them to be more engaged in the group. Or it might help them decide to drop out of the group.
- If participants drop out, this is okay. These workshops will not be suitable for everyone. If this happens, be sure to write down in your notes the reason for their dropping out. Try to

get them to complete the post-workshop assessment as soon as possible too. This information will be very important to gather.

5) Participants disclosing too much information

- Sometimes participants will share very personal information. This might make other participants uncomfortable. It will be your job as leader to decide if the information being shared in the group is too much or too personal.
- If you decide a participant is sharing too much information or it is too personal, you can do one or all of the following:
    - Ask the participant to watch how much they are sharing and try to reduce it by themselves
    - Decide on a secret sign you can give to the participant if they are sharing too much information so they can stop (e.g., raising your hand)
    - Agree that you will gently cut them off when they are sharing too much information (e.g., *"Thank you (name) for sharing this. It sounds like it has been very difficult for you. I wonder whether others would like to share their experiences."*)
    - Ask the participant to stop themselves from sharing too much but instead they can tell you what they would like to say on their own during the break or at the end of the session

Role-Play Group management skills

Aim: Improve familiarity and confidence in managing groups

Time Frames:15 minutes

Participants: All trainers/facilitators

Instructions:

Invite a volunteer to lead a group discussion about anything (e.g., who is a better singer Pakistani). Any member can act as a dominant participant and invite leader to practice ways to manage this. You can repeat the role play for different situations (quiet participant/or someone who takes the discussion off topic). Give 5 minutes for each role play.

Discussion

Spend 10 minutes of discussion at the end of role plays.

Ask participants to reflect on the difficulties they faced in managing participants in their experiences and how did they try to manage these difficulties.

Tea Break

What is Adversity

Discussion

Prepare trainers/facilitators to role-play 'What is Psychosocial Skills development for Trainee civil servants?' and 'What is Adversity?' (Refer to training manual).

Reminders for 'trainers/facilitators':

1. All BHS are important when providing education
2. Do not assume the trainee civil servants' experiences. e.g., "*From what you have described it sounds like you are feeling tired a lot of the time. Do you think this sounds right?"*
3. Do not directly tell the trainee civil servant the reason for their problems (e.g., you are stressed because you are not taking interest in your career)
4. Use a gentle tone- remember you have given this education to many Trainees but it may be the first time the participants trainee civil servant has heard it.
5. Give general education about Psychosocial Skills development for Trainee civil servants strategies e.g. "*I am going to teach you strategies to improve well-being and problem-solving skills.*
6. Avoid giving any advice (e.g., "*You should talk to your co-workers")*
7. Avoid saying '*things are not that bad'* for the trainee civil servant, comparing them with others or dismissing their problem
8. Remember the trainee civil servants are the expert of their own selves and their feelings!

Role-Play: Demonstration **10minutes**

Role-play of 'What is Adversity?' *What could be sources of stress?*

How do these difficult situations affect civil servants?

How do these difficult situations affect civil servants' family lives?

How do these difficult situations affect civil servants' Careers and lives?

Ask trainers/facilitators to share their ideas in the large group.

- W*hen people live in difficult circumstances and experience stressful events, most people will usually experience a range of different emotions, like intense fear, grief, extreme sadness and excessive hopelessness. Have you seen people around you experiencing similar emotions?*

Inserting already known examples into dialogue- you can use the ones in the Annexures of the training manual.

Discussion

Discuss importance of explaining ‘What is Psychosocial Skills development for Trainee civil servants?’ and ‘What is Adversity? 'What role does it play in the training?

Provide opportunity to answer questions about Overview of Psychosocial Skills development for Trainee civil servants before continuing with next section.

Motivating Participants

See presentation for Workshop 1.

Emphasize,

- Advantages/Disadvantages table is used to engage trainee civil servants in the workshops
- The trainer chooses 1-2 questions from the table they believe are relevant to this group of Trainee civil servants.
- This table is reviewed regularly to maintain Trainee civil servants’ engagement (e.g., at the beginning for each training workshop, when the trainee civil servant is disengaging or wants to discontinue).

Reasons to Join Psychosocial Skills development for Trainee civil servants (Advantages)	**Challenges to Joining Psychosocial Skills development for Trainee civil servants (Disadvantages)**
“Lots of people have benefited from this training.”	“I also understand that it can be challenging for some people to join this training.”

- What do you think you will personally get out of this training?
- What might improve in your life if you join these workshops for Psychosocial Skills development for Trainee civil servants?
- What do you think you might be able to do that you cannot do now?

- What are some of the problems for you in joining this training?
- What will you have to give up or lose if you join these workshops?
- Will these workshops reduce your time with your family?
- Will these workshops take you away from other important tasks? like sports or studies

Examples:

- Time away from work
- Time away from other interests
- Time away from CTP

- If your problems reduce, how might this be good for other areas in your life?
    - For example, your work, your life, your family etc

Discussion

Discuss how the advantages/disadvantages table can help to manage unmotivated or ambivalent Trainee civil servants.

Remind trainers/facilitators they can refer back to this table at any time in the program. This is encouraged if the trainee civil servant's motivation or engagement have changed since the first training workshop (e.g., after 2 workshops they are unsure if they want to continue).

Discuss how trainers/facilitators can use their BHS with Advantages/Disadvantages table. For example,

- To understand and validate a trainee civil servants' ability to perform his or her job.
- To help the trainee civil servant make an informed choice about engaging with the workshops for Psychosocial Skills development for trainee civil servants.
- To identify the trainee civil servants' strengths and improve their confidence in engaging in the training
- To model an open relationship between trainee civil servants and trainer &facilitators

Key points to emphasize,

- Start with questions the trainee civil servants can answer easily, judging on how certain they are to engage (e.g., what would you like to get out of the workshops?) or how uncertain they are about engaging

- Always respect a trainee civil servant's decision not to engage or address their problems (even if you disagree)
- Always use BHS when completing the advantages/disadvantages table with a trainee civil servant
- At the end of completing the table, the trainer & facilitator gives a summary of the advantages and disadvantages, emphasizing the reasons to join the workshops

Note. Trainers/facilitators will have a chance to role-play the whole of the education component of the Psychosocial Skills development workshops at the end of the day

Workshop 1 Managing Stress (MS)

Discussion

Review aims of the workshop i.e., to manage physiological symptoms of distress, such as heart racing, tension, and over-breathing.

Show when this strategy will be delivered (Psychosocial Skills development for Trainee civil servants' flowchart) in the end of workshop 1. This strategy can also be used at any time in the workshop if the trainee civil servant is becoming stressed or over worked.

Group Activity & Role-Play

Note. This activity encourages trainers/facilitators to induce mild hyperventilation. They should not be forced to do this if they do not want to. You may wish to demonstrate this first to show trainers/facilitators that there is nothing unsafe about breathing in this way.

Aim: Trainers/facilitators experience feelings associated with shallow and rapid breathing and how Managing Stress can be effective in slowing one's breathing down and help them feel more relaxed.

Draw 3 columns on the board.

Instructions:

- Ask trainers/facilitators to count their breaths while you time them for 1 minute. One breath = breathing in and out. (Tell them not to change their breathing in any way.) Write their numbers in the 1st column.)
- Trainers/facilitators count the number of breaths for 1 minute again. Write these numbers on the board again in a 2nd column.
- Master Trainer leads the whole group in Managing Stress.
- Trainers/facilitators count their breaths for 1 minute again and record numbers in the 3rd column.

The last two steps of this activity should be done when the trainer has discussed and explained the "Managing Stress" to the trainers/facilitators.

Discussion

Discuss trainers/facilitators experience of the above activity:

- What happened for them when they tried to breathe slowly? Was it effective?
- What did they find difficult about slow breathing?
- Would an additional instruction or doing something differently have helped with this problem?

(You may ask the first two questions at the end of the hyperventilation activity)

Additional points to discuss:

- Common problems people have with Managing Stress (refer to table of difficulties in Psychosocial Skills development for Trainee civil servants (Workshop 1 from training manual)
- Culturally appropriate alternatives to slow breathing for Managing Stress such as praying etc.

Role-Play Managing Stress

Aim: Learn how to deliver Managing Stress

Time Frames: 2 minutes to form small groups; 10-15 minutes for role-play

Participants: All "trainers & facilitators"

Group sizes: 3-4

Instructions:

- Review steps to Managing Stress first
- One Trainer & Facilitator leads the group in Managing Stress
- Choose another volunteer from the group to repeat the activity

Be mindful that some female trainers might be uncomfortable in doing breathing exercises in a mixed setting.

Workshop 2 Managing Problems

. Managing Problems helps to manage trainee civil servants' problems (such as career problems, work life imbalance problems, career difficulties managing boss and family expectations, or conflict or quarrel with others (family, friends or colleagues etc.)

Discussion

Introduce Problem Tree approach to Managing Problems as explained in the presentations. Be sure to know these beforehand to avoid reading them out from manual.

Points to emphasize:

Observe:

- First step in managing problems is to collect all the information that is out there. Observe all the information regarding problem at hand objectively.
- Observe all the aspects of the problem i.e., what is the baseline issue, what are your stakes and what could be all the possible reasons/aspects of this problem.
- List down all the problems you are currently facing and separate them into two columns; ones you have a control over or you can influence them, and the others you do not have any control on.
- Choose/prioritize one problem you think is of immediate concern to you, and also that you can control/influence.

Interpret:

- Analyse all the information collected so far about the problem, try to explain all the aspects of this problem. Ask yourself; what is the problem, what happens when this occurs, what I do/do not do when this problem occurs.
- Think all of all the possible ways you can tackle this problem

Intervene:

- Think: What are you going to do about this problem?
- Think of one best suited solution (considering pros & cons)
- Think about all the resources you will need to execute this solution
- When and how would you execute? Strategize and plan out.

Observe, interpret, intervene cycle

Role-Play: Demonstration

Aim: To show trainers/facilitators common errors or unhelpful ways of delivering the workshop. If trainers/facilitators are aware of what a trainer looks like when they are being directive or giving advice to a trainee civil servant, they will be better at catching themselves doing the same and hopefully correcting this!

Have a volunteer to act as a trainee civil servant.

Instructions:

- Tell the group to be very attentive to how the "Trainee civil servants" might feel in this role-play
- "Trainee civil servant" identifies 3 practical problems they are having currently (real or made-up minor practical problems or indecisions)

- Introduce Managing Problems to Trainee civil servants (use script from manual of workshop 2)

- The most common error in delivering Managing Problems is being *too direct* or telling the Trainee civil servants what they should do to solve the problem. So, in the bad role-play it is recommended that you tell the Trainee civil servants the solutions

Other potential errors to demonstrate:

- Skip 1st step
- Give a general, vague definition of the problem
- Be judgmental of trainee civil servant's potential solutions
- Give advice on what solutions you think are good
- Choose the solution you think is best and not want the trainee civil servant can do due to lack of resources

Discussion

Discuss the role-play:

- "Trainee civil servant" describes their reactions and feelings.
    - E.g., how did they feel when you told them what solutions they should do? Did they feel motivated to carry out the solution? Did they feel a part of the process? How did they feel towards you?

- Discuss reactions of the group
    - How might they have felt if they were the Trainee civil servants in this situation? Could the trainers/facilitators identify what they would do differently or what was done so poorly in the role-play?

- Normalize urge, trainers/facilitators might have to be direct with Trainee civil servants but why this is unhelpful.

- Provide brief examples through role-play of how you can try to encourage solutions from the Trainee civil servants or give general prompts
    - Asking them to think of solutions that might work for a friend in a similar situation, but who does not feel stressed out.
    - Asking them what they have been able to try in the past (regardless of whether it has worked or not)
    - Give broad or vague ideas e.g., "some people have found talking to others can be helpful. Does this sound like a solution you could use? Who could you talk to? What could you say or ask that might help solve part of the problem?"
        - In this last example emphasize the pattern of questions: the first question is *broad*, followed by more *specific* questions.

Role-Play

Content: Managing Problems

Aim: To show trainers/facilitators delivering Managing Problems using difficult cases and to brain storm as many solutions as participants can. These cases include Trainee civil servants identified problems that are large and/or vague (therefore helping trainers/facilitators practice Step 2)

Participants: All trainers/facilitators

Choose difficult problems from the list of problems: Examples can be seen in Appendix at end of manual.

Discussion

Discuss the balance between giving trainee civil servants advice and assisting them in thinking of potential solutions to problems.

Emphasize to trainers/facilitators that some Trainee civil servants will find it hard to think of solutions because of the current challenges they are facing. Although trainer should avoid giving direct advice, they do not want to leave the Trainee civil servants to think of all the solutions without any help as they may feel like a failure or not feel confident in this strategy. We want to guarantee to an extent that the Trainee civil servants will be successful in managing their problem when they complete their action plan. This will help them feel more confident. Also, the Trainee civil servants may be able to think of more solutions without assistance for the 2nd problem they address.

Remind trainers/facilitators how to encourage solutions from Trainee civil servants:

- Asking them to think of solutions that might work for a friend in a similar situation, but who does not feel stressed out.
- Asking them what they have been able to try in the past (regardless of whether it has worked or not)
- Give broad or vague ideas e.g., *"some people have found talking to others can be helpful. Does this sound like a solution you could use? Who could you talk to? What could you say or ask that might help solve part of the problem?"*

Managing Problems strategy is best suited to manage practical problems such as decision making and leading others. It is not relevant for problems related to security, finance or other such things. Remember to differentiate between solvable and unsolvable problems.

The trainer can ask the Trainee civil servant some more questions about the problem to identify the practical aspect of it. (e.g., *"Can you explain more about the problem? As you mentioned there are various parts of this problem, let`s take one part at a time and try to manage it first then we will move on to the next part of the problem)*

Teaching the use of problem trees and objectives trees for make action plans to address problems is quite effective. Please use the presentations to explain this approach.

Group Activity

Managing Problems

Aim: To practice delivering Managing Problems to a group. These problems may include trainers/facilitators own problems trainers/facilitators. You can take examples from the appendix of the manual too.

Time Frames: 2 minutes to form small groups (3-4 people, one person acts as trainer & facilitator and others as trainees/trainee civil servants. give instructions; 10 minutes for role-play; 5 minutes for discussion/feedback

Participants: All 'trainers/facilitators'

Group Sizes: 3-4

Note: Be sure that trainers/facilitators practice completing the problem trees and objectives trees.

Ask the trainers/facilitators to reflect upon their experience of delivering managing problems, discuss and brainstorm solutions for difficulties they faced.

Group discussion

Before starting next strategy, revise the steps of managing problems with the trainers/facilitators.

Suggested question: Can anyone recall how to structure a problem tree?

Workshop 3 Get Going Keep Doing (GGKD)

Refer to Manual Chapter 6 and accompanying presentation.

Stress impacts peoples' activity in their daily life. They often feel too stressed, too sad or without energy to do the things they used to do. Get Going Keep Doing is designed to improve their activity.

Case Example Discussion

Read out the case example of a civil servant presenting with symptoms of stress and low mood from the manual.

Discuss the consequences of these problems.

Suggested discussion points:

- Invite trainer & facilitators to reflect (and share if willing) on times when they or a friend have felt similar feelings

- What happens when people continued to withdraw from activities that are enjoyable (i.e., would it alter their feelings? How so?)
- Would they ever feel positive when they are not engaging in pleasant activities?

The Vicious Cycle of adversity/low productivity

Problems related to personal and professional life leads the person to feel distressed that reduces the ability to manage problems. When the ability to manage problems decreases, the problems related to personal and professional life worsen which in turn makes a person more distressed. This is the vicious cycle of adversity.

