The Trauma of Loss & Abuse

Mental Health, Psychosocial Care & Protection for Children & Adolescents

Training Series 2

Developed by

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"Experience has taught us that we have only one enduring weapon in our struggle against mental illness: the emotional discovery and emotional acceptance of the truth in the individual and unique history of our childhood."

— Alice Miller,

The Drama of the Gifted Child:

The Search for the True Self

Contents

1. Trauma Basics

1.1. The Experience of Trauma

Objectives

- To understand the experience of trauma.
- To introduce experiential methodology in working with child trauma.

Time

1 hour

Concept

In as long as we learn about trauma as a theoretical concept, we will never really know how children experience it. So, let us do an exercise to (re)experience what trauma means and then discuss the implications for psychosocial care in the context of trauma.

Activity for the Experience of Trauma

Method: Visualization, drawing, narrative

Materials: paper or notebook and pen

Process:

- Ask participants to do the following, step by step:
  - Close your eyes and think of a traumatic time/event in your lives.
  - Imagine the event as an image (not a narrative/ not in words)…like a still photograph.
  - Now, draw it.
  - Now describe it—either to yourself or the person next to you.

Discussion:

- What sort of images and feelings came back to you?
- Was it easy to express the emotions you felt?
- Explain:
  - How (for children especially) images of trauma are first coded into memory as images, sights, sounds, smells and tastes…not as narratives. This is a distinguishing feature of traumatic memories—they are first stored as sensory memories, often in fragments. It is only later that people piece them together to form a narrative. (This is also the reason why it is difficult for children to verbalize or articulate experiences of trauma). Even after developing a personal narrative for the traumatic experience, for most people, these experiences continue to be come back as sensory perceptions and as affective states.
  - The body keeps a physical memory of all of our experiences…
  - Trauma does not just go away (time is not always a great healer!). A traumatic event cannot be forgotten and the memory of it may remain even lifelong.
  - But it can be processed so that a child is able to understand and make sense of the experience, to take perspective on what happened in such a way that he/she is able to lead a relatively happy and productive life thereafter.
  - Unresolved trauma will affect the way children think, what they believe, how they view themselves and the world around them and consequently, their decisions and actions, both in the present and in the future (when they become adults). Therefore, addressing trauma in children is critical.

1.2. Impact of Childhood Trauma

Objectives

- To learn about the impact of trauma on children.
- To familiarize participants with some basic child and adolescent mental health problems that may result from trauma experiences.

Time

1 hour

Concept

A. Types of Trauma

Trauma may occur in different contexts such as natural disaster or war; it may be caused by accident, wherein disfigurement and loss of limb may be additional traumatic events. Death, dying, bereavement and other experiences of loss comprise traumatic experiences, as do physical and difficult sexual experiences. Violence, exploitation, gender, patriarchy, trafficking also make the context for traumatic experiences:

Domestic Violence
Natural Disasters
Man-made Disasters
Death, Dying, Bereavement
Loss Experiences
Rape, Child Sexual Abuse
(Child) Trafficking
Accidents – Disfigurement, Loss Of Limb
Terminal Illnesses
Torture
Difficult Experiences
Sex and Sexuality
Abuse, Violence, Violation, Exploitation
Gender and Patriarchy
Power and Domination

The difference between trauma and other difficult experiences is that traumatic events are usually out of the ordinary, and extreme in nature, such as those described above. They are times when individuals feel ill-equipped to cope i.e. their normal coping mechanisms, mainly resilience, family and social supports, are either dysfunctional or inadequate in helping them address their problems. Traumatic events also have adverse long term impacts on individual psyche, their inter-personal relationships, and interactions with the world. Thus, what characterizes a traumatic event is one or more of the following features:

i) it happened suddenly and unexpectedly;
ii) the person is unprepared for it;
iii) the person felt powerless to prevent it;
iv) it happened repeatedly and/or a long period of time;
v) someone was intentionally cruel:
vi) more than one (traumatic) event occurred close to each other or in succession.

Another way of categorizing childhood trauma is as follows:

a) Acts of omission (things caregivers should do to children but do not do): consist of psychological neglect, sustained parental non-responsiveness and psychological or physical unavailability. [Parents who do not respond to children with love, affection and caring].
b) Acts of commission (things caregivers should not do to children but do them instead): Involve actual trauma directed toward the child. These acts (of abuse), whether physical, sexual, or psychological, can produce longstanding interpersonal difficulties, as well as distorted thinking patterns, emotional disturbance, and posttraumatic stress.

B. Impact of Trauma on Children

(i) Negative Assumptions about Self

- "I must be basically unacceptable/ bad"; "something must be basically wrong with me to deserve such punishment".
- Consequently, the child perceives herself as weak and inadequate.
- Child also views others as dangerous or rejecting or hurtful.

Negative assumptions refer to how the child makes inferences based on how she is treated. Example: a young child who has been maltreated (physically or sexually abused) often infers a negative sense of the self from such acts—"I must be basically unacceptable/ bad"; "something must be basically wrong with me to deserve such punishment". Consequently, the child perceives herself as weak and inadequate. Additionally, the child develops a general mistrust of the world at large and thus views others as dangerous or rejecting or hurtful. Such perceptions of the self result in anxiety and guilt, while perceptions of others result in anxiety and/or aggressive behaviours.

(ii) Trauma Flashbacks

- Re-experiencing trauma at a later time (weeks, months or even years after)—as flash backs.
- Children remember the details of event, especially sights and sounds.
- Thoughts can be triggered or 'switched on' by exposure to some environmental stimuli or experience that is similar to the trauma.

Example: a person who was sexually abused by her uncle, year later and well into her adulthood, would feel huge stress and anxiety and recall her sexual abuse trauma, whenever she saw a man with white shoes; she then realized that her uncle always wore white shoes, which was the first thing she saw when he appeared near her room each night. Thus, her body had encoded the memory of white shoes in association with the trauma so that years later, it served as a trigger for her anxiety.

Or children who have lived in areas of armed conflict and been exposed to shooting and gun fire, when moved to a place of safety (such as a refugee camp) still feel a sense of anxiety and panic when they hear see smoke or hear loud noises—because these trigger memories of the conflict and the traumatic experiences of violence and death they suffered at the time.

(iii) Interference in development of emotional regulation/tolerance skills

- Reduced affect or emotional regulation skills.
- Risk for being more easily overwhelmed by emotional distress.
- Use of dissociation (fainting/ black-outs) and other methods of avoidance.
- Difficulty in responding in a 'balanced' way, within a moderate range of emotions: the slightest provocation, even if unrelated to the event may produce extreme reactions of intense fear or anger.