Review the important steps of this strategy:

1. Give education/rationale for Get Going Keep Doing, including Vicious Cycle of adversity/low productivity
2. Define different types of activities - pleasant activities and tasks. Both are important-to encourage pleasant feelings in the former and a sense of mastery or achievement in the latter. (Reference Manual Chapter 6 and Appendix with examples of different types of activities.)
3. Choose one pleasant activity and/or task
4. Ask the trainee what was it they used to do more previously that they enjoyed and have reduced doing that; what is it they need to start doing more again; or what is something new they have always wanted/think they now need to do?
5. Break down chosen activity into smaller and more manageable steps

Review aims of GGKD by showing poster of adversity i.e., working in difficult, fragile and conflicted settings can cause stress among civil servants. This leads to impact their decision-making abilities; therefore, they do not feel confident in taking tough decisions even if they are critical. This further affects their career and personal life which leads to more stress. Due to this, they get caught in a vicious cycle of adversity/difficulties.

Get Going Keep Doing introduces an "experimental mindset" to encourage trainee civil servants to try out different ways to manage their challenges in everyday life. By doing experiments and trying out new solutions to problems, they can get out of the vicious cycle of the problems/adversity. It proposes to continue with enjoyable activities despite the stressful environment.

Emphasize the following message during discussion

"To err is human" one must not fear the failure, taking tough decisions make us feel uncomfortable and push us to get out of our comfort zone.

- This happens because we fear failure, mistakes and possibility of being wrong. All these fears stop us to break through this vicious cycle of problems/adversity.
- The most difficult aspect of GGKD for trainee civil servants is to break this cycle. Doing more experiments and strategizing different solutions is critical in breaking the vicious cycle.

Role-Play: Demonstration	**10 minutes**

Aim: Trainer's role-play 'Get Going Keep Doing" with Trainee civil servants

Instructions:

- The same roles (of trainer and trainee civil servants) are played by the trainers
- Use scripts for from workshop 3 manual
- Be sure to *individualise* the education about Get Going Keep Doing depending on the nature and composition of the group- you may do this by referring back to the responses the trainee civil servants gave earlier in Workshop 2**.**

Discussion

Key Points to emphasis

- Asking for examples when describing vicious cycle of difficulties/adversity- e.g., when people live in difficult circumstances and experience stressful events, most people will usually experience stress. Have you seen people around you experiencing such feelings?
- Inserting already known examples into dialogue- e.g., from Appendix of manual When people experience stressful events, it can influence their decision-making abilities and can restrict the ability to address their problems in a new way. In this way, this vicious cycle of adversity/difficulties continues, that effects not only their personal health but also their career. To break this cycle, we need to start trying different ways to manage our difficulties.

Workshop 4 Strengthening Social Support

Refer to Chapter 7 of manual and accompanying presentation.

Discussion

There are many forms of social support. As a larger group, brainstorm examples of "social support". The aim of this discussion is to encourage trainers & facilitators to recognize there are multiple forms of social support. Many people will believe seeking support is only talking to someone about their problems, but this is not the case.

The support network can be of multiple forms, it can mean having developing a network of seniors and colleagues to provide moral support. Support network help you to recall why you are investing your energies and what is the goal you want to achieve. Without having support network, it becomes difficult to take tough decisions and to get out of the troubles. Having all these boxes checked in your life will help you be more focused on your purpose.

As a group, brainstorm examples of "support network". The aim of this discussion is to trainers/facilitators recognize there are multiple forms of support network. Many people will believe seeking support is only talking to someone about their problems, but this is not the case.

- Tell trainers/facilitators to write down as many ways they can seek support they can think of

- Tell them to be as specific as possible in their examples (e.g., avoid writing "get support from friends", rather specify the type of support they could get)
- Trainers/facilitators are given **5 minutes** to write as many examples as possible
- Review each group's ideas and discuss as a larger group. In discussion you can review different types of support network Some examples are given at the Appendix of the manual.

Discussion

Review SSS steps.

1. Provide education about SSS
2. Help the trainee civil servants to decide how they want to strengthen their social support
3. Managing reluctant trainee civil servants (e.g., use disadvantages/advantages table, discuss rationale for SSS, ask the trainee civil servant's reasons for their reluctance)
4. Develop an action plan
5. Schedule steps

Role-Play: Demonstration

Trainer role-play SSS with trainers/facilitators.

Aim: Demonstrate how to deliver workshop to a group of Trainee civil servants

Instructions:

- The same roles are played by the trainers
- Use scripts from workshop 4
- Be sure to *individualise* the education depending on the nature and composition of the group

Role-Play

Content: SSS

Aim: Practice delivering SSS

Time Frames: 10 minutes for preparation, 20 minutes for each trainer & facilitator (2x role-play); 15 minutes for discussion (see next session).

Participants: All trainers/facilitators

Group Sizes: 2 groups of 4-6 participants

Discussion

Continue discussion/feedback after role-play as larger group. Consider the difficulties of delivering this strategy.

Ask trainers/facilitators which types of trainee civil servants might have difficulty with SSS.

Consider trainee civil servants who,

- do not share problems with others,
- do not want to burden others,
- believe that seeking support is a sign of weakness,
- are with limited resources, live far from their peers, few people around them they trust isolated etc., and
- Have difficulties trusting others (e.g., civil servants deceived by others earlier).

Points to emphasise:

Discuss why trust is important and how a trainer & facilitator might adjust this strategy for someone who has difficulties trusting others.

Themes to consider:

- Ensure (as much as possible) the person or organization you are encouraging the trainee civil servant to seek support from, can be trusted
- Trust is developed slowly and the trainee civil servant does not need to trust someone completely to seek some kind of support from them

Workshop 5 Staying Calm & Looking Forward

Please Refer to manual chapter 8 and presentation.

Introduce staying calm and looking forward. Be sure to know this beforehand to avoid reading this out from the manual.

Instead of working to exhaustion, take care of yourself and stay calm. If you keep on consuming all of your energies, you will eventually burnout. Taking care of yourself will help you to remain stick to your goal. This can be anything which suits you, like spending a couple of hours with your family, going out for a walk, enjoying your favourite food or company of your friends.

Discussion

Review the steps to Staying Well& Looking Forward

Ask trainers/facilitators to role-play all workshops

- Praise the trainee civil servant for reaching the end of the workshops
- Educating the trainee civil servant about the nature of problem management- expect feelings of distress to return especially in times of significant stress. The return of these feelings is likely to be more manageable, less severe and brief.
- Educating the trainee civil servants on how they can stay well and respond to problems (i.e., keep practicing the Psychosocial Skills development strategies)
- Test the trainee civil servants' understanding of the strategies they have learned

Staying Well case examples

Group Activity

Content: Helping Others Which strategies are most useful for the case example?

Time Frames: 5 minutes to form groups and allocate case examples; 20 minutes for each group to complete task; 10 minutes for large group discussion

Participants: All group members

Group Sizes: 4

Instructions:

- What are the activities trainers/facilitators can do to better care for themselves? (To take care of their physical health and for staying calm)
  - Group reads one of the examples and decides which Psychosocial Skills development strategies will be most helpful to the trainee civil servants and why?
- How can these activities impact your well-being and career?

Points to emphasise:

- It is important to take care of our health (physical and mental) to achieve our goals
- We need stamina to tackle challenges in our life
- Everyday challenges make us forget to take care of ourselves, and be consumed by the stressors of life
- To come out of this vicious cycle of adversity, it is important to reconnect with ourselves and our purpose. One can achieve this by gaining energy and revitalizing oneself from pleasurable activities.

Discussion

Discuss, ‘Looking Forward’

Congratulate the trainers/facilitators on completing training of Psychosocial Skills development for Trainee civil servants.

Optional activity to aid discussion: If trainers/facilitators wrote down any expectations/goals from this training on day one, invite them to review these in the same way you would ask a trainee civil servant.

- Were this goals/expectation achieved?
- If not, what stopped them from achieving these goals (e.g., unrealistic etc.)
- What can they do to continue to work towards these initial goals?
- What are their goals now? What steps can be planned to help achieve them?

If not, ask the trainers/facilitators what problems they might face in future and how can the strategies of the workshops help them? Encourage them to describe in detail how they would manage those problems.

Points to emphasize:

- Problems and challenges are a part of life and are inevitable but offer opportunities as well
- Be optimistic but realistic!
- We have learnt some strategies to cope with these challenges effectively
- Keep practicing these strategies so that you make best of all the opportunities,
- To stay engaged passionately with your purpose, stay calm, manage your problems, seek support and take care of yourself.

Conclusion

Options for ending the day:

- Discussion: Ask trainers/facilitators to provide feedback about the day, what they learned, what went well and what did not go so well

- Activity: Provide trainers/facilitators with post-it notes and pens. Ask them to write one new thing they learned today and how it might change something in their life (e.g., improve their confidence, change the way they talk to their friends/family/others, change the way they think about adversity etc.).

Discussion & Review of workshops

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Review all Psychosocial Skills development for Trainee civil servants training sessions or strategies and answer any questions.

If there are no major concerns, use this time to conduct role-plays of sessions or strategies ‘trainers/facilitators have found challenging or not had enough practice of.

Give trainers/facilitators time to prepare for the role-plays.

Steps to giving feedback

The following steps are a general guide for how to give feedback to 'trainers/facilitators', for example, after observing a role-play or during supervision (if group supervision).

1. Give positive feedback

- Be specific with your praise
  - Avoid saying "It was good"
  - Describe what was positive – e.g., you used the basic helping skills appropriately; you had good eye contact and you were able to reflect back what the 'trainer' was saying in a way that normalized their feelings.
- Give an example of when you noticed that behaviour
  - E.g., when the trainee civil servant was reluctant to engage in Get Going Keep Doing, you reflected back his concerns in a gentle and understanding way. Then you revisited the education for this strategy in a way that made sense to him and helped him see that this strategy would be helpful for him. You then reassured him that you would help him to develop experimental mindset.
- Describe how this positively affected the trainee civil servant (i.e., in the case of a role-play)
  - E.g., By demonstrating basic helping skills and revising the education for Get Going Keep Doing the trainee civil servants felt their concerns were valid and listened to. It also helped them understand and engage in the strategy.

2. Invite reflections from the trainer & facilitator

- Ask the trainer & facilitator to reflect on the following:
  - What they believed they did well (in the training session or in the role-play)
  - What they would change if they could (e.g., what would they have done differently or included)

3. Provide feedback about areas to improve (only if necessary)

- If there is an area that you believe the trainers/facilitators need improvement in or you need to make a correction of some kind, do so gently and using your basic helping skills
- As with praise, be specific, give an example and discuss how this may have negatively affected the trainee civil servants (or is outside of how these workshops should be delivered)
- Invite the trainer to respond
  - E.g., "What do you think? Would you agree or disagree with this comment?"
- You can follow this up with a wider group discussion or a role-play
  - E.g., supervisors modelling the skill/strategy or helper's practicing the improved/correct way of delivering the strategy

Supervision

Discussion

Begin this topic by reflecting on trainers/facilitators experiences of participating in role-plays during the training. Discuss what it was like giving and receiving the feedback.

From these comments, discuss the importance of supervision and discuss what is expected of supervisors/master trainer and trainers/facilitators in supervision.

Themes to consider:

- Supervision is an important ingredient to providing effective training to Trainee civil servants.
- Helps to ensure quality delivery of Psychosocial Skills development for Trainee civil servants training
- Can prevent trainer burnout
- Helps trainers/facilitators feel well supported and confident in managing challenging trainee civil servant problems.
- Opportunity to give master trainer/supervisors feedback- This can support trainers/facilitators in being an active part of supervision and on-going training

Expectations of Trainers/facilitators:

- To attend (or notify the supervisor/master trainer if they cannot attend and arrange alternatives)
- Complete supervision forms prior to the supervision (given below)
- Be ready to actively participate in supervision
- Role of peer supervision (outside of formal supervision)

Ongoing Training for Trainers/facilitators /competency assessments

Discussion

Orient trainers/facilitators to the idea of competency assessments:

- 2 possible settings:

    i. Trainers/facilitators will be given a part of training content and asked to role-play with a group to demonstrate how to conduct a particular workshop
    ii. An assessor/trainer will observe that training session
- They will be assessed on Basic helping skills and in delivering various strategies of the workshops
- Competency assessments will occur at the end of their training period

Ongoing Support and Supervision

Tell trainers/facilitators that they have completed the training workshop. However, to conduct the training workshops with Trainee civil servants, they may need support and ongoing supervision. The master trainers will be available to support them in between the training workshops. They can also contact the master trainer whenever they feel some difficulties or challenges in conducting training workshops with trainee civil servants. (Discuss when and through which means they can contact you other than the scheduled supervision sessions)

Throughout the delivery of intervention, there will be pre and post workshop sessions with the researcher and master trainer to discuss progress and challenges in intervention implementation.

Your Role as a Trainer

Your role as a trainer is two-fold,

1. Improve the skills and knowledge of 'trainers/facilitators' so they can competently deliver Psychosocial Skills Development Workshops for Trainee civil servants.
2. Fill them with confidence to competently deliver psychosocial skills development for Trainee civil servants.

Of course, by the end of the classroom training, they might not be 100% confident in delivering the workshops. That Training will continue in Pre and post workshop sessions and during the workshops.

In regards to the second aim, be careful about how your delivery of the training can influence their confidence. For instance, be careful not to jump in and correct immediately. Instead, give them the opportunity to correct their own mistakes or even ignore minor errors for the sake of preserving their confidence. Also remind yourself of the key steps to providing feedback to 'trainers & facilitators' - namely, always being affirming (positive, encouraging, identifying what the 'trainers & facilitators' did well).

Self-care for Trainers/facilitators

Discussion

Trainers/facilitators' Burnout:

When trainers/facilitators begin to feel overworked and possible physical symptoms due to ongoing stress (e.g., working with many difficult trainee civil servants).

Discuss how trainers/facilitators and supervisors/master trainers can be mindful of these experiences (what are the signs to look out for?). For example, it is important to keep clear boundaries with trainee civil servants- keep a professional relationship with them, be on the lookout if you are acting like a trainee civil servant's friend, avoid sharing too much personal

information with them, avoid meeting with them outside of the training workshops and do not ask for a personal favour.

To facilitate discussions, you may wish to provide case examples of trainers/facilitators displaying any of the below.

Signs of trainer burnout might include:

- Talking about trainee civil servants in a very familiar way or as though they have no care or empathy for them.
- Becoming emotionally upset when talking about a trainee civil servant's challenges and problems.
- Thinking and worrying a lot about trainee civil servants
- Feeling like a failure
- Low motivation in their work or withdrawing from their responsibilities

Signs trainers/facilitators should look out for in themselves:

- Feeling like every day is a bad day
- Caring about your work or home life seems like a total waste of energy
- You're exhausted all the time
- The majority of your day is spent on tasks you find overwhelming
- You feel like nothing you do makes a difference or is appreciated
- Physical symptoms may include headaches, feeling tired all the time, getting sick a lot

How to prevent or respond to these issues:

- Supervision
- Self-care of trainers/facilitators- brainstorm what self-care might look like for different people
    - Scheduling breaks between work
    - Leaving work on time
    - Not taking work at home
    - Setting boundaries- saying 'no' to requests that cannot be achieved- this includes with colleagues, supervisors and trainee civil servants
- Practice Psychosocial Skills development strategies on yourself
- Talk regularly with colleagues and supervisors/master trainers possibly on WhatsApp etc
- Identify when your stress is impacting on your ability to be a trainer & facilitator
    - Let your supervisor/master trainer know
    - Reduce work load
- Maintain a healthy lifestyle outside of work- healthy eating habits, exercise, engaging in pleasant activities, healthy sleeping habits
- Be aware of your own expectations about improvements or changes in trainee civil servants. Sometimes trainees' problems will not improve even if trainers/facilitators have delivered Psychosocial Skills development workshops very well. Oftentimes it has something to do with the trainee civil servant-, living in very adverse situation, not ready to confront problems, unable to engage or the problems are such that they cannot be influenced in such short span of time.

Quiz

Conduct Psychosocial Skills development for Trainee civil servants quiz to test the 'trainers/facilitators' knowledge and skill retention. You may choose to do this in teams or individually and have prizes.

Psychosocial Skills development for Trainee civil servants Quiz

The following questions are suggested questions for a quiz. You may wish to select those that are most relevant to the group you are training (e.g., areas of difficulty etc.). You may write your own questions.

1. Who is Psychosocial Skills development for Trainee civil servants intended to help?
    - Trainee civil servants working in a challenging environment
2. What are the aims of assessment?
    - To give the trainee civil servant an opportunity to talk about their current difficulties
    - To develop a relationship with the trainee civil servant
3. Name as many basic helping skills as you can
    - Confidentiality
    - Communicating concern
    - Non-verbal skills
    - Praising openness
    - Validating
    - Putting aside your personal values
    - Not giving advice
    - Other terms that might be used-warmth, empathy, reflective listening
4. Demonstrate one of the basic helping skills (master trainer to act as trainee civil servant)
5. A trainee civil servant discloses that she has been having conflict with her partner or boss. What might be a basic helping skill that is particularly important to demonstrate with this trainee civil servant?
    - BHS include, non-judgmental attitude, praising openness, validating her feelings and communicating concern
6. What is confidentiality? How is it important to the trainee civil servant? Can you demonstrate how you talk about it with a trainee civil servant so they understand?
    - Keeping everything that the trainee civil servant discloses private- this privacy extends to the whole team (i.e., to cover for supervision)
    - Any other content discussed in the sessions must only be shared with others with the trainee civil servant's permission
    - Confidentiality helps the trainee civil servant trust their trainer and feel comfortable to disclose private information about themselves or others
7. What are the 2 parts of the education component in workshop 1?
    - Education about Psychosocial Skills development for Trainee civil servants' workshops
    - Education about adversity and stress management
8. How many Psychosocial Skills development for Trainee civil servants' strategies are there?

- 5

9. What are they?
    - Managing Stress
    - Managing Problems
    - Get Going Keep Doing
    - Strengthening Support Network
    - Staying calm
10. For what problems is Managing Stress helpful?
    - Physical symptoms of distress- e.g., hyperventilating (breathing too quickly and shallow), heart racing, dizziness, muscle aches and tension
11. What is one of the most common errors made when delivering Managing Problems?
    - Trainers/facilitators being too directive/telling trainee civil servants' solutions/giving advice
12. What kinds of problems does Get Going Keep Doing help with?
    - low productivity
    - Experimental mind-set
13. How does Get Going Keep Doing improve someone's productivity?
    - By helping a trainee civil servant to start running experiments, the person's mood and sense of achievement increases. People begin to feel better once they start doing things they enjoy
14. After Get Going Keep Doing what is the next strategy you introduce to a trainee civil servant?
    - Strengthening Support Network
15. Give examples of different types of Support networks.
    - Asking someone for practical help
    - Seeking assistance from a specific agency or organisation
16. What are the mains aims of the last workshop?
    - Educate the trainee civil servant on what to expect with Psychosocial Skills development for Trainee civil servants
    - Educate the trainee civil servant on how to stay calm and respond to future problems
    - Test the trainee civil servant's knowledge of the Psychosocial Skills development for Trainee civil servants' strategies and when to use different strategies (i.e., what problems each of the strategies can be used to deal with)
    - Help the trainee civil servant set future goals and plan how they might begin to achieve these goals
    -

Conclusion

Discussion

Review the aims of the training and reflect on goals you believe the group has achieved (areas where they have improved etc.). Highlight those areas that remain a challenge and encourage

trainers/facilitators to monitor their progress with these and to continue to talk with peers and in supervision about these issues. You may also encourage them to focus particularly on these areas when they begin practice cases.

- Thank the group for their hard work, concentration, effort etc.
- Ask 'trainers/facilitators' to complete the Training Evaluation Form (given below)
- Provide 'trainers/facilitators' with graduation certificates

……. End of training……

Training evaluation tools

1. Post-training evaluation form

Participant's ID: _____

Name of the trainer _____

Venue of the training _____

Date _____

Please consider your experience of the training you have completed and provide responses to the questions below. Your responses will help us improve our training programs. Your responses are anonymous.

1. Please complete the following by checking the column of your choice.

1.	The facility or venue where training took place	Very good	Adequate	Inadequate
2.	Number of participants in workshop	Too much	Adequate	Too few
3.	Length of the whole training workshop	Too short	Adequate	Too long
4.	General quality of the training	Very good	Moderate	Poor
5.	The training was helpful in understanding strategies of the workshops (managing stress, managing problems, developing experimental mind set, strengthening support system & self-care)	Very helpful	Helpful	Not helpful

6.	Use of the participatory training methods in the workshop (group activities, group discussion, role plays etc.)	Too much	Adequate	Too less
7.	Overall content of training workshop	Good	Fair	Needs improvement
8.	Trainer & facilitators' manual and presentations	Good	Fair	Need
9.	Group activities & role plays	Good	Fair	Need improvement
10.	Presentation of material by master trainer (e.g., teaching points, discussions, demonstration role plays)	Good	Fair	Needs improvement
11.	Facilitation of activities by the master trainer	Good	Fair	Needs improvement

2. Please rate how much you agree with the following statements

	STRONGLY DISAGREE	DISAGREE	NEUTRAL	AGREE	STRONGLY AGREE
The difficulty level of the workshop was about right (given my level of experience)					
The master trainer actively involved me in the learning process					
The master trainer clearly explained concepts, strategies and how to manage difficult situations during training workshop					
The master trainer supported me and attended to my needs					

(e.g., explained concepts when I did not understand them)					
As a result of this training, I feel confident in my capacity to deliver Psychosocial skills development workshops					

3. Now that you are familiar with Psychosocial skills development workshops, please rate the following 2 statements

	Not at all	A little	Somewhat	very	Extremely
How motivated are you to deliver this training to trainee civil servants					
How relevant do you think it will be for trainee civil servants working in challenging settings of Pakistan Government service.					
How effective do you think it will be for trainee civil servants working in challenging setting of Pakistan service.					

4. If you were given the task of revising, adjusting, or redesigning this training, what would you change?

5. Please provide one example of how your practice will change as a result of this training (if any).

6. Any other comments.

PSYCHOSOCIAL SKILLS DEVELOPMENT
FOR TRAINEE CIVIL SERVANTS

Training of Trainers workshop

My life my career
Leading Change in Times of Uncertainty

17th-18th October, 2018

Civil Services Academy, Lahore

Training Schedule Day 1			
Topic	**Session Time**	**Activities**	**Materials**
Introductions Background What is Adversity Wat is Stress	1 hour	Discussion	Presentation Whiteboard/ Flip Charts and markers
Basic Helping Skills	20 minutes	Role-plays Discussion Quiz set-up	Presentation Whiteboard/ Flip Charts and markers
Group management skills	20 minutes	Discussion Role-plays	Presentation Whiteboard/ Flip Charts and markers
Tea Break	20 miniurs		
Managing Stress	1 hour	Activity Role-plays Discussion	Presentation Whiteboard/ Flip Charts and markers
Managing Problems	2 hours	Discussion Role-plays Quiz	Presentation Whiteboard/ Flip Charts and markers
Lunch Break			
Get Going, Keep Doing	1 hours	Discussion Role-plays Quiz	Presentation Whiteboard/ Flip Charts and markers
Strengthening Support Network	1 hours	Discussion Role-plays Quiz	Presentation Whiteboard/ Flip Charts and markers

Training Schedule Day 2

Topic	Session Time	Activities	Materials
Review and **Workshop 5**	**1 hour 3900 minutes**	Discussion Role-plays Quiz	Presentation Whiteboard/ Flip Charts and markers
Tea Break	**20 minutes**		
Role-plays & feedback Workshop 1 and 2	2 hours 30 minutes	Discussion Role-plays	Whiteboard/ Flip Charts and markers
Lunch Break			
Role-plays & feedback Workshop 2 and 3	2 hours 30 minutes	Discussion Role-plays	Whiteboard/ Flip Charts and markers
Supervision	1 hour	Discussion	Whiteboard/ Flip Charts and markers
Trainers' self-Care	30 Minutes	Discussion	Whiteboard/ Flip Charts and markers

UNIVERSITY OF LIVERPOOL

Human Development Research Foundation

Improving lives through Research

PSYCHOSOCIAL SKILLS DEVELOPMENT

FOR TRAINEE CIVIL SERVANTS

Training of Trainers workshop

DAY ONE

Aims of this workshop

- To train a group of trainees to conduct a series of workshops in CSA to improve psychological capital, well-being and decision-making ability among civil servants and to help them cope with the psychological strain of working in stressful environments

- To discuss on how to adapt the workshops for civil servants

Background

- Depressive and anxiety symptoms -leading causes of disability worldwide
  - significantly impair the quality of life, social functioning, and workforce participation
  - affect individuals' work performance, short-term disability, absenteeism, and turnover rate
- Workplace mental health-
  - A legitimate concern for employers – WHO
  - MH a priority under UN Sustainable Development Goals (SDGs)

Work related stress in Civil Servants

- During political and civil instability, Civil servants face considerable occupational stress.
  - Studies in high-income countries suggest that the prevalence rates of such problems is high in civil service
  - The Whitehall Study*-
    - landmark study on social determinants of health in civil servants
    - Strong relationship between work, stress and health
- Depressive, anxiety symptoms and burn out are most common manifestation of psychological distress.

*"The Whitehall Study archive collection". LSHTM Archives. Retrieved 17 September 2018.

Workplace CMDs costs more than you think

- Worldwide >600 m suffer from depression/anxiety
- CMDs can result in lost productivity
- Can manifest itself in :
  - Absenteeism (people suffering from mental health problems take 5% more days off work)
  - Presenteeism (people working long hours but with little impact).

Workplace CMDs costs more than you think-II

- A WHO study found that globally by 2030, 12 billion working days will be lost to depression and anxiety every year.
- For the global economy, it costs >$900 billion.
- Every dollar invested in improving the care of people with mental health issues has a return of $4 for the economy.
- Think of mental health care as an investment – one that's worth the up-front time and cost.

62% of workers say their job is their main source of stress

$300bn estimated cost of job stress at work

1 in 4 workers have taken a mental health day off from work to cope

26%
of workers say they were 'often or very burned' out by their work

25%
of workers view their job as the number one stessor in their life

Stigma of Mental illness/stress

- Prevents acknowledgment and treatment
- Civil service structure promote stigmatization
- Studies show public knowledge about mental health has recently increased, but considerable stigmatization of individuals with CMDs remains. Mental illness is ranked near the bottom of other illnesses in terms of public acceptance (Hinshaw 2007).
- According to US Surgeon General report, stigma is the main barrier to mental health care: It deters the public from seeking and wanting to pay for care.
- Stigma can be related to causes such as shame, guilt, self-image, and concerns for social discrimination - Effect on career

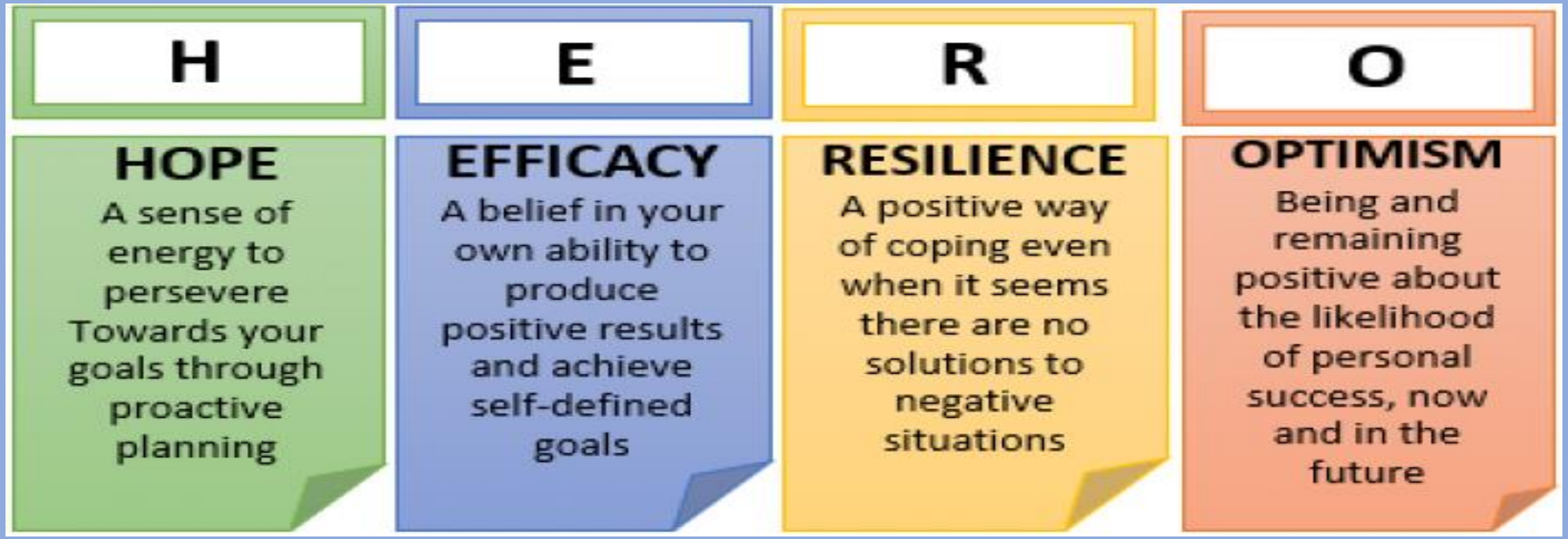
Stress can be good for creativity /productivity

- An artist needs a certain amount of turmoil and confusion," Joni Mitchell
- Eustress and Distress
- Nothing unusual
  - Tchaikovsky -I assert that life is beautiful in spite of everything! In a word, there are many thorns, but the roses are there too.
  - Churchill's black dog

Psychological Capital

- **Factors for workplace stress**
  - specific acute stressful events, work hours, job involvement, control over job, personality variables and social support.
- **Resources for combating occupational stress**
  - perceived organizational support and psychological capital
- **Psychological Capital**
  - Positively associated with job performance, job satisfaction, and well-being, but negatively associated with depression and burnout

Psychological Capital



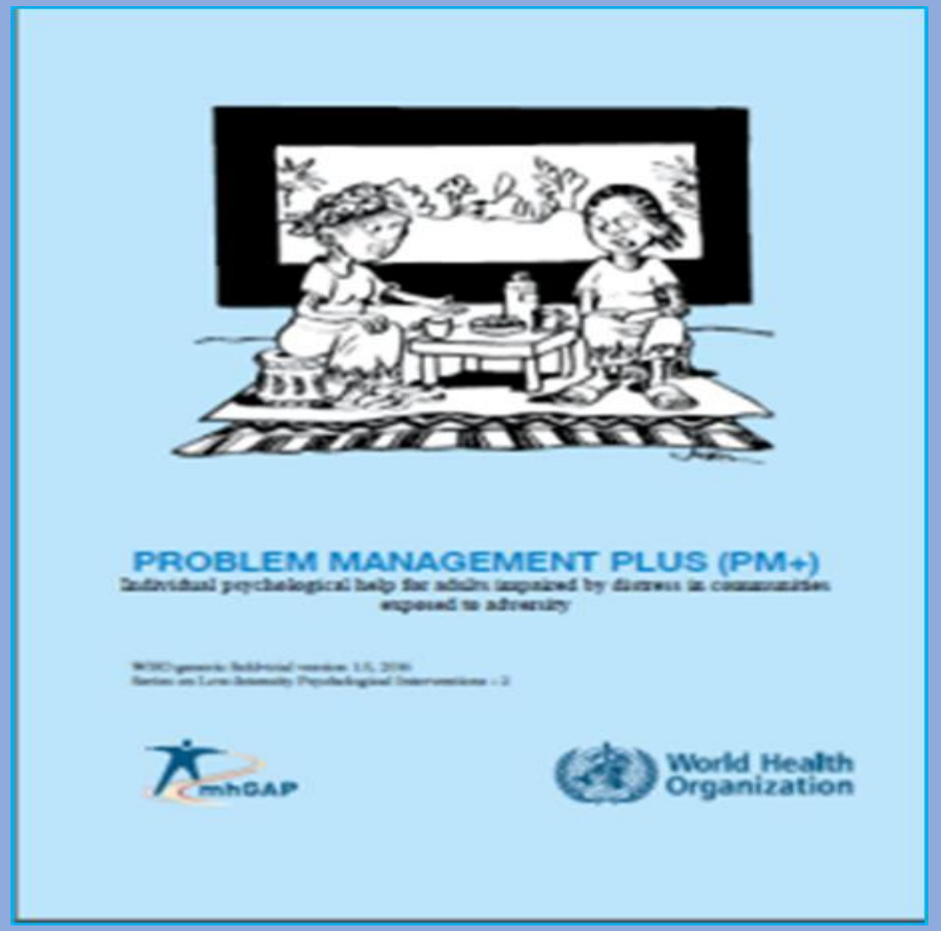
The challenge

To identify suitable evidence-based interventions for occupational stress that are: sustainable and scalable, i.e.