Children who have suffered trauma have reduced affect or emotional regulation skills. They are at risk for being more easily overwhelmed by emotional distress. They find it difficult to respond in a 'balanced' way, within a moderate range of emotions: the slightest provocation, even if unrelated to the event may produce extreme reactions of extreme fear or anger. Preclinical and clinical studies have shown that repeated early-life stress and trauma experiences lead to alterations in central neurobiological systems leading to increased (mal) responsiveness to stress; this in turn increases the risk of psychopathology in both children and adults.[9]

What is emotional regulation?

A fan has a regulator that controls speed. If this regulator does not work, the fan may either not run or do so only at the highest speed. Similarly, each individual has an internal mechanism that works to regulate emotions—an emotional regulator. Events of trauma and abuse (especially when repeated or chronic in nature), can cause this emotional regulator to become dysfunctional. As a result, a child with trauma experience may respond to a given situation with extreme emotions: if a situation triggers annoyance, he may become extremely angry, to a point of violence; if a situation makes him feel powerless, he may become extremely anxious—to a point where he may have a dissociative episode i.e. extreme anxiety causing him to avoid the situation entirely by having a 'black-out' or 'fainting fit'. Alternately, the experience of threat may give rise to either of two opposite reactions, one of complete fear and withdrawal or that of intense anger and aggression.

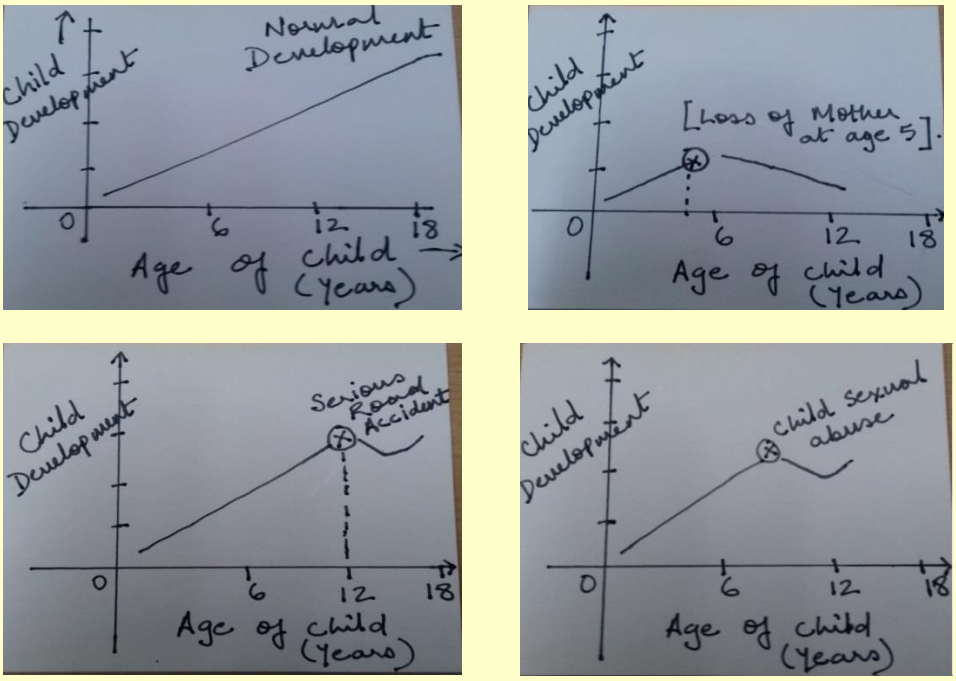
(iv) Adverse Impact on Developmental Trajectories

- Severe trauma interferes with the usual acquisition of self-capacities and developmentally appropriate skills in children.
- Difficult for the child to acquire and process new information, develop family, social and peer relationships.
- Impairment of other developmental functions relating to self-identity, social and cognitive skills

Recall the five domains of child development we discussed in the previous workshop--physical, speech and language, social, emotional and cognitive development. In analyzing and responding to the effects of trauma in a child, it is essential not to forget the importance of keeping the child's developmental trajectories on track—because these are likely to go awry following loss and abuse experiences. Consider a child who has suffered the loss/ death of a primary caregiver such as his mother—his physical growth may suffer due to poor nutritional

and other basic care; the surviving parent might become extremely over-protective of the child and not allow him to go out and play with his peers as a result of which his speech and language and social skills will be negatively impacted; his own sadness and grief and anxiety about how he will be taken care of and whether the surviving parent may also die, is likely to cause emotional distress that also impairs his attention and concentration abilities, consequently affecting his cognitive and learning capacities.

Impact of Traumatic Events on Child Development



Early and severe trauma thus interferes with the usual acquisition of self-capacities and developmentally appropriate skills in children. This includes the development of affect regulation skills (explained above) but also impairment of other developmental functions relating to self-identity, social and cognitive skills. The achievement of developmental milestones is impaired because trauma experiences and emotions make it difficult for the child to acquire and process new information, develop family, social and peer relationships.

If the trauma itself is on-going and protracted and if it involves breakdown of social and civic amenities (due to breakdown in family and social support systems), this by itself leads to a loss of developmental opportunities because access to school is hindered and peer interactions are reduced. Trauma affects development both indirectly and over long term. At an inter-mediate level, if a child has lost someone or is being abused, the anxiety or the pre-occupations it causes affects learning capacities—children cannot learn in an atmosphere in an environment of unresolved doubts, questions and worries.

Irrespective of whether the geographies or spaces are distal or immediate, trauma and its impact lead to a loss of sense of mastery. Where there is unpredictability about events that happen or children are unable to control how events play out, this loss of efficacy also affects

self-image in a way in which the child begins to think of herself as weak and unable to predict negative events or control them when they occur. This then leads to a negative self-identity.

C. Common Trauma-Related Child & Adolescent Mental Health Problems

Traumatic events such as a death in the family, separation from family and institutionalization or sexual abuse often trigger strong or long-lasting reactions in children. Children affected thus may have a hard time coping with their emotions and may become depressed or anxious, exhibit hostility, pick fights, or refuse to go to school, among other responses. These 'abnormal behaviours' need to be understood as normal reactions to abnormal situations. While not all children will go onto developing mental health morbidities as a result of traumatic experiences (temperament, resilience, access to social support systems may play a protective role), it is important to be aware that many children will at least temporarily have some symptoms of mental health problems as they struggle to cope, and we need to be alert to these symptoms in order to recognize that children may be going through difficult experiences (as children will not always articulate or report their problems).

Now, if you recall the context and inner voice exercise we did in workshop 1, you will remember we discussed that different children may have different emotional and behavioural responses, even if the events and experiences they have undergone are the same. This is based on the child's internalization and processing of the events and experiences i.e. the child's inner voice (and on the child's temperament and resilience). So, in two children of the same age, both of whom may have suffered sexual abuse by a family member, one child may experience anxiety, including psychosomatic symptoms while the other may have more depressive symptoms by way of self-harm behaviours.