- Sustainable
- Feasible
- Affordable
- Effective and cost-effective
- Culturally adaptable
- Open access
- High adoption rates

WHO Problem Management Plus (PM+)

- **Trans-diagnostic (treatment)**
- **Non-specialist administrated**
- **Multi-components behavioural intervention such as:**
  - **Problem Solving Therapy**
  - **Behavioural Activation**
  - **Stress Management**
  - **Strengthening Social Support**
- **Open access**



(http://www.who.int/mental_health/emergencies/PM_plus_2018/en/).

THE WORLD BANK
IBRD • IDA | WORLD BANK GROUP

World Health Organization

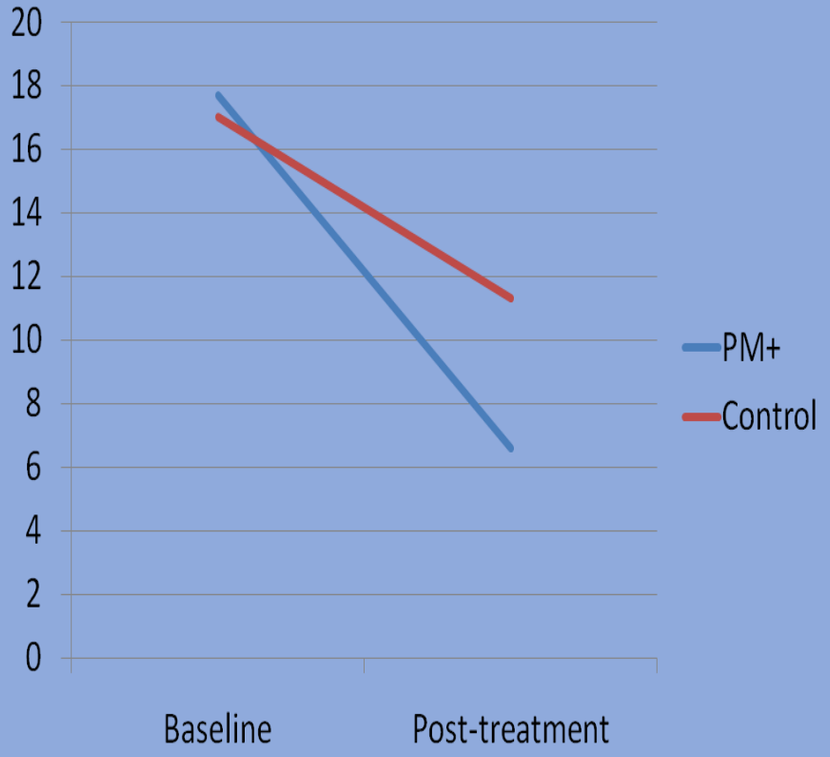
Improving well-being and productivity for entrepreneurs through Problem Management Plus (PM+) Training in Pakistan's conflict affected KP/FATA Province

UNIVERSITY OF LIVERPOOL

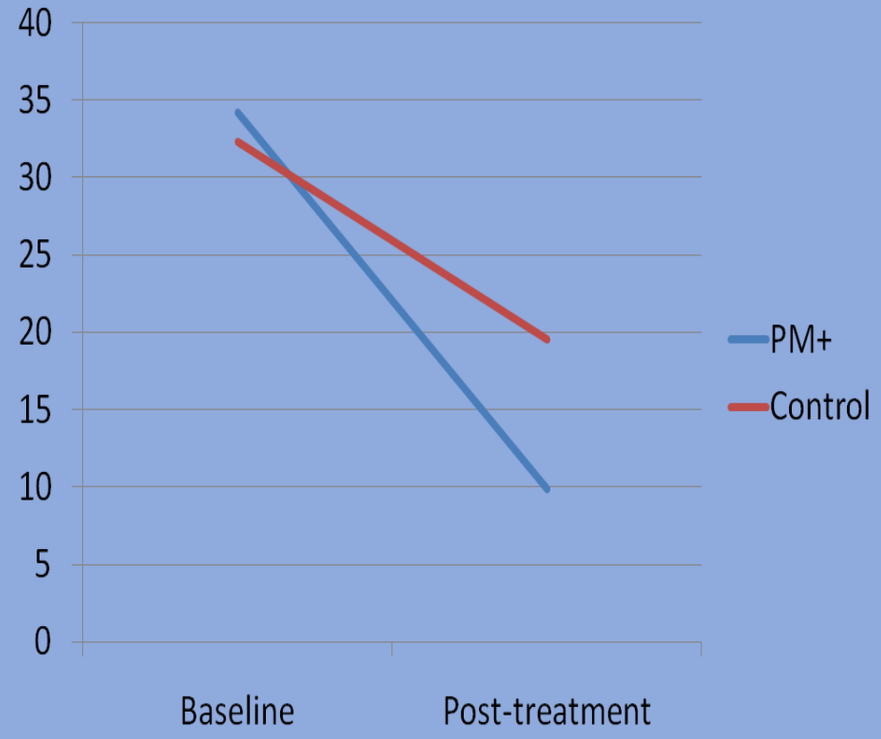
Human Development Research Foundation
Improving lives through Research

Evaluation results from Pakistan

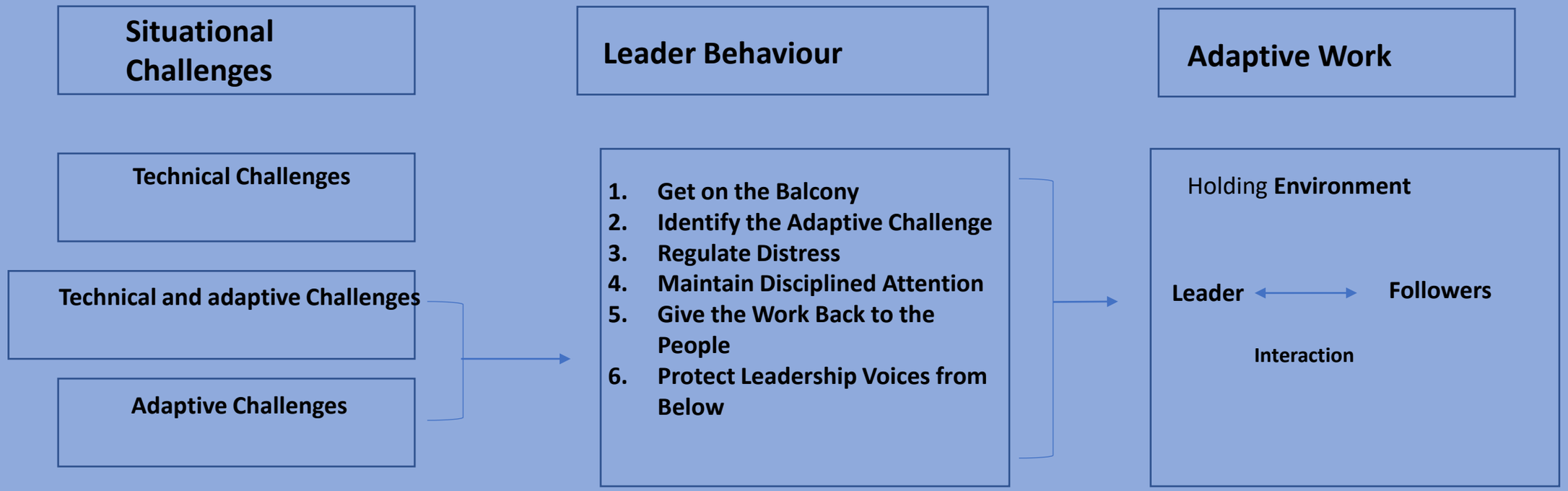
Mean Functioning scores (n=60)



Mean distress scores (N=60)



Adaptive Leadership Model



* Heifetz R, Grashow A, Linsky M. The Practice of Adaptive Leadership: Tools and Tactics for Change your Organization and the World. Boston, MA: Harvard Business Review Press; 2009

Aims of Workshops developed for Civil Servants

1

Help civil servants manage their stress as a result of performing their duties in adverse situations

2

Help improve resilience, decision making, leadership skills and well-being

Introduction to workshops

- Training program to enable civil servants to function better in their professional & personal lives by helping them cope with the psychological stress of working in uncertain and risky environments.
- Does not provide any solutions rather strategies & tools to help trainee civil servants deal with their problems
- Does not cover problems out of trainee civil servants control but provides strategies & tools to tackle stressors & challenges that arise due to these circumstances.
- Research based & evidence based training program.
- We it will not share its findings with the Faculty.
- We will not attempt any kind of judgment about psychological health of trainees. not diagnostic or evaluative.
- Not for those who are affected by illness. preventive in nature. to create awareness for psychosocial issues and to provide support to people on the borderline.
- Serious psychological issues might need individual therapy/medication.
- Those who feel need for individual psychological therapy would be recommended to penal of experts.
- These workshops are not about the stress caused by CTP. But life and career.

Training Material-Programme manual

1st Section

- What is PSSD for Civil Servants
- Basic helping skills & Group management skills

2nd section

- Understand the program and Managing stress
- Managing problem
- Get going keep doing
- Strengthening support network
- Staying calm and looking forward

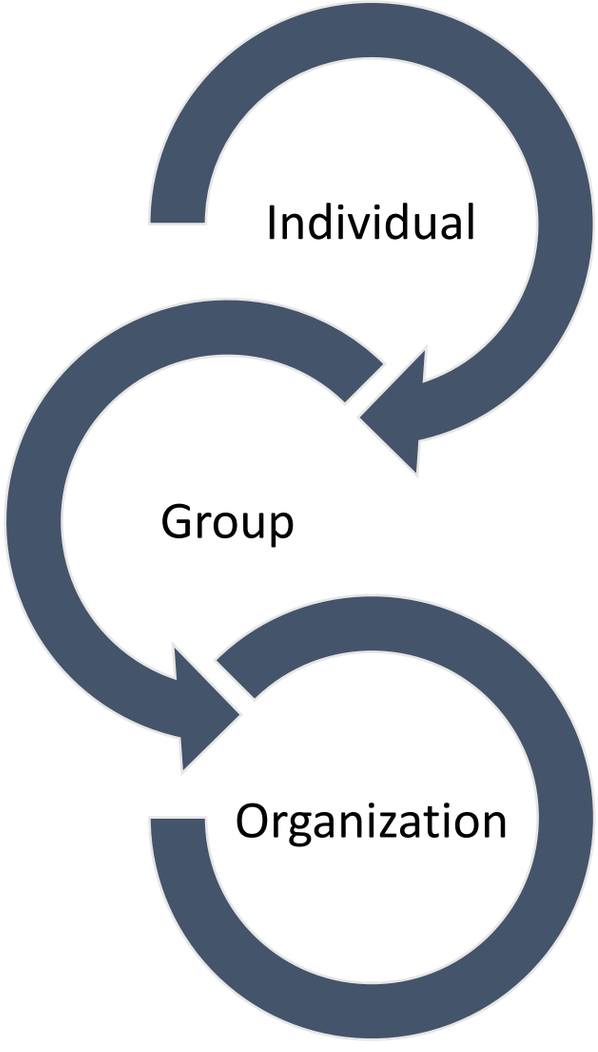
3rd section

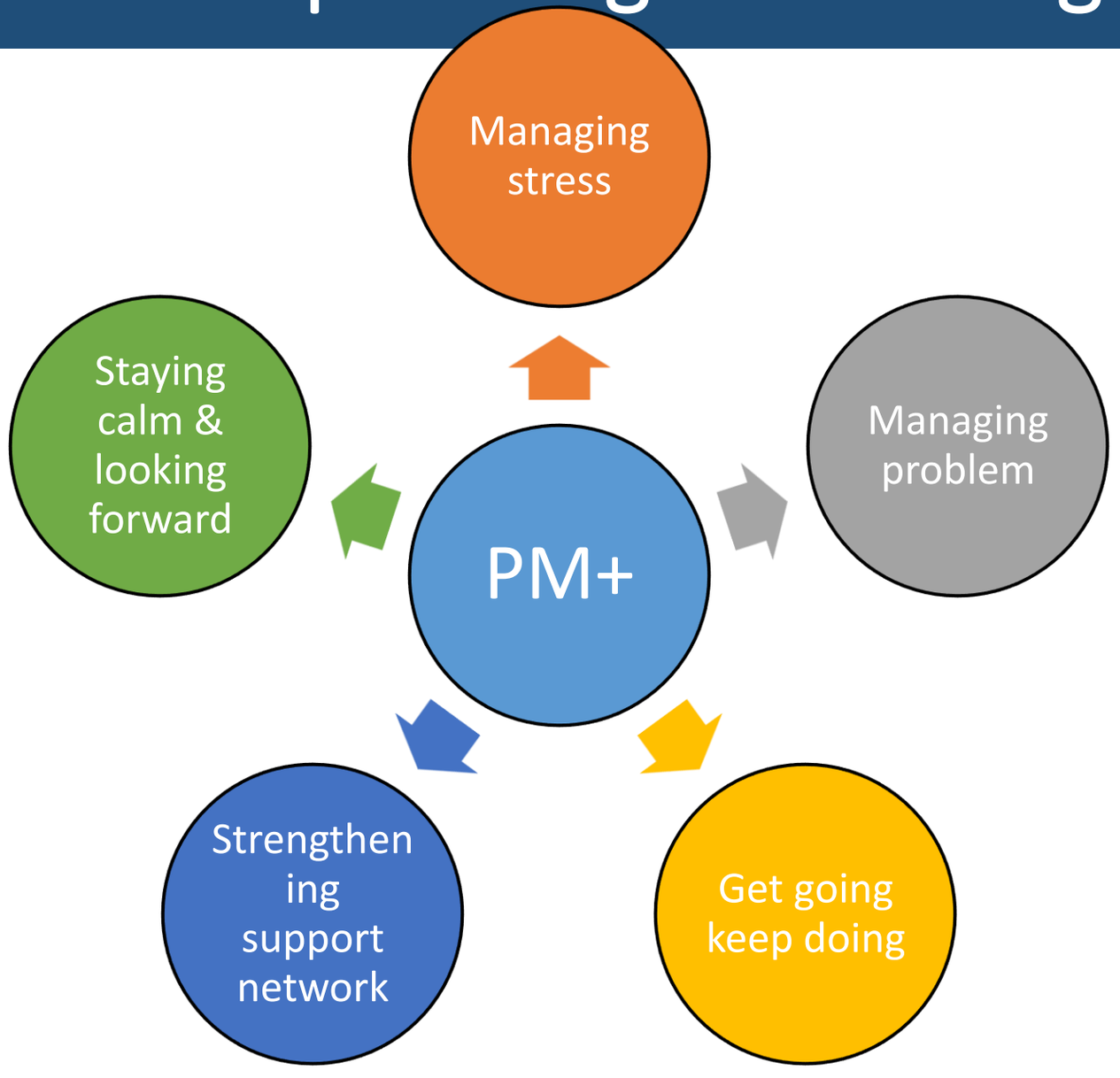
- Presentations
- Problem checklist
- Case examples

Workshops overview

1. Understanding Psychosocial Skills Development Workshops for Trainee civil servants program and Managing Stress
2. Managing Problems
3. Get Going, Keep Doing
4. Strengthening Support Network
5. Staying Calm and Looking Forward

Workshops Developed Program Strategies





Workshop Framework

Our Investment

1.5x5 hours

Each session at least after five days of execution and synthesis

Norms

Respect

- Respecting each other

Commitment

- Commitment to being an active participant (including in role-plays
- Not interrupting each other

Encouraging

- Being encouraging and thoughtful when providing feedback to each other

Arrive

- Arriving and finishing on time
- Staying in the training room during training session

Mobile phones

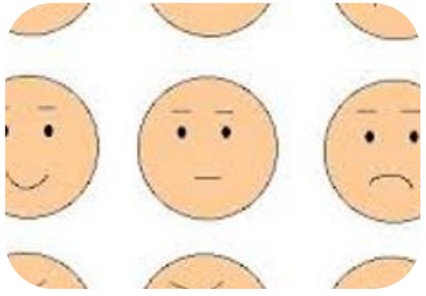
- Turn off or put away mobile phones

Listen & Ask

- Listen with full attention
- Ask questions- there are no silly ones!