Traumatic experiences in children (as indeed in adults) results in one or the other psychiatric disorders, namely Post-Traumatic Stress Disorder (PTSD), Anxiety Disorders and/or Adjustment Disorder and Depression. It is useful to be familiar with signs and symptoms of these disorders because:

a) They help understand the emotional and behavioural changes that have occurred in the child due to traumatic experiences. In fact, most often children who present at mental health facilities come with caregivers complaints about their emotional and behavioural problems, not with direct reports about traumatic loss or abuse experiences; so based on the emotional and behavioural issues reported by the child and caregivers, further assessment and inquiry reveal the underlying cause or trauma that caused these issues.

b) They help plan and design psychosocial interventions to address children's distress i.e. overall, therapeutic goals involve working towards reduction in emotional and behavioural symptoms.

c) Some symptoms (such as recurring images and nightmares of the event as happens in PTSD or self-harm as happens in case of depression) are also indicative of the severity of children's distress; in cases where children's anxiety/depressive/PTSD symptoms are very severe, rendering children dysfunctional, decisions must be made to suspend psychotherapy and refer the child to a mental health or psychiatric facility immediately as the child may require pharmacotherapy.

Activity for Impact of Childhood Trauma

Method: Film viewing and discussion

Material: Film 'Stanely ka Dubba' (Hindi with English sub-titles) is about a young boy named Stanely. It is a story that is largely set in school and centres around themes of bullying, friendship, and resilience. Central to the film are is the theme of food, and its links with Stanely's narrative about his parents. The film shows how each child processes and responds to loss in unique ways (at times, inexplicable—to the adult world).

Process:

- Screen the film for the participants

Discussion:

- Let us reflect on the film through 3 levels of processing:

  i) Do a basic emotive and empathic sharing of impactful and unforgettable characters/images/issues/scenes in the film.

  ii) What psychosocial themes do you observe playing out in the film? What are themes particularly relevant to loss and grief?

  iii) How might we use the understanding of these themes to inform our work in the area of loss and grief?
- What kinds of questions and themes would you discuss if you were using this film with a group of children (particularly those who had suffered separation/ loss trauma)?

Note: It is useful to end the day (particularly day 1 and 2) of the training with this activity; it can also be done after 5 pm as it is enjoyable and allows the participants to relax and be entertained but at the same time continuing the immersion in issues relevant to the training and work with children.

2. The Trauma of Loss

2.1. Introducing Loss, Grief and Death Work with Children

Objectives

- To understand the nature of loss and grief work with children.
- To explore our notions of childhood loss and grief.

Time

1 hour 15 minutes

Concept

Death, loss and grief are universal experiences—everyone goes through them at some point in life. However, despite the universality of these experiences, many people struggle with what to say to persons who have undergone loss and death experiences. For instance, when people offer condolences to those who are bereaved, many are unsure what to say, how to say and whether their words will be hurtful rather than comforting to the other person. When adults find it difficult to talk to each other about loss and grief experiences, it is that much more difficult for adults to explain or speak with children about such complex experiences.

Some people, including professionals hold that death is a 'part of life' and is therefore a 'normal experience' for all. While these clichés are not untrue, death and loss experiences for children can certainly never be 'normal'. Indeed, how can it be or feel 'normal' for a child to lose a caregiver or a loved one? Let us consider the following example: An 80 year old man dies (of illness or old age); he has lived a full life with a career and family, he has made investments wisely and seen his children and grandchildren grow and develop. But when he dies, his 55 year old daughter/son will, in all likelihood, grieve deeply for him, and naturally so. If it can be difficult, even traumatic (in case of very close relationships/ attachment), for a 55 year old to lose a parent, it could never be normal for a 3 year old or a 10 year old or even a 16 year old to lose a parent or loved one, especially considering that children and adolescents (unlike the 55 year old), whose lives are still at the formative stages, are both financially and emotionally dependent on the caregiver who passed away. Further, if you consider the issue of a loss versus one of tragedy…it is certainly a loss for a 55 year old when his 80 year old father passed away but is it a tragedy? If an 8 year old loses his 35 or 40 year old father, is that just a 'normal' loss or would this be a tragedy and therefore also very traumatic for the child?

Despite the universality of loss and grief experiences, few professionals work in it. What is interesting and challenging about this area of child mental health work is that it is dependent on socio-cultural beliefs around death and mourning—and there are many religious traditions and beliefs on these issues. Moreover, how loss and grief issues are resolved depends on the personal beliefs and philosophies of an individual therapist or facilitator. However, the idea is not to impose one's own personal beliefs and philosophies on the grieving person. Loss and grief work with children is about how we are going to convey deeply philosophical ideas and issues in ways that makes sense to them…that helps them grapple with an issue such as death,

that is shrouded in the mysterious and the unknown. And this is what distinguishes loss and death issues from others: that loss and death counselling is based on beliefs not facts…we don't actually know what happens to people when they die or where they go. The answers to such questions are only in the form of beliefs, not facts. Lastly, while we are focussing mainly on loss as experienced in death, for the purposes on this training workshop, is important to recognize other forms of traumatic loss as well, namely, rejection, abandonment and separation.

Activity for Introducing Loss, Grief and Death Work with Children

Material: Statements on children and loss/death (below)

Method: Discussion

Process:

- Present each of the statements one by one, asking participants whether they think it is a myth or reality i.e. whether they agree or disagree.
- Ask participants to present reasons for their beliefs or positions on children and death.
- Encourage debate and discussion—these statements do not have a single/ 'right' answer.

Statements about Children and Loss/Death

- Children do not understand or experience loss & death.
- It is alright never to tell children the truth about separation/loss/death because they will forget. (i.e. to say 'Mummy will come back/ she has gone out of town'—when the mother is dead).
- Children will be scared if they find out the truth.
- When children become scared about a death, they are afraid about related issues, such as remaining parents or supports going away.
- Children may also be reflecting fears and anxiety from the adults who are also involved in the family.
- Children don't hurt as much because they understand less.
- Infants and toddlers are too young to grieve.
- Children are resilient; they bounce back.
- Speaking of the deceased will reopen a child's grief wounds.
- Children should be protected and shielded from the pain of grief.
- Children should NOT attend funerals or be involved in grieving.

Discussion:

Issues raised by each of the statements could be discussed in the following ways:

- Children as young as 6 to 7 months of age are aware when their caregivers are not around, so while they may not comprehend death as a phenomenon, they certainly experience loss (of caregiver). Remember child development…children develop separation anxiety at about 6 months of age. If a child is old enough to love and attach, he is old enough to grieve.
- Children will not 'forget'—especially when the person is a primary caregiver; if you do not tell, they will ask questions anyway and want to know where the person is.
- Telling children lies about the death will only serve to confuse the child more; and lies such as 'she has gone to the market/ will come back are not credible—the child will keep asking questions and only get more and more anxious when the person does not come back (as promised). Finally, when the child discovers the truth, he/she will feel angry and betrayed and loose trust in the person (whether therapist or family member) who told the lie in the first place.
- Children may be scared when they find out the truth—and why shouldn't they be? Their fears have a basis in questions such as 'what will happen to me now? Who will take care of me? Will daddy also dies just like mummy did?' But if these questions are addressed and they are reassured, the fear will reduce. The question is: are we afraid that children will be scared…or that it is us, as adults, who are afraid, because we don't know how to explain death issues to children and deal with their fears and upsets? In most instances, it is adults' fear and discomfort of engaging children in conversations about death…that prevents them from telling children the truth.
- It is believed that continuing to speak of the deceased and expressing the emotions of grief will add to the child's grief experience rather than help dissipate the emotions. But allowing for expression of grief (rather than suppression) and staying connected to the loved one through the sharing of memories helps with the integration of the loss and the changing of the relationship. It is when we hide pictures, speak in hushed tones or maintain silence about persons the child has lost (through separation or death) that make children anxious as they are unable to understand why we behave in these ways…and they learn that their grief is to be suppressed. This in turn intensifies rather than helping resolve the grief.
- We cannot completely shield children from grief—after all, they have the right to grieve. But we can protect them, during the process of grieving by providing them with age-appropriate information on loss and death and support and reassurance as they cope with their grief experiences.
- There are 3 elements to consider when making decisions about children attending funerals: i) the child's age and temperament—if the child is relatively young and has an anxious temperament, it might be better not to involve the child in rituals that may cause more fear and distress; ii) the child's willingness—in case of older children who wish to be part of rituals, explanations on what the rituals would entail could be provided, following which they could decide on participation; iii) the nature of the ritual—in case it involves ceremonies such as lighting of the funeral pyre and shaving off hair (as happens in certain Hindu rituals), it could be exceedingly traumatic for a child and create lasting memories of trauma around a loved one; if it is rituals involving prayers, with a picture of the deceased, and people coming together to remember a loved one, it may be less traumatic or more comforting for a child, in which case it would be alright for him/her to participate in rituals.

2.2. Understanding How Children Experience Loss & Grief

Objectives

- To learn how children understand death and how they grieve
- To explore the child's inner voice on thoughts, confusions and queries about death.

Time

1.5 hours

Concept

In order to be able to respond to children's questions, concerns and feelings around loss and death issues, we need to first be able to understand how children experience and understand death and how they express their grief. The table below presents how typically children's understanding of death evolve and what their patterns of grieving are i.e. behavior manifestations, as they grow up. In other words, children's experience and understanding of death depends on their socio-emotional and cognitive capacities, which for normal children (i.e. children without intellectual disability) is age-determined.

In general, children develop an understanding of death i.e. the irreversibility of it, when they are about 7 to 8 years of age. However, children who experience loss and death issues in their early years, for instance when they are 4 to 5 years of age, (when normally they would not have an understanding of death), may also develop an understanding of death. This is not because they develop it naturally even when the event occurs; it is because they are forced to develop some understanding of it, based on their personal experience of it, and on what they are told about the phenomenon of death.

It is important to have knowledge of children's understanding of death at various ages (as provided in the above table) so that we tailor our responses according to their ability to understand and process information about the phenomenon, depending on where they are in their developmental cycles. For instance, even if a 4 year old child is confronted with the death of her mother, and we know that at this age she will have no understanding of death, she will still have questions about her loss experience, and therefore we must respond—to provide comfort as well as answers to her questions in a manner suitable to her (4 year old) socio-emotional and cognitive abilities. For older children and adolescents, who already have an understanding of death, it is not a matter of explaining the concept of death but more one of understanding their emotional reactions and behavioural responses to death. In adolescents, experiences of loss and grief often tend to manifest themselves as anger. Thus, aggressive or violent behaviours, in them, may be a consequence of loss and grief. Consequently, the use of behaviour modification techniques with such adolescents would not resolve their problems. Working with them requires understanding and acknowledgement of loss/death experiences, validation of grief and feelings of anger, in order to impact their behaviour.

Children's Understanding of Death and How they Grieve

Age group	Understanding of death	Patterns of grieving in children
0-3 years	- No understanding of death - Absorbs emotions of others around her/him	- May show signs of irritability - May exhibit changes in eating, nursing patterns, crying, and in bowel and bladder movement. - Dependency on nonverbal communications; physical care, affection, reassurances
3-6 years	- Child thinks death is reversible; temporary, believes that people who die will come back. - "Magical thinking"; believes their thoughts, actions, word caused the death; or can bring deceased back;	- Craves for affection / physical contact, even from strangers - Connects events that are not connected - Greatly impacted by parent's emotional state - Regressive behaviors; bed wetting, security blanket, thumb sucking, etc. - Difficulty in verbalizing, and acts out feeling - Have worries of abandonment and fear that when others leave that they are not going to come back.
6-10 years	- Child begins to understand the finality of death; some do and some may not. - Sees death as a taker or spirit that comes and gets you	- Fear that death is contagious others can die too - Asks concrete questions - May worry how the deceased can eat, breathe, etc. - Guilt - blames self for death - Continues to have difficulty expressing feelings verbally - Increased aggression, Somatic symptoms, School phobia (especially if single parent)
10-13 years	- Child's understanding is nearer to adult understanding of death; - More aware of finality of death and impact the death has on them.	- Concerned with how their world will change; - Questions have stopped - Self-conscious about their fears (of own death, remaining parents)- Reluctant to open up - Delayed reactions - at first seems as if nothing has happened, then grief reaction May show strong degree of affect - Disrupted relationships with peers - Increased anger, guilt, somatic symptoms, school phobia
13-18 years	- Death is viewed as an interruption. Death is an enemy - Bodily changes emphasize growth and life.	- Increased vulnerability due to many other changes - A sense of future becomes part of their psychology - Wants to grieve with her/his peers not adults - Suicidal thoughts, Somatic symptoms - Represses sadness, feels anger, depression - Escapes; uses drugs or alcohol sexually acts out - Denial - tries not to think about it, doesn't want to talk about it - Difficulty with long term plans

Reference: http://www.hospicenet.org/html/understand.html , accessed on 3rd March, 2011, 4 pm
Reference: Slate, C. N., & Scott, D. A. (2009, March). *A discussion of coping methods and counseling techniques for children and adults dealing with grief and bereavement.* Paper based on a program presented at the American Counseling Association Annual Conference and Exposition, Charlotte, NC.