Basic Helping Skills

Confidentiality



Non-verbal skills

Validating

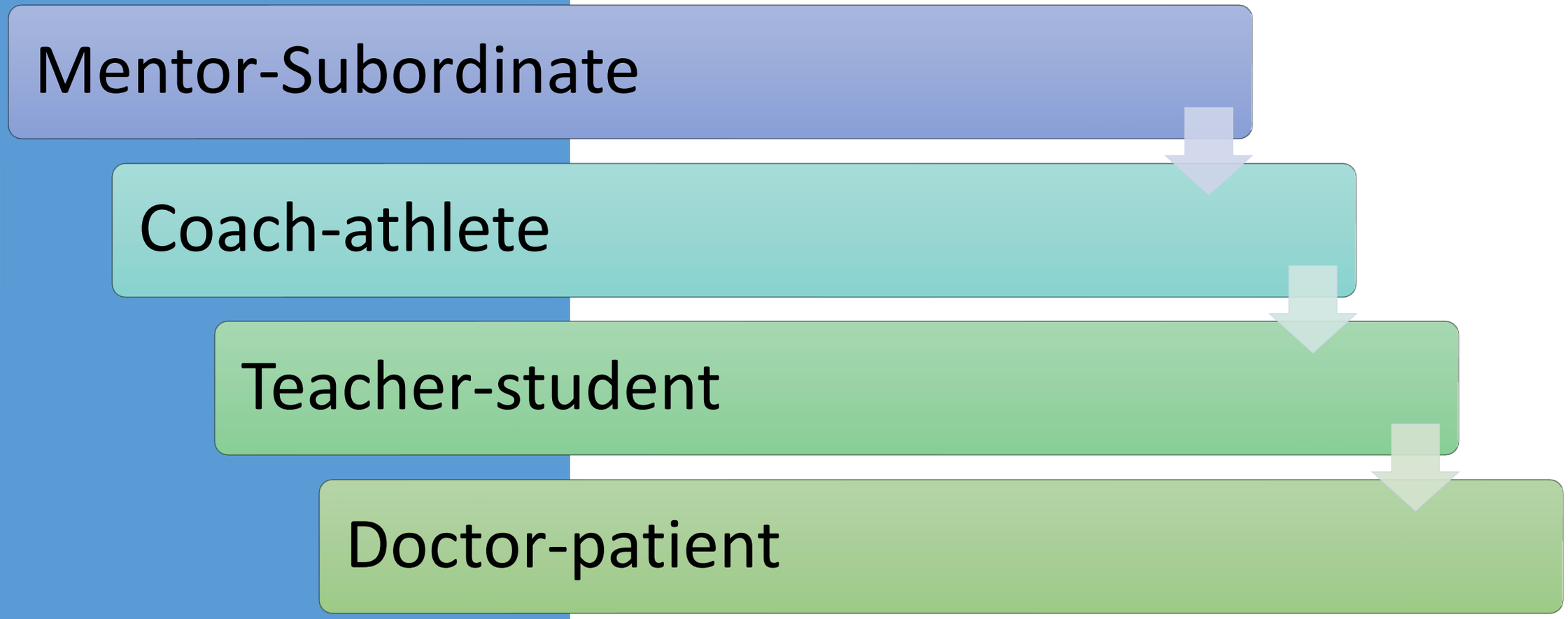
Putting aside your personal values

Praising openness

Communicating concern

Giving advice

Trainer Relationship



Practice of Norms + BHS

Workshop 1

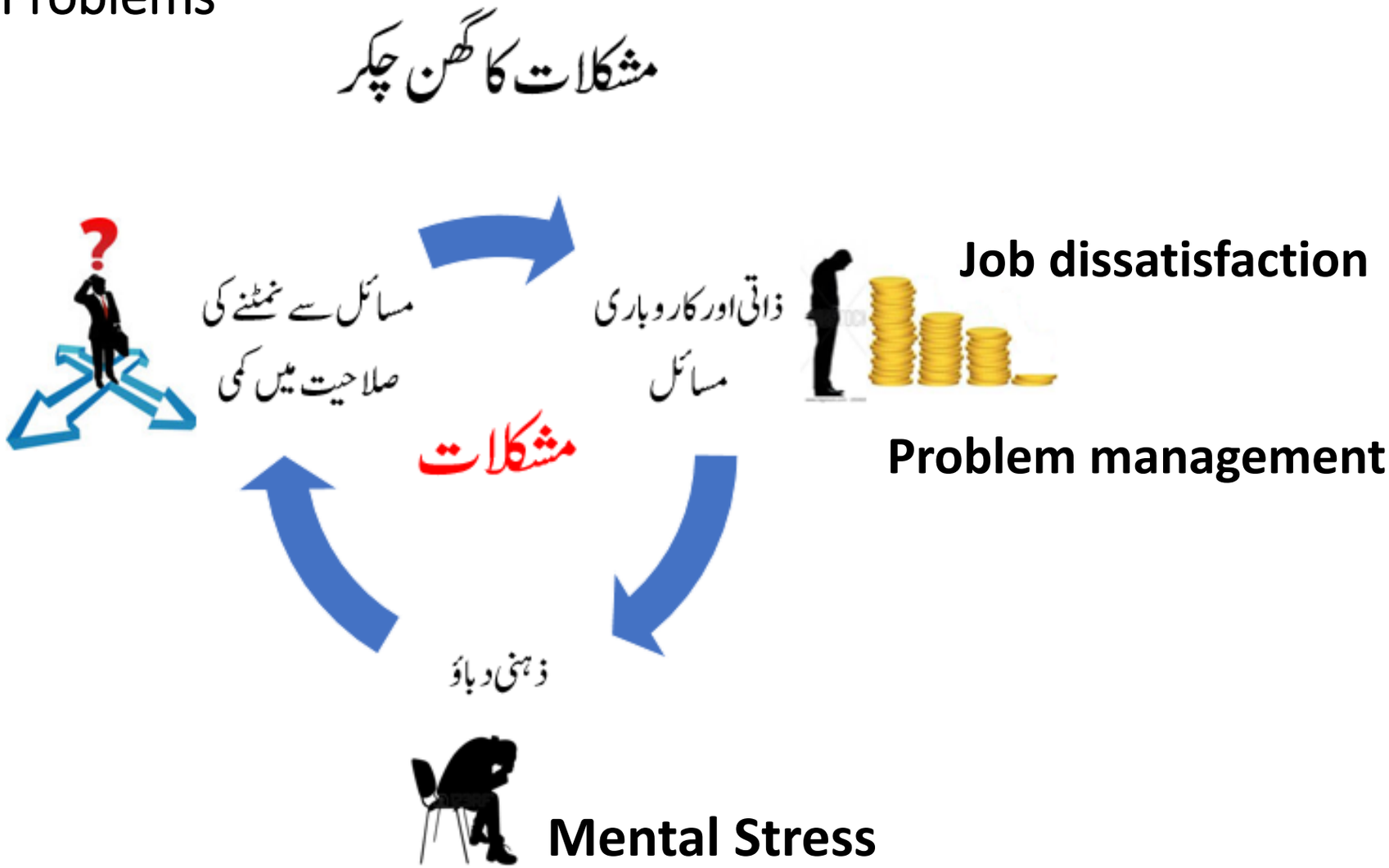
Objectives and structure of workshop 1

- Introduce all the participants
- Introduce the objectives of workshop

At the end of first workshop the participants will be able to:

- Define what is Workshops developed
- Understand what are difficult situations and how to manage them

Vicious Cycle of Problems



Adversity

A difficult negative situation

- Work place stress
- Death of loved one
- Terrorism
- War
- Disaster (floods, earthquake, tsunami etc.)
- Job loss
- Conflict
- Family dispute
- Illness

Where does adversity take us?

Understanding Stress

One of the common reaction to adversity is stress

- **stress**
- **Depression**
- **Anxiety**

Understanding Stress

Civil servants working in fragile environment, political pressure, and conflict like situations may face problems like:

- **Law and order and insecurity**
- **Worried about their families**
- **Work life imbalance**
- **Political pressures**
- **Un-predictable future situation**
- **Job conditions and promotion**
- **Home sickness**

What is stress ?

- How to define stress
- How stress affects our body
  - E.g., headaches, pain in the body, stomachaches, tingling, dizziness, racing heart, difficulties breathing
- Sometimes people experience physical problems and this can increase their stress.
- Regardless of whether the physical problems are or are not caused by stress, learning ways to reduce stress may also help alleviate the physical problem.

- What do you think are the main challenges faced by civil servants of Pakistan?

- How do you see these challenges affecting overall performance of Civil Servants(leadership and management capacities, physical and mental health)

- Does anyone among you have any personal stories or friends from civil servants experiencing such kinds of challenges?

Why Psychosocial Skills Development

Advantages

- What can you personally get out of this programme?
- What might improve in your life ?
- What do you think you might be able to do that you cannot do now?
  - Balance between family and career
  - Better at job related tasks (e.g., decision making, completing work on time, better problem management)
  - Self-care
- If your problems reduce, how might this be good for other areas in your life? e.g., your relationships, your work, your other duties

Why Psychosocial Development

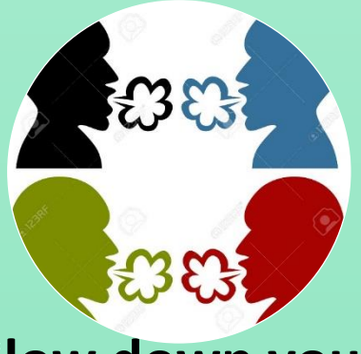
Challenges /Perceived Disadvantages

- What are some of the problems for you in joining the programme?
- What will you have to give up or lose if you join the workshops?
- Will it reduce your time for your other studies, sports or family and friends?
- Will the programme be used to profile you or make a pen picture which can affect your future career?
- Sharing weakness with co workers

Steps to Managing Stress

relax body (shake out arms, legs, relax the neck)

breathe from the stomach



Slow down your breathing

(3 seconds to breathe in

3 seconds to breathe out)

Practice regularly

Group activity

Managing Stress

Role plays

Content: ‘What is PSSD for Civil Servants?’ ‘What is Adversity and ‘managing stress’

Aim: To learn how to introduce the workshops and to deliver managing stress ”

Time Frames: 5 minutes to form small groups and give instructions; 15 minutes for each role-play; 5 minutes for discussion/feedback

Participants: All ‘trainers’

Group Sizes: 3-4

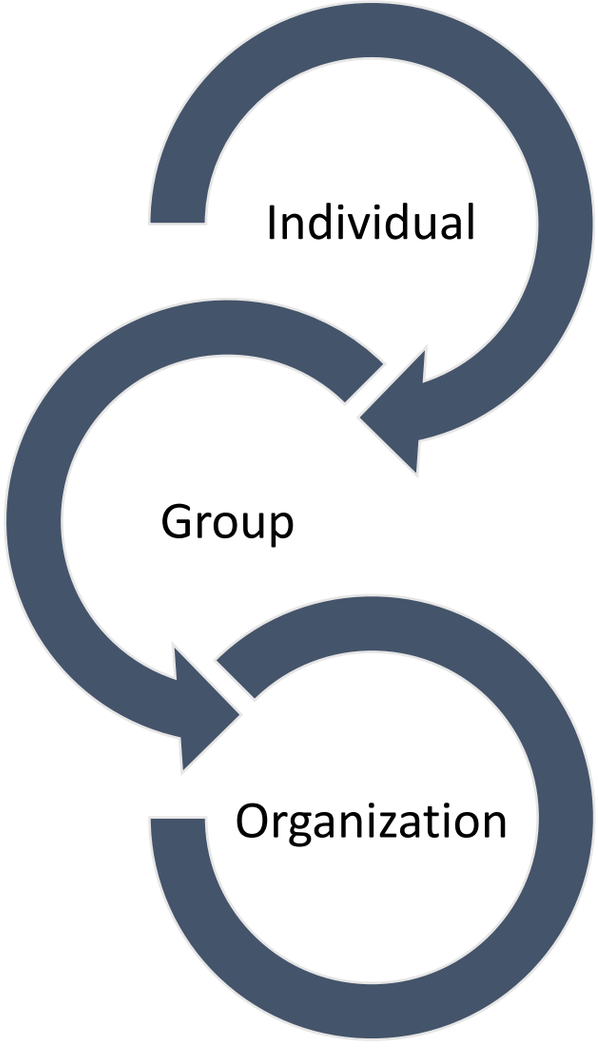
Instructions: Groups role-play ‘What is PM+ for civil servants?, What is Adversity and managing stress

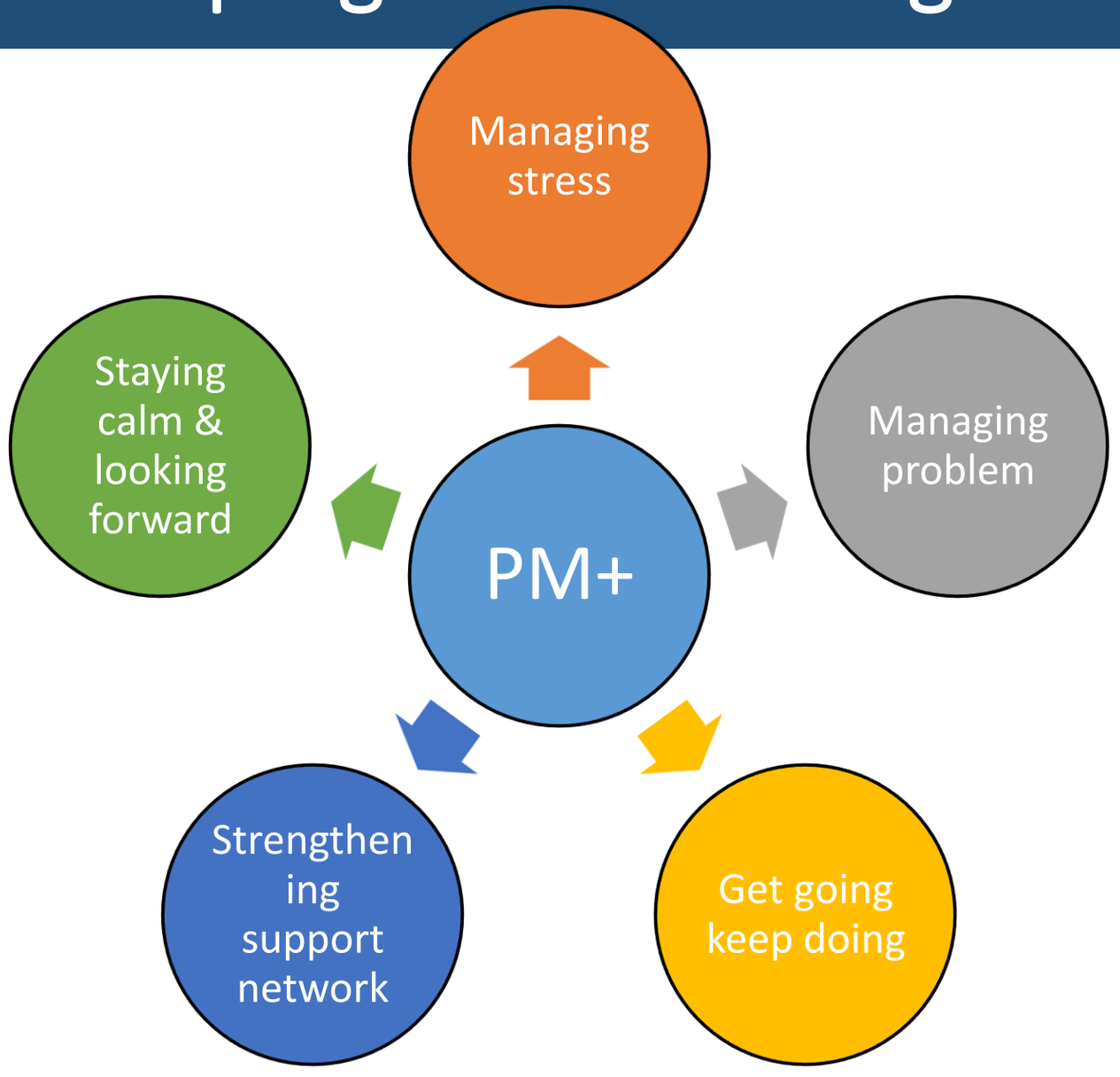
Purpose of ‘Managing Stress’:

- How adversity causes stress
- How stress affects the body
- To introduce a basic strategy to manage stress through calming the body **Steps to ‘Managing Stress’:**
- **This strategy focuses on Managing Stress through our bodies**

Workshop-2

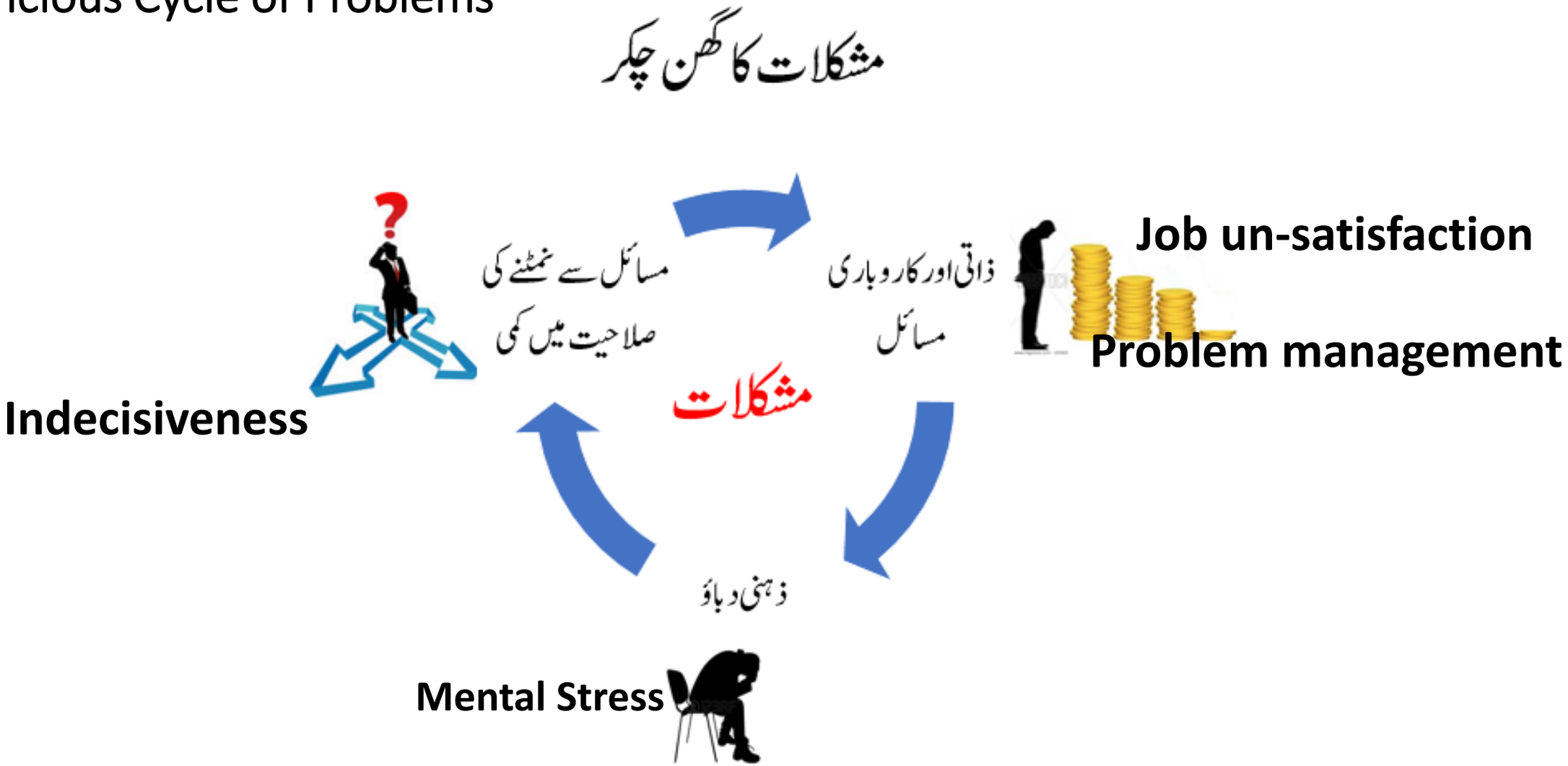
PM+ for Civil Servants-programme strategies





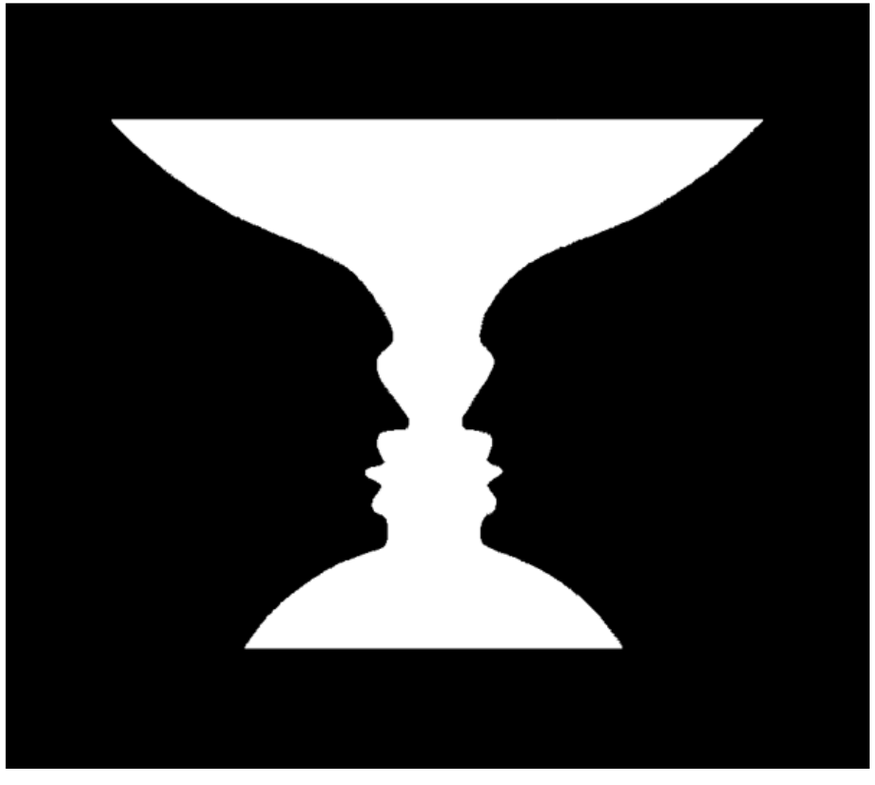
Workshop Framework

Vicious Cycle of Problems



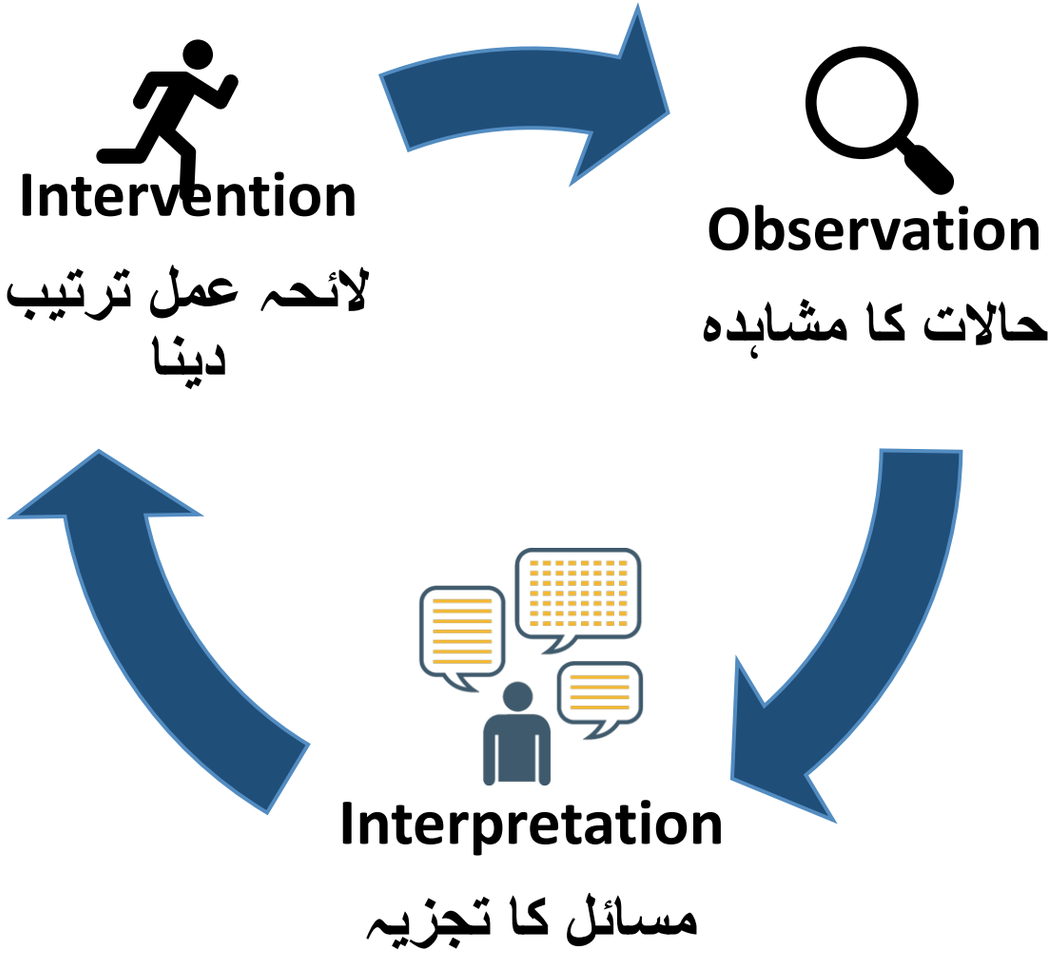
Challenge: Defining a problem?

Deep observation: floor + balcony



Balcony view

Adaptive Leadership Process



Defining need and problem

- What is need
- What is a problem
- Two major types of problems
    - Solvable
    - Unsolvable

Managing Problems

- List down all the problems
- Divide problems in two categories i.e.
  1) problems in your control and
  2) problems out of control
- Select one major problem
- Conduct problem tree analysis

Distinguishing technical problems from adaptive challenges

Kind of challenges	Problem definition	Solution	Locus of work
Technical	Clear	Clear	Authority
Technical & Adaptive	Clear	Requires learning	Authority & stakeholders
Adaptive	Requires learning	Requires learning	Stakeholders s

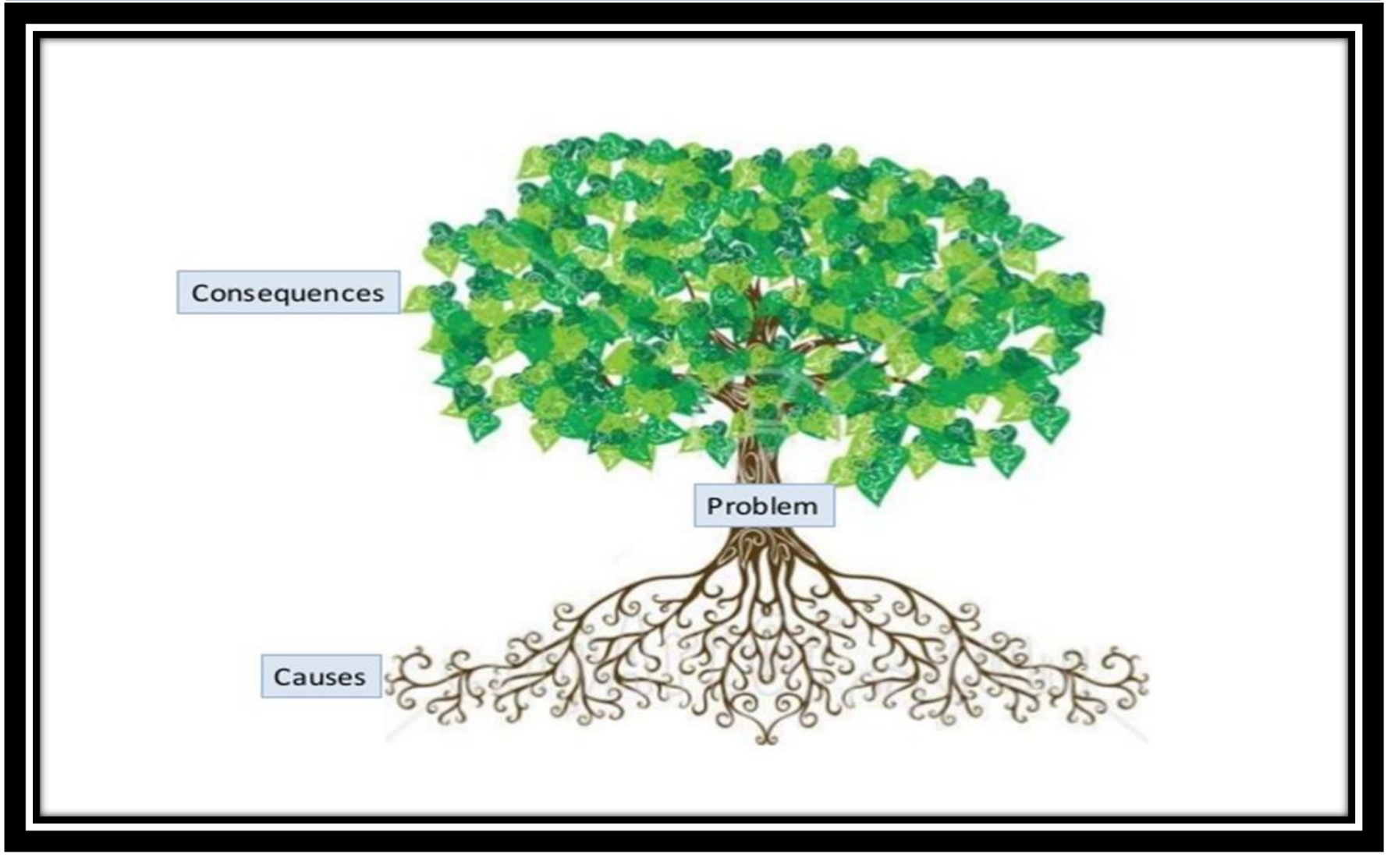
Practical Problems

- Problems in career
- Problems due to political or economic instability
- Law and order issues
- Lack of professional training
- Conflict with superiors, colleagues or subordinates or stakeholders
- Work life imbalance
- Raising children and care giving