The Impact of Loss & Grief on Children: What to Assess

Nearly all children in care and protection have experienced some form of loss, whether in the form of people (separation/death), places or opportunities. However, as previously discussed, not all children experience a loss/death event in the same manner, and consequently, their internalizations are different and therefore so are their emotions and behaviours. Even if there are contextual similarities in two given children, their internalizations or inner voices are not necessarily the same. For example, one child may be extremely anxious, thinking 'who will look after me now that my mother is no there?' while another child may be very angry, thinking 'why did my mother leave me?'

Therefore, despite the universality of the phenomenon of death and of similarities in experiences and responses, it is still important to acknowledge that each child's experience of loss and death is unique; only in doing so can we be effective in our interventions with a given child. Above (in the table, above, titled '**Factors Influencing Children's Experiences of Death and Loss: What to Ask & Why'** are some factors that influence children's experience of loss and death, and consequently their emotional and behavioural responses—these are parameters that we can use in our assessment of a given child's loss and grief experiences. They are not laid out in any particular sequence or order of importance but they are all relevant and require to be understood in order to lay the grounds for grief work with the child. In particular, the child's understanding and processing of the loss experience and questions and thoughts about death are essential to understand—because this is will form the starting point and the crux of loss and grief work with the child.

The Concept of Ambiguous Loss

A soldier who has disappeared during a war…he has not come home; no one knows whether he is dead or alive. His parents keep hoping (for years, even) that he will return home; they don't believe he is dead because there is no evidence of that either.

A child who has a mentally ill mother who is unable to take care of him…his mother is physically present but does not feed or nurture him, play with him or respond to him emotionally.

A child who is abandoned on the street by her parent… she keeps waiting, hoping and believing that her parent will return for her but he does not. She does not know what happened to the parent and why he did not return for her.

When we know that we have lost someone (usually to death), we can then mourn and go through various grief rituals and processes. However, when we do not know for sure what happened to a loved one and there is no proof that the person does not exist anymore, the situation becomes more complex because we are not sure how to respond, and yet we are grieving because it is a loss that we experience. Ambiguous loss refers to a loss that occurs without closure or understanding. This kind of loss leaves a person searching for answers, and thus complicates and delays the process of grieving, and often results in unresolved grief. Children and families who experience ambiguous loss may go through many years of waiting and searching, not knowing what to believe or how to cope with the loss they are experiencing. Ambiguous loss can be of two types:

- Occurs when there is physical absence with psychological presence.
- Occurs when there is psychological absence with physical presence.

Factors Influencing Children's Experiences of Death and Loss: What to Ask & Why

Factors/ Parameters Influencing Children's Loss & Death Experiences	What to Ask (Caregivers/ Children)?	Why Ask?
Child's grief reactions / Traumatic grief	- What has child's response been to the loss/ death? - Check for PTSD and depression symptoms.	Depression and Severe PTSD could make a child dysfunctional—intrusive images and flashbacks, for instance, may be interfering with child's sleep and abilities to perform daily tasks.
Circumstances of the death, i.e. anticipated/sudden/ violent	- How did the death occur? - Did the child have any idea that the person would die? - Where was the child at the time the death event occurred? - Did the child witness any of the events? Or was she told later?	Anticipated: such as in case of a long-standing illness/AIDS—this can be traumatic but a relatively slow and long-drawn experience of sadness and worry. Sudden: such as in case of an accident or in case of an unexpected illness—which could be a shock due to its unexpectedness. Violent: such as an accident or killing or suicide—which could be the most traumatic due to their violent nature.
Child's relationship with the deceased	- What kind of relationship did the child share with the deceased? - Was it a very close one, of love and attachment? - Was it a somewhat inconsistent one i.e. a love-hate relationship? - Was it one in which the child absolutely disliked the person even if it was a close relation such as a parent?	If the deceased was a primary caregiver/ attachment figure for the child and they shared a close and loving relationship, the child may experience the loss more acutely. If the child's relationship with the deceased was ambivalent i.e. at times close and loving but also ridden with a lot of anger and conflict, or in a situation where the child disliked the deceased, the child may feel a sense of loss but also be confused how to feel i.e. he may not feel a sense of loss at some levels but then feel guilty that he does not especially as there may be family/ societal pressure to mourn. In case of difficult relationships with the deceased, the child may not mourn the individual/ person but may still feel a sense of loss due to loss of a relationship (such as a parent) i.e. the loss if not of an individual person with certain qualities and attributes but the loss is of a father/mother figure.
Child's involvement in mourning rituals	- What mourning traditions and rituals did the child participate in? - How did the child feel about participating in the rituals? Was the child coerced in any way to participate in them?	If the child was coerced to participate in rituals, it may have made the experience more traumatic for him, especially if the rituals were perceived by him to be frightening. Or, if the child wants to participate in certain rituals but is prevented from doing so by family members, for fear that it will traumatize him—as a result of which the child becomes resentful and experiences a lack of closure.
Child's understanding of loss/ death	What has the child been told about the death? (especially in case of younger children). How does the child understand the event? Does the child ask any questions about it? What thoughts or feelings does the child express about the death? (in case of	Very young children may not know at all about death or have no understanding of it. However, since they experience loss and they may have come up with their own explanation for the disappearance of their loved one. It is essential to understand what this is in order to do grief work with the child. Similarly, slightly older children may understand death but may still have various confusions and questions about it. Older children/ adolescents fully comprehend death but may have certain questions/ thoughts and responses to the loss experience—such as, 'I also want to die so I can be with my father' or 'why did my mother commit suicide?'

	older children)	
Family's grief reactions and ability to communicate openly about the death	- Who remains in the family/ at home with the child? - How is the family coping? - How have others in the family been affected by the loss experience?	If the family has been rendered dysfunctional by grief and the 'normal' household activities are not taking place, there is also a chance that the child is not being cared for adequately. If the family has instructed the child not to talk about the deceased or the child is prevented from having pictures of the deceased and expressing his feelings, it creates increased anxiety in the child and also does not allow for the child to grieve. Suppression of grief makes the processing and over-coming of loss experiences harder as compared to a family that grieves together, supports each other in their sadness and allows a child to express his sadness.
Family's strengths and vulnerabilities in caring for the child	- Who takes care of the child? - Are other caregivers in the family able to meet the child's needs and take care of him?	
Cultural and family beliefs and traditions regarding death and mourning, especially with regard to the child	- What are the family's beliefs about death? - What have they conveyed (or not) to the child? Why? - Is the child allowed to talk about the deceased and express his feelings about the person? Why/ why now?	
Child's relationships with family, peers, community	- Is the child social? Does he have a peer group/ friends? - Is there an extended family that is supportive of the child?	If children have strong social support systems, such as peer group/ friends and extended family, they tend to cope better with the loss experience, as compared to those without any social networks.
Other major stresses in the child's life	- Other than the loss experience, has the child any other problems and difficulties at home or at school? - Have there been any other difficult or unusual events in the family?	A child who has pre-existing psychosocial problems i.e. family or school issues even before the loss experience is already vulnerable to emotional and behavioural disorders. In this case, the loss experience may not be the only reason for the child's emotional and behavioural issues—this last experience is super-imposed on other difficult experiences and may exacerbate the situation for the child. So, interventions need to address the loss experience as well as other issues.
Child's emotional, social, cognitive functioning before and after the death	Check if child is achieving age-appropriate developmental mile stones i.e. is the child's physical/ social/ speech & language/cognitive/ emotional development as it should be according to her age? Does she do her daily activities/ go to school/ play with other children? Has there been a difference in her developmental milestones after the loss experience? Is there a difference now in how she follows her daily routine/ does tasks? (Is she lagging behind?)	Traumatic experiences such as loss affect children's developmental trajectories. If the family is dysfunctional and has difficulty meeting the child's developmental needs, such as talking to the child/ playing with him/ sending him to school, it makes recovery from loss and grief experience more difficult for the child—and therefore the child's daily developmental activities are harder for him to do. Also, if the child has PTSD, anxiety or depression symptoms, he may find it difficult to focus or pay attention in school (because of his pre-occupation with the loss and grief experience)—therefore, his learning is affected and he may have a developmental lag.

Activity for Understanding How Children Experience Loss & Grief

Method: Inner voice analysis using case study

Materials: Case studies (provided below)

Process:

- Divide the participants into sub-groups and allot one case to each of them.
- Request participants to read the case and be the child's inner voice…make a list of thoughts and questions, with a focus on the loss/death experience.

Discussion:

- Request participants to share their cases and list of child's inner voice in plenary.
- Ask participants to add any thoughts and questions they can think of to other groups' cases.
- During sharing & discussion, remind participants about children's age and relationship with the loved one they have lost.
- Request them to hold on to their lists—they will be used in the next session/ activity.

Case Studies

Case 1: A 6-year old boy, Nishant, has recently come to the institution. His mother hanged herself and the child was witness to this but is unclear what happened. He cries all the time and wants his mother; he refuses to eat and wakes up several times at night.

Case 2: A 4-year old boy, Dinesh, was abandoned at the bus stop by his father. His mother had recently died and the father was re-married to someone who did not want to care for the boy. The boy wets his bed every night, and soils his clothes during the day. He is very disorganized at the institution and in school—his teachers complain that he is inattentive in class. He tells people that his biological mother (whom he loved a lot) is dead but he also says she will come back to take him home.

Case 3: A 15 year old girl, Shilpa, has in the past year, lost her brother, father and pet dog. He brother committed suicide; her father died in hospital, of sudden illness; her dog was brutally killed by someone in the neighbourhood. Her mother complains that she is always/ easily angry, not motivated to go to school and has already tried to cut her wrists three times.

Case 4: Anita, a 14 year old girl, had no father and her mother recently committed suicide—after which the child joined your institution. She loved her mother very much, and said that they had done everything together since her father died several years ago. She is now angry all the time, refuses to eat and keeps expressing the desire to take her own life. She says she does not care anymore to go to school or to study/ become a doctor as she had once wanted to. Sometimes, she also says she hates her mother.

Case 5:
Sonia is a 15 year old child had a mother who was deaf and mute and had been sexually assaulted by the person she worked for; and that Sonia had been born as a result of the abuse. Her mother died soon after her birth and she was raised by a neighbouring family in the village. The family that raised her did not give her food to eat or send her to school. The villagers taunted her saying that she was a child who 'didn't have her father's name'. Unable to bear their taunts she ran away, following which she was placed in a child care institution. She says that she desperately misses her mother and wants her mother all the time. She also constantly inquires as to whether it would be possible for her to be adopted by a family.

Case 6:
Ravi is a 12 year old HIV-infected child. He has lived in several child care institutions from infancy. He has no memory of his parents—he was told that he had been in institutional care since he was 3 months old. Now, he feels very depressed and says he wants his mother…he cries a lot of the time but he also has a lot of demanding behaviours (asking for special foods and play time/ privileges in the institution) and breaks objects and hits people when his demands are not met.

Case 7: Omar, 10 years old, was playing with his cousin. He teased her a bit and she got upset. So, she left and went back to her house. That night, there was shooting near her house and Omar heard in the morning that she died. He now refuses to play with his siblings or friends, is not able to eat or sleep.

Case 8: After the mid-day prayers, the forces came and fired tear gas shells and pellets at a peaceful procession. 12 year old Nasir who was on his way back from school went missing. Suddenly, the forces made an announcement that a boy had been killed. When Mansoor, his 17 year old brother found out that Nasir had been killed, he went to file an FIR but there has been no progress on the complaint. Mansoor now sleeps poorly, does not hang out with his friends any longer and has discontinued school.

Case 8: In a congested classroom, 13-year-old Sahil Majeed is trying to copy on his note book what his teacher is writing on a white board with black marker pen. Sahil has two younger sisters and a mother who is a half widow. His voice trembles with fear and frowns become visible on his little forehead every time he recalls how his father became disappeared. "I was sleeping that night when army raided our house. They took my father along and then there came no news about him," he said. He was a seven-year-old when his father disappeared after being abducted. He had to be admitted in a child care institution as his mother had no income to take care of him. He often says he wants to run away from the institution.

Case 9: Nasrin, now 12, was an eight-year-old child when he knew that his father, a militant, was killed. Nasrin was admitted in an institution by her mother who found financially difficult to take care of her. Every time she is allowed to leave the orphanage to visit his family, he refuses to return from home. "He weeps every time he returns visiting his family. We try to soothe him, but he gets angry at time and starts tearing apart his books," other children say.

2.3. First-Level Responses to Children's Loss & Grief Experiences

Objectives

- To develop first level responses to children's confusions and queries about loss and grief experiences.
- To explore scripts that provide age-appropriate explanations in various contexts of loss and grief.

Time

2 hours (for about 4 to 5 cases…can vary depending on the number of cases discussed)

Concept

Given the culture of silence that often surrounds death, especially when it comes to adults communicating with children on the issue, children (especially younger ones) may not always articulate their questions and concerns about death. The next step, after assessment of loss, is understanding what questions and confusions exist in a child's mind. Based on the child's age and developmental level (recall child development concepts!), we may need to also imagine the kind of concerns and questions a child may have in mind and respond accordingly.