Four Adaptive Challenge Archetypes

- Archetype 1: Gap Between Espoused Values and Behavior
- Archetype 2: Competing Commitments
- Archetype 3: Speaking the Unspeakable
- Archetype 4: Work Avoidance

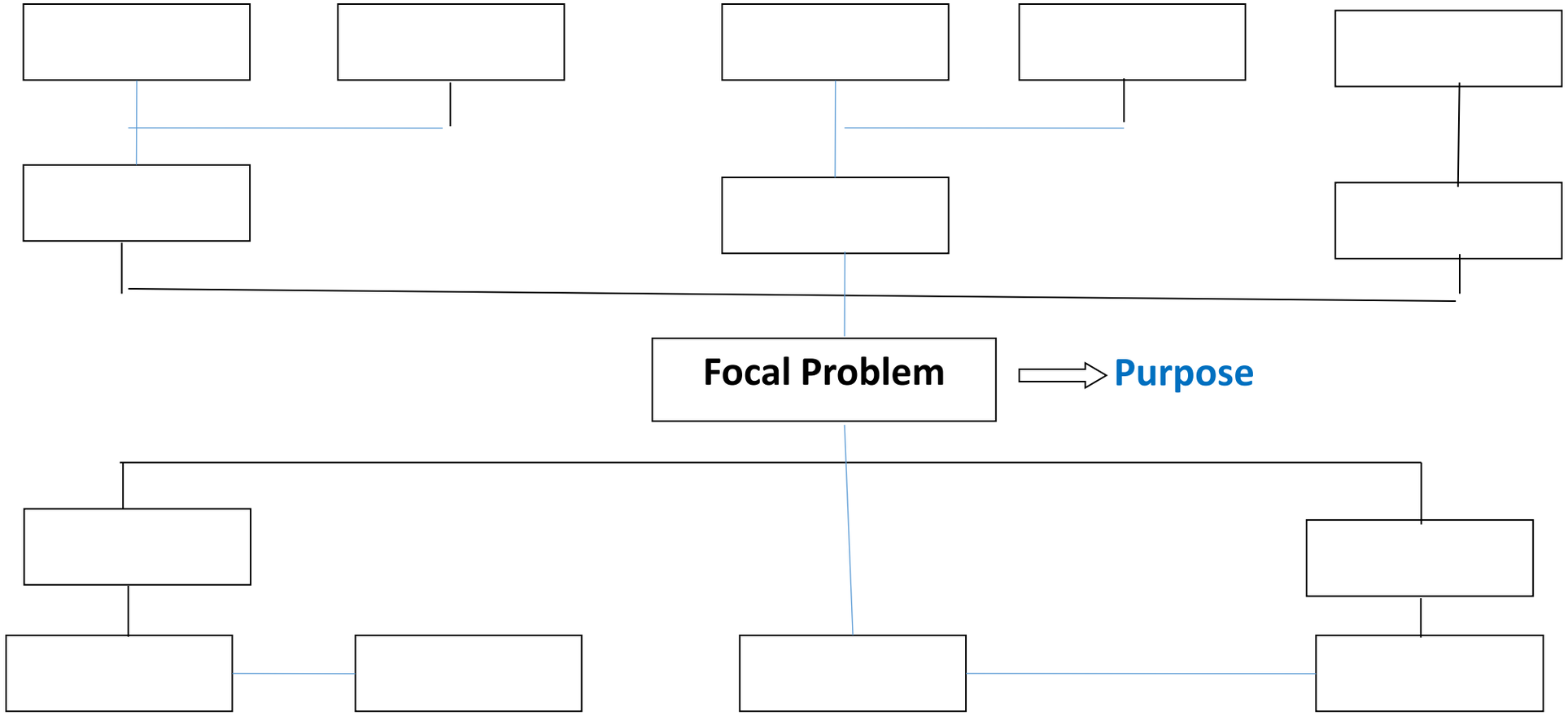
Problem Tree analysis



Problem Tree ⇒ Objective Tree

Effects of the Focal Problem ⇒ **Outputs/Results**

Effects ⇒ Outputs



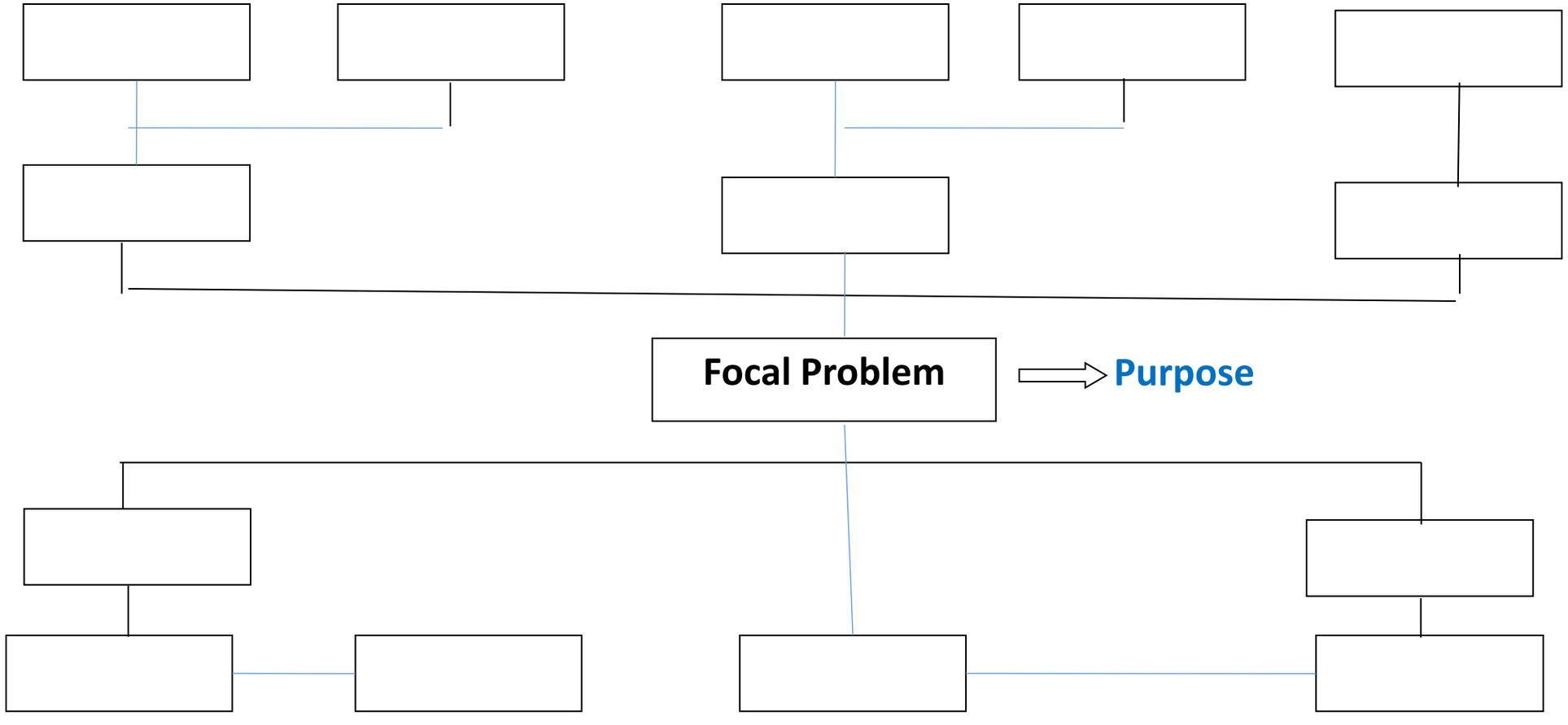
Causes of the Focal Problem **Overall ⇒ Objectives**

Cause ⇒ Objectives

Problem Tree ⇒ Objective Tree

Effects of the Focal Problem ⇒ Outputs/Results

Effects ⇒ Outputs



Causes of the Focal Problem **Overall ⇒ Objectives** **Cause ⇒ Objectives**

Relationship between problem and objective tree

Problem tree	**Objective tree**
• **Effects**	**Overall objectives**
• **Focal problem**	**Project Purpose**
• **Causes**	**Results/Outputs**

Group Work

- **Select problems that you face in your personal or professional life**
- **Conduct Problem tree analysis through cause and effect analysis**
- **Prepare objective tree by converting root causes into outputs and define activities**

Examples

Home work

Everyone to select a problem and conduct its analysis

We will review your work on second day.

Workshop-3

Workshop 3: Objectives

- How to defeat failures
- Live and move forward in the face of adversity
- Cope with the stress and disillusionments

Three possible scenarios while managing problems

1. You have completely solved the problem
2. You have partially solved the problem
3. You have not been able to make any progress (Failed)

Get Going Keep Doing

- **No single best solution of your problem**
- **Every effort is a kind of experiment**
- **Problem may be simple, complicated, complex or chaotic**
- **Some times you do not get anticipated results which might overwhelm your physical and mental abilities and put you under stress**

Workshop 3: Basic Purpose

- **How to defeat failures**
- **Live and move forward in the face of adversity**
- **Cope with the stress and disillusionments**

Three Scenarios

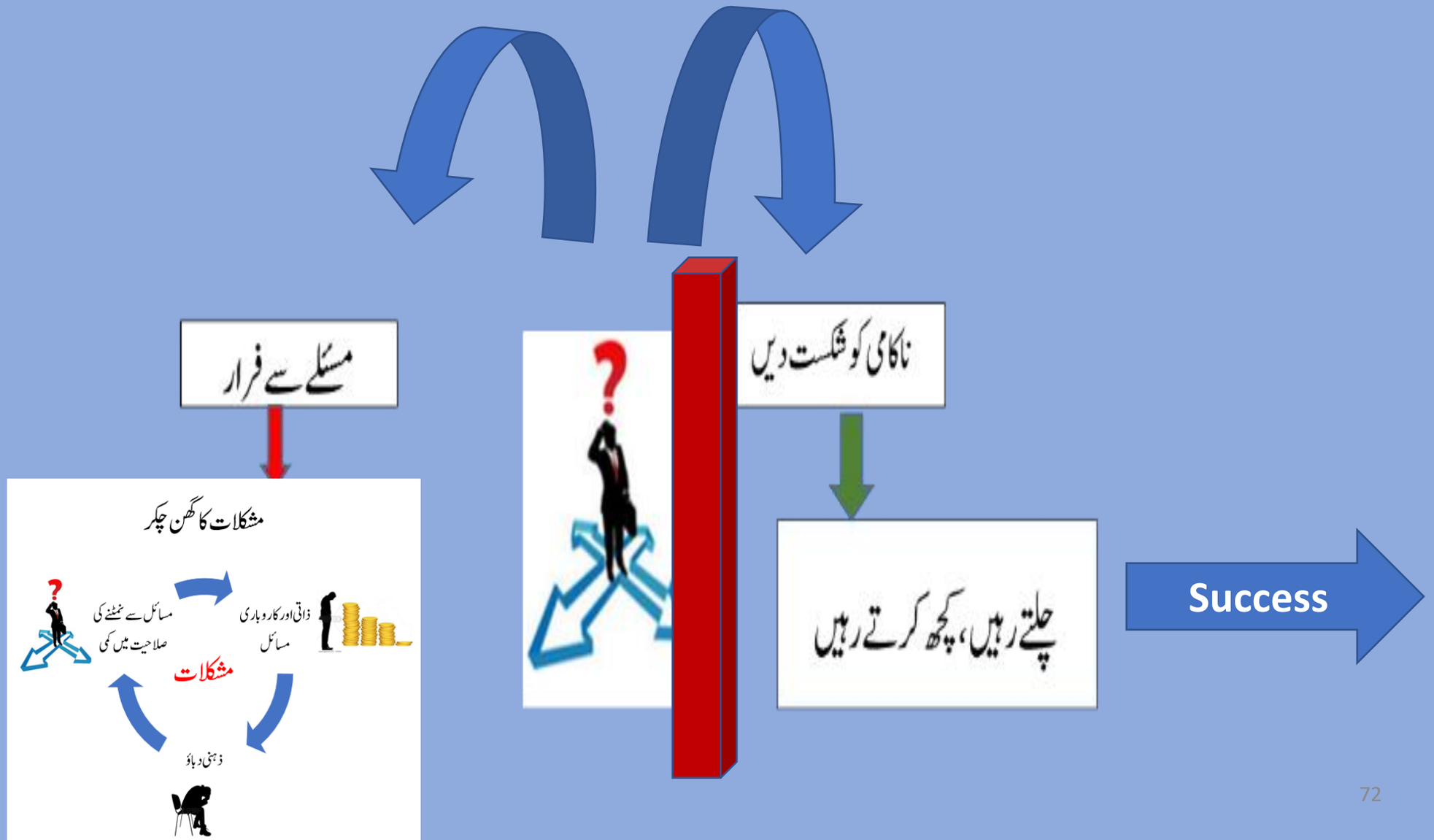
You might confront three possible scenarios while managing any problem

What could be those possible scenarios?

Three Scenarios

1. **You have completely solved the problem**
2. **You have partially solved the problem**
3. **You have not been able to make any progress (Failed)**

Challenge of adversity: Fight or Flight



Moving from obstacle thinking to opportunity thinking

مسائل سے نمٹنے کی صلاحیت میں بہتری

چلتے رہیں، کچھ کرتے رہیں

ذہنی دباؤ سے نمٹنا

Group Discussion

Participants in small groups of 3-4 will discuss following questions:

- **What sort of challenges did you face in the recent past?**
- **What possible solutions were available to you and what type of decisions did you make?**
- **What elements were in your control and what were not in your control**
- **What have been your results in relation to the decisions you made**
- **What will you prefer to do if experience same situation again**

End of Workshop 3

- **Stress management exercise**
- **Home assignment: work on previous or new problems**
- **Feedback**