There is no set recipe or formula for responding to children's concerns and feelings about loss and death. The idea is not to have ready-made answers but to be prepared for all kinds of questions that children may ask. Sometimes, children can ask difficult questions. In this case, we do not need to feel compelled to answer immediately. It is alright to say 'I don't know…give me a little time to think about your question and I will get back to you'—and do get back to the child! The basic aim is to address problematic experiences (including thoughts and feelings) around the loss/ death and alleviate the associated distress. An extended aim is to facilitate a wholesome growth where the loss and death do not occupy the child's thought and identity to an extent that it is disabling. Thus, our framework for response also needs to be predicated on certain premises:

- The response needs to be truthful i.e. no lies; but it should answer children's doubts and questions.
- At the same time, it should be comforting and reassuring to the child i.e. to bring peace and closure, not serve to increase sadness and trauma.
- It should center on the child's personal beliefs, or what he wishes to believe i.e. it should never be an imposition of our beliefs.
- It should never be one-word or half-sentence answers as these create more confusions and questions in the child's mind; but detailed enough to provide the information sought.
- It should be based on the child's age and developmental level i.e. an older child may be provided with more detailed information and ways that are more direct while younger children need to be given simpler explanations using stories and examples that they can comprehend.

Activity for Responding to Children's Loss and Grief Experiences

Method: Case study discussion

Materials: Case studies (from previous activity)

Process:

- Continue on from the previous activity—wherein each group developed a list of thoughts/ queries/ confusions related to loss and grief issues, for a given case.
- Request the participants to now develop responses to the list of thoughts and questions they had drawn up. (What are some of the things they may say to the child?)

Discussion:

- Request participants to share their responses in plenary.
- Ask participants to attempt alternative responses.
- During sharing & discussion, remind participants about children's age and relationship with the loved one they have lost—and the criteria for response.
- Help them examine children's responses/ reactions to the responses provided i.e. 'if you say this…what will the child think or feel? What other questions might emerge in the child's mind as a result of what you said?'

Responding to Young Children's Loss and Grief Experiences

What happened to mummy?

Mummy was very sick. Sometimes people get really sick and even after the doctor tries to cure them with medicine, they are unable to get well—like with mummy. People who do not get well, die—they are not able to stay with us, in this world, any more.

Where did Mummy go? Will she come back?

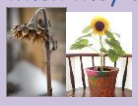
When people die, they do not come back…so mummy will not come back (and I know you will be sad about that). No one is sure about where people go when they die but we all believe different things about it…some believe that dead people go to God or to heaven…some believe that they become a tree or flower or a star in the sky…what would you like to believe about mummy?

Will I also die when I get sick? Can I go to where mummy is?

There are illnesses that are small (like cough, cold, fever…), for which if you take medicines, you will get well. And there are illnesses that are bigger and more difficult to cure—those are the only ones people die of. Usually, two kinds of people die—those who are very sick and those who are very old…and you are not old or sick. So, you can't go to where mummy is now—but I understand that you really miss her.

What does dying mean?

Here are two flowers…what do you observe? As you can see, the first one is alive…means that it drinks water and eats food, so it looks healthy and can move when the wind blows; the second one is dead—since it has no life, it cannot drink water or eat and it looks dried up and cannot move at all. People are like that too—when they are alive, they can breathe, walk, sleep, eat, play, work…but when they die, they cannot do any of these things—so they cannot even be in the same place as people who are alive. Some people also believe that like plants and flowers, people also become mud when they die.



What does soul (or spirit) mean?

When a person dies, his body is buried in the grave and his spirit goes up to heaven. (What is spirit?)…the body is like a rose…and the spirit is like the fragrance of the rose—you can smell it and feel it but you cannot see it.

Can mummy see me?

I believe mummy sees you and watches over you every day. And because she loves you so much, she wants you to be healthy and safe and happy.

Did mummy go away because she was angry with me? May be I did something wrong…
No, mummy did not go away because she was angry with you. You are not responsible for what happened at all—and mummy would never think so either. She loved you very much. Sometimes things happen in ways we don't expect…illness or accidents happen.

Who will look after me now?
I know you are worried about how you will be taken care of…but we are here to take care of you and keep you safe. We will feed you, make sure you have all you need, send you to school…and while this is a new place for you, and adjusting to new things can be hard, we will help you….I believe you will find new friends to play with…and I hope you will be happy with us.

Responding to Adolescents' Loss and Grief Experiences

Why did this happen to me?
I understand that you feel that what happened was not fair and it is alright for you to feel angry, in addition to feeling sad. Nothing you did or said caused your mother's death. Sometimes things happen in ways we do not expect or understand-- whether they are illness or accidents.

Why did my mother do this [suicide]?
There is an illness called depression…a person who has it feels extremely sad, anxious and upset all the time. When the depression gets worse, the person may start feeling more and more hopeless—like there are no solutions to her problems. When that happens, the person also becomes very anxious and her mind becomes less clear, less able to make decisions clearly…that is what happened to your mother…when she decided to take her life.

I could have prevented this from happening…and saved my mother's life.
I understand that you feel frustrated…and I have no doubt you would have taken your mother for help, had you known her condition. But the other thing about depression is it is not easy to recognize…even doctors find it difficult to know sometimes how serious the depression is.

Why didn't my mother tell me about her problems?
Yes, she could have, in which case you would surely have helped. But perhaps she did not want to worry you with them/ she may have thought they would upset you. Also, when people become very depressed and don't want to live, they already have a strong belief that they problems have no solution, so they think it is pointless even to tell someone….and their judgment is their also poor, as I said.

Why should I live? I don't want to live…
That you feel that way now is legitimate—considering how much you loved your mother and how important she was to you. What were some of your future plans? What were your mother's dreams for you? Let us talk about them…

2.4. Depth Interventions for Childhood Loss & Grief

Objectives

- To provide an orientation to depth level interventions on childhood loss & grief issues.
- To try out some methods that can be used with children and adolescents in the context of loss and grief.

Time

1.5 hours

Concept

Often in loss and grief, what assumes prominence in the remembering process is the loss itself or the traumatic processes leading up to/around the loss. Distressing as loss is, there may be many other experiences that the grieving child has shared with the person he/she has lost. Jointly allowing for the memory of positive and joyous times together allows for the pain of grief to be lessened due to meaning and contribution of these good memories to a child's life. Thus, starting with a narrative of the loss process but moving beyond and backwards to other preserved memories makes for the conversion of traumatic memories into ones of strength.

The objectives of healing memory work in the context of loss and grief are therefore as follows:

- Allowing for grieving processes to occur/ loss and grief to be expressed.
- Converting negative memories to positive ones.
- Keeping alive memories of loved ones…using them to provide strength and move forward.

Activity for Depth Interventions on Childhood Loss & Grief

Method: Experiential learning (do and learn)

Materials: Paper and pencil

Process (i): Expressing loss and grief

- Divide participants into pairs.
- Think of someone you loved and lost.
- Draw the event…who it was/ what happened/ how it happened…how you felt/ what other people felt or said…
- Now, tell (the other person) about it.