Workshop 4

Strengthening Support Network

Review of workshop 3

Three possible scenario

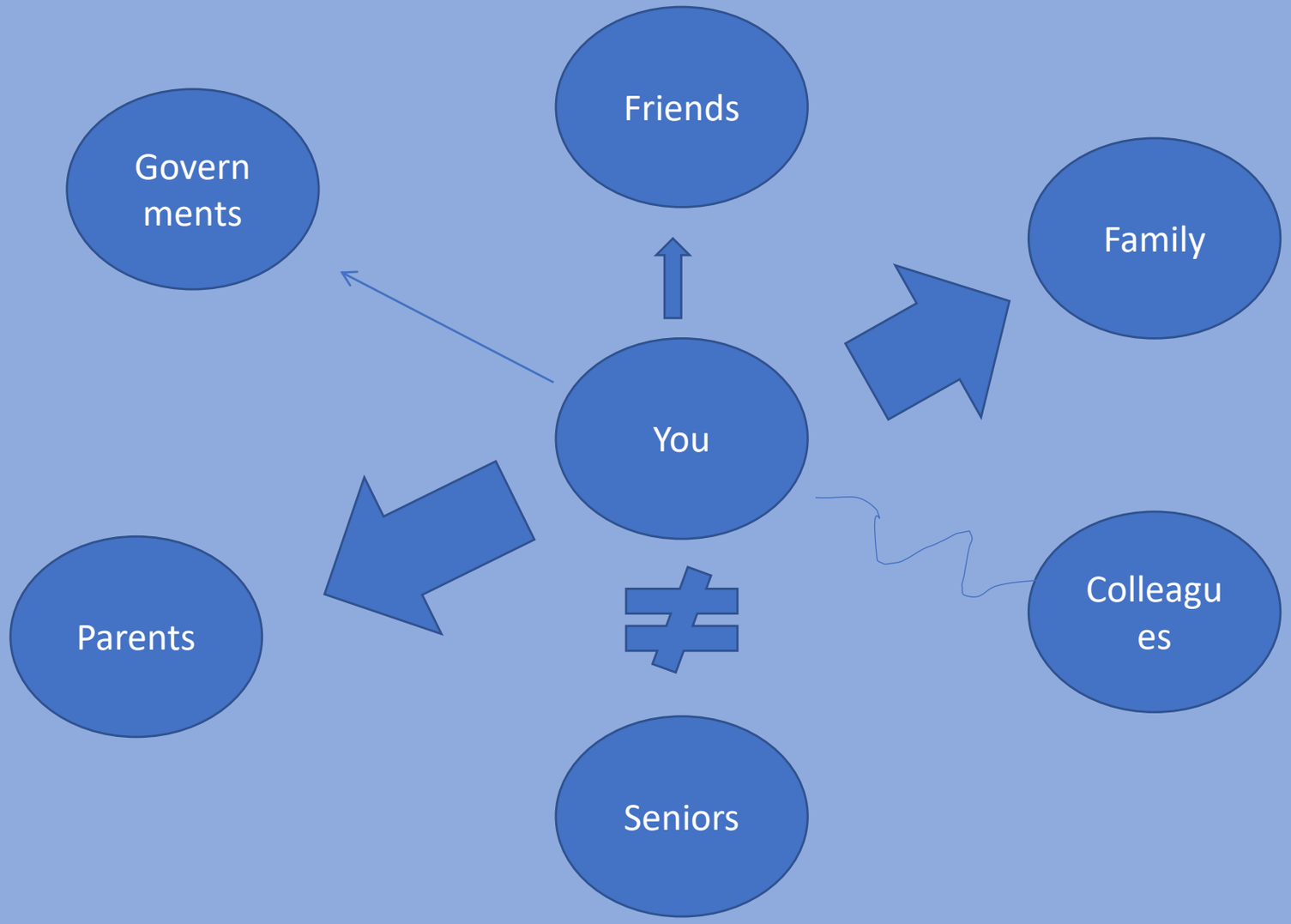
1. You have completely solved the problem
2. You have partially solved the problem
3. You have not been able to make any progress (Failed)

Basic Purpose of Workshop 4

- **Moving from individual efforts to collective efforts**
- **Seeking alternate strategies from other stakeholders**
- **Making use of collective wisdom**
- **Using participatory approach**
- **Moving from conventional solutions (2+2) to more innovative and adaptive solutions**

Who else can support you in solving the problem

List all stakeholders who either have stake in the problem or can be helpful in addressing the problem


Friends
Govern ments
Family
You
Parents
Colleagu es
Seniors

Strengthening your social support

- Its all about connecting with others to be more supported and able to manage problem better
- Having good support helps people cope better in adversity
- Can help people not become as stressed, depressed etc.
- Can help people better manage practical problem
- Help people they are not alone in the problem they are experiencing

Types of social support

Types of Social Support	
Emotional	Expressions of empathy, love, trust and caring
Instrumental	Tangible aid and service
Informational	Advice, suggestions, and information
Appraisal	Information that is useful for self-evaluation

Examples of Strengthening Support Network

EMOTIONAL SUPPORT	PRACTICAL SUPPORT
• Having a friend or family member listen the your concerns rather than be dismissive and not show any care • Spending time with others but not necessarily talking about problems (i.e. sharing a meal) • Connecting with an organization that is providing appropriate information and support to you • Helping other People (while not forgetting to take care of oneself)	• Getting help from others for example, learning new methods and tools to handle terrorism • Strategies of conflict transformation and peace • Helping other colleagues to manage stressful and difficult situations

Group work

List your network members and write down what sort of support they can provide you in addressing the problem you are faced with

Consider civil servants who

- Do not share problems with others,
- Do not want to burden others,
- Believe that seeking support is a sign of weakness,
- With limited resources- live far from town/Pakistan , lack of transport, few people around them they trust isolated etc.,
- Have difficulties trusting others.

PSYCHOSOCIAL SKILLS DEVELOPMENT FOR TRAINEE CIVIL SERVANTS

Training of Trainers workshop

DAY TWO

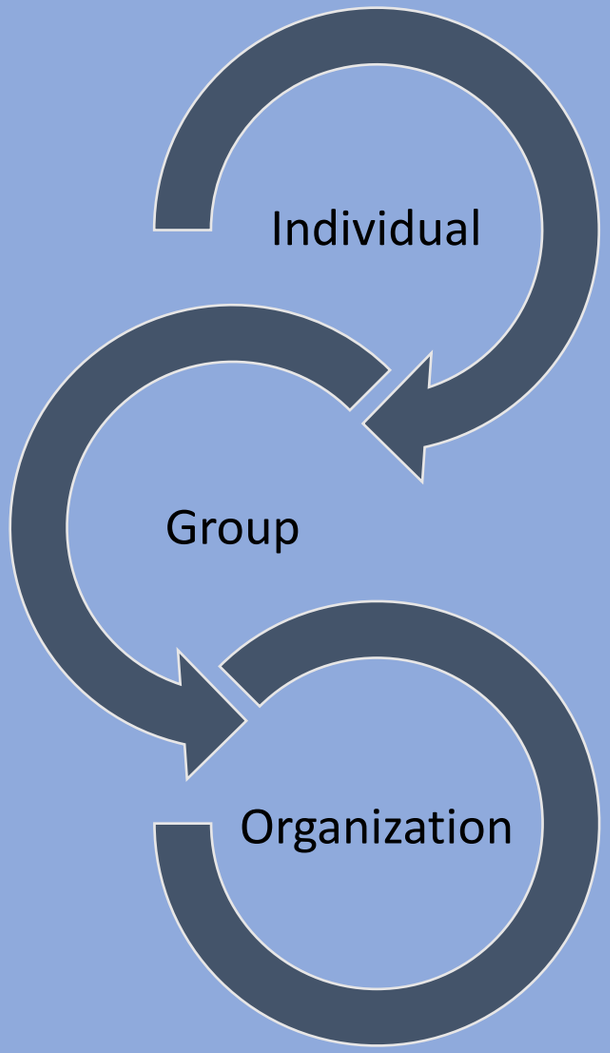
Workshop-5

Objectives of Workshop-5
Staying Calm & Looking Forward

- Look back and feel proud of achievements
- What to expect when finishing the group
- Continue to stay well by preparing the best response to future problems
- Help participants learn how to remain calm in the face of adversity
- How to help each other and mobilize support in the event of critical circumstances
- Prepare plan of action for future

Workshop Framework

PM+ for Entrepreneurs-programme strategies



Staying Calm & Looking Forward

- Instead of working to exhaustion, take care of yourself and stay calm.
- If you keep on consuming all of your energies, you will eventually burnout.
- Taking care of yourself will help you to remain adherent to your goal.
- spending a few hours with your family, going out for a walk, enjoying your favorite food or company of your friends

Group work: What makes you happy

List down the things which:

a) Make you happy
b) Make you unhappy

How can these activities impact your well-being, decision making power and passion for work?

Steps to Staying Well

- Positive review of achievements
- Review of the original goals for the program
- Importance of practicing strategies even in the absence of a problem
- Discussing potential future stressors and problems
- Identification of the strategies for each potential future stressors
- Suggesting ongoing support
- How to remember to practice these strategies

Discussion

- One thing you have learned in these workshops that has been helpful
  - Any missing point ?
- Regularly practice Managing Stress
  - Which day and time ?
  - Friends or a family members can remind to do the breathing exercise
  - Any group member can also remind everyone (through a call or message)
  - A Whatsapp group including all the participants can be created (in which the coach can remind everyone or participants can remind to one other)

Discussion II

- Preparation for the future
- Review old personal goals not achieved in the duration of the workshops
- Thinking the ways to keep improving (name new goals)

Triangle of peace

Review

- What did you find good about the workshops?
- During the week did you practice the strategies?
- Did you find them useful?
- Did you have any difficulties?

Managing Stress

relax body (shake out arms, legs, relax the neck)

breathe from the stomach

Slow down your breathing

(3 seconds to breath in

3 seconds to breath out)

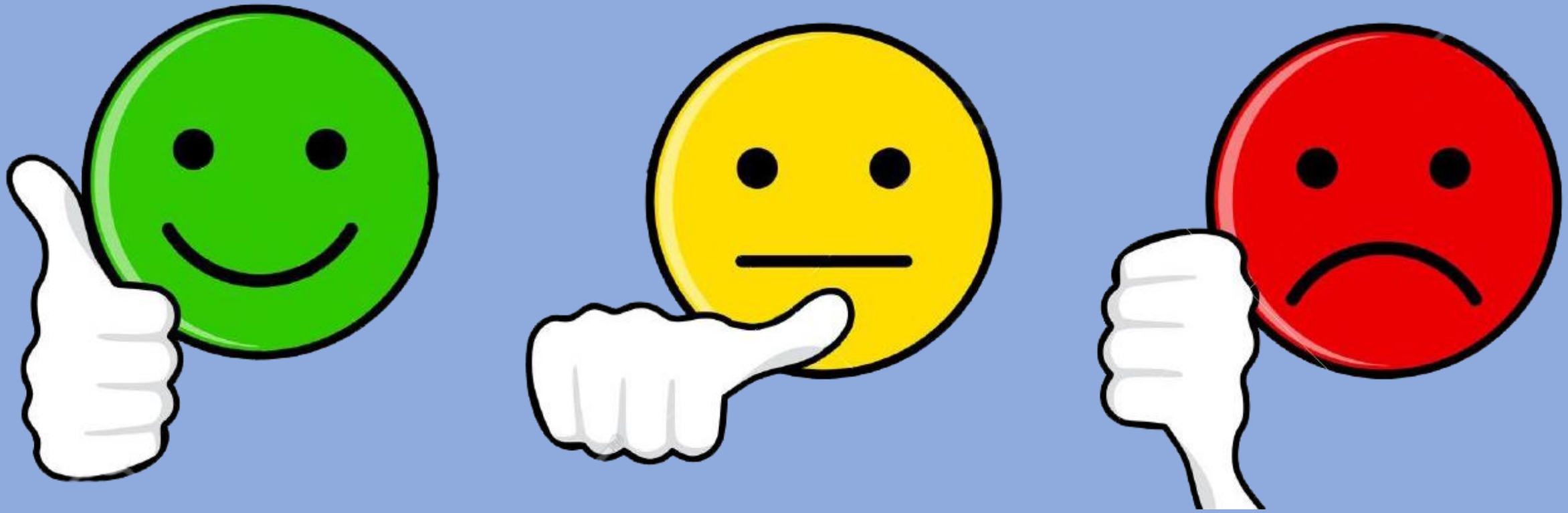
Practice regularly

Preparation for role plays

- **At the end of workshop series, tell ‘coaches’ about the end of training role plays & simulation exercises**
- **Make a team of two coaches. Give each team a workshop to deliver to the group, while rest act as participants**
- **Team 1: Workshop 1 Introduction and Managing stress**
- **Team 2: Workshop 1 Managing problems**
- **Team 3: Workshop 1 Get Going Keep Doing**
- **Team 4: Workshop 1 Strengthening support network**
- **Team 5: Workshop 1 Staying well and looking forward**

Reminders

- Be sensible- role-plays are not formal tests, but should be taken seriously
- Trying not to be deliberately difficult
- When providing feedback, consider giving a positive comment first then commenting on what could have done differently or included
- Consider each other's feelings (e.g. nervous, embarrassed etc.) when providing feedback
- Not laughing at other's mistakes
- There are no wrong answers



Feedback

End of Training Evaluation

Human Development Research Foundation

NPO SEAL OF GOOD PRACTICES
HDRF has been certified by the Pakistan Centre for Philanthropy (PCP) on September 11, 2015, for meeting certification standards in the areas of Internal Governance, Financial Management, and Programme Delivery

Institutional Review Board-HDRF

Dr Zahoor Ahmed
July 17, 2018

Dear Dr Zahoor Ahmed,

Submission Title: Evaluating a multi-component group intervention for improving psychological well-being of trainee civil servants in Pakistan: A randomised controlled study

HDRF IRB Ref: IRB/003/2018

Thank you for submitting your protocol for ethical approval on July 10, 2018.

The board has reviewed your application and the relevant documents.

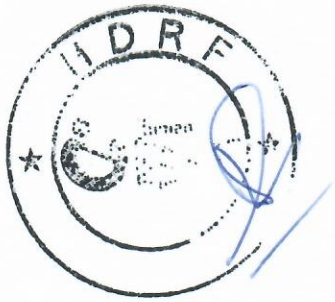
Confirmation of Ethical Approval

On behalf of the board, I am pleased to confirm a favourable ethical opinion for the above titled research on the basis described in the application form, protocol and supporting documentation, as specified below.

Approved Documents

The final list of documents reviewed and approved by the board are as follows:

Document Type	File Name	No. of Version	Date
Appendix 1	Patient Health Questionnaire (PHQ-9)	1	10.07.18
Appendix 2	Research information sheet and consent form for participants	1	10.07.18
HDRF Ethical Approval Application			10.07.18
Study Protocol			10.07.18



After Ethical Review

The IRB must be updated on the finalized version of the Patient Health Questionnaire before administering them and on any subsequent changes to the application/protocol/consent during the lifetime of the study.

Sincerely,

Shamsa Zafar
Chair IRB- HDRF
Human Development Research Foundation

HDRF
Human Development Research Foundation

Central University Research Ethics Committee for Physical Interventions

10 August 2018

Dear Prof Rahman

I am pleased to inform you that your application for research ethics approval has been approved. Application details and conditions of approval can be found below. Appendix A contains a list of documents approved by the Committee.

Application Details

Reference:	3831
Project Title:	Improving psychological well-being of trainee civil servants in Pakistan
Principal Investigator/Supervisor:	Prof Atif Rahman
Co-Investigator(s):	Mr Zahoor Ahmed
Lead Student Investigator:	-
Department:	Psychological Sciences
Approval Date:	10/08/2018
Approval Expiry Date:	Five years from the approval date listed above

The application was **APPROVED** subject to the following conditions:

Conditions of approval

- All serious adverse events must be reported to the Committee (ethics@liverpool.ac.uk) in accordance with the procedure for reporting adverse events.
- If you wish to extend the duration of the study beyond the research ethics approval expiry date listed above, a new application should be submitted.
- If you wish to make an amendment to the study, please create and submit an amendment form using the research ethics system.
- If the named Principal Investigator or Supervisor leaves the employment of the University during the course of this approval, the approval will lapse. Therefore it will be necessary to create and submit an amendment form within the research ethics system.
- It is the responsibility of the Principal Investigator/Supervisor to inform all the investigators of the terms of the approval.

Kind regards,

Central University Research Ethics Committee for Physical Interventions

ethics@liverpool.ac.uk

0151-795-8355

Appendix - Approved Documents

(Relevant only to amendments involving changes to the study documentation)

The final document set reviewed and approved by the committee is listed below:

Document Type	File Name	Date	Version
Other Committee Application Form	HDRF IRB application_ZA_UoL	10/07/2018	1
Other Committee Approval Letter	Appendix 5_HDRF IRB aproval letter	17/07/2018	1
Evidence Of Peer Review	Peer review_FM	20/07/2018	1
Evidence Of Peer Review	Peer review_AM (1)	20/07/2018	1
Research Tools	Appedix 4_Outcome measures	21/07/2018	1
Other Committee Terms Of Reference	HDRF IRB_ToRs	22/07/2018	1
Participant Information Sheet	Appendix 3a_Information sheet v2	22/07/2018	2
Participant Consent Form	Appendix 3b_Consent Form V2	22/07/2018	2
Research Tools	PhD_ZA_22.07.2018 v10	22/07/2018	10
Fieldwork Risk Assessment	fieldwork risk assessment	22/07/2018	1