Discussion:

- Often, children do not have the space to grieve—to talk about the loss event and their feelings at the time or after. Suppression of emotions resulting from (loss/ trauma) experiences give rise to mental health problems whether through emotional issues such as anxiety and depression or behavioural ones such as running away and aggression.
- Obtaining the child's narrative is important for the following reasons:
    - To allow for the child's unique experience and perspectives thereof to emerge, through verbal and non-verbal expression.
    - To validate and acknowledge the child's emotions (a powerful counseling technique as we have earlier learnt and discussed)
    - To understand the nature of the child's (loss) experiences in order to plan for further interventions.
- Especially for children who might have difficulty providing a verbal narrative, drawing and art work is a useful entry point into the child's trauma narrative. Once the child has drawn a picture of the incident/ events, the counselor can use the picture to then engage the child in some discussion around the event. It is critical to engage the child, encouraging her/him, through gentle inquiry to explain the picture and tell more about what happened. Open-ended questions such as 'who is this? What is happening here?' are preferable to 'is this you/ your mother?' because close-ended questions can feel more threatening to the child.
- Remember that if children's art is used in such a way that the counselor draws his/her own interpretation of the picture/ objects to make inferences of the child's experiences and feelings, it is highly likely to be inaccurate! Red may not always be the colour of blood or danger…the child may have used it to represent something else, so ask the child!

Process (ii): When there was no time or opportunity to say good-bye…

- Write a letter to your loved one (the person you lost/ were separated from):
    - What would you tell him/her about how you feel?
    - Was there something you'd like to have said before or at the time of the loss/ separation?

Discussion:

- Sometimes there is no opportunity to express the deep grief we feel/ felt…there was no time to say good-bye…the purpose of this activity is for children to obtain some closure on issues they would otherwise be feeling regretful about.
- This activity is used with older children and adolescents, who are able to write—and if they are unable to write, they can dictate the letter, which can be written for them by the counselor.
- With children, the letter is read out by the child (or counselor)—and reassurance may be provided to the child that we believe that his/her loved one can hear/ knows what the child wanted to say to him/her—wherever he/she may be.

Process (iii): Things you want to still say…

- Use a toy telephone or make your own telephone using two match boxes and connecting them with a string (the matchboxes serve as the receivers and the string as the telephone wire connecting 2 people).
- Ask participants to form pairs in which one assumes the role of the counselor and the other that of the child, to play the telephone game.
- Ask the counselor to tell the child: *'I know that you have often wished to be with your mother, to see or talk to her…so here is a game we will play…Imagine that I am your mother [the person child lost]. You can talk to me about anything you want, ask me any questions you like, tell me anything that you feel*'.
- They then proceed to have a conversation on these lines—your response to the child needs to be one of comfort and reassurance; respond openly and truthfully but in a simple way. For example, if the child asks *'why did you leave me?'* Your response as the mother may be *'I did not wish to but I fell very ill…I am still there for you and will always be—in your heart.*' Or if the child were to say 'I miss you and want you back with me', your response as the mother may be *'I miss you too and always think of you…I hope you will remember me and some of the things we talked about…like what you want to do in the future…it will make me very happy if you follow your dreams…'*
- At the end of the conversation, ensure that you bring the child back to reality by gently reminding the child that it was a nice way to connect to his/her mother and that these experiences of connection, though in the form of a phone game, are reassuring.

Discussion:

- The objective of this activity is to allow the child to express some thoughts to his/her loved one and make a connection with the special person.
- The counselor needs to be vigilant to the emotional tone of the child's conversation and guide it towards gentle and reassuring dialogue, particularly when the child shows emotional fragility.
- Furthermore, the counselor needs to be cautious of the child's identification of the lost figure in the counselor, and preface as well as conclude the activity by telling the child that it was a privilege to assist the child through this game.
- The counselor should avoid statements such as 'think of me as your mother…I am just like her'.

Process (iv): Remembering the special person

- Light a candle/ 'diya'…spend a few moments thinking of this person and all the ways in which he/she was special to you.
- To be done in pairs, with one person playing the counselor and the other playing the child:
    - Draw a picture or bring a photograph of the special person…
    - What was she like? What were some of the qualities about her that you loved most? What things did you do together? What is one very happy memory you have of her? What were this person's dreams/aspirations for you? What are some things he/ she said that inspired/ encouraged you?
    - How would you like to use the memory of this special person…to be sad and depressed or to think about her and remember the good times/ fun things you did together?
    - Where would you like to keep this picture/photograph? What will you think each time you see it?

[The art work is done by the child and the counselor initiates discussions using the questions above].

Discussion:

- The objective of this activity is to enable the child to focus on happy memories of times spent with the special person.
- The counselor is presenting an option to the child on the use of memories—whether the child wants to focus on/ emphasize only the traumatic memories/ times or whether he/she could shifting the focus to memories of comfort, happiness and inspiration—which will also lessen the child's grief.

Last Thoughts on Loss and Grief

Working with Silences…

The therapist does not have to keep up a continuous stream of verbal communication. When the child is exceedingly upset or overwhelmed by her feelings, she may not wish to talk or engage in activities. At such times, the therapist's response may include: i) holding the child's hand and providing physical comfort and reassurance (use this with caution in case of children who may have suffered sexual abuse); ii) Reassure the child by saying, "It is alright if you don't feel like talking or doing anything. I just want to be with you for a while…I am here for you…we can just be"; iii) do a simple activity along with the child in silence, should the child wish to—for instance, draw or colour with her. Remember that being silent at times when the child wishes to be so shows that you respect her; that you empathize with her feelings and are 'one' with her; that you do not intend to ever pressure her to do or be anything unless she wishes it.

Is it wrong to offer explanations about death in term of beliefs? Are beliefs akin to lies?

There is no 'right' answer to questions about death—because no one really knows the 'truth' about death. Answers based on religious and spiritual beliefs are as true and valid as those that are not i.e. responses about going to heaven are as valid as those about dead people becoming stars or flowers. This is because 'right' answer is really about what the child believes or chooses to believe. In responding to children's questions about death therefore, it is important to focus on what the child believes in and is able to draw comfort from. You are free to offer and present options—in terms of either what you believe or what people in general believe; but the child chooses what suits him/her to believe (not what *you* believe or what you think the child *should* believe). Further, the response should be one that is reassuring and provides a sense of hope to the child.

When the child has been told an untruth to hide information about death…

If a child has been told that the dead person has temporarily travelled somewhere or will be returning, the childcare worker needs to work with the child to tell the truth. First, find out from the child what he has been told and has understood. Then, explain to the child that "Sometimes we are afraid to give people bad news…because we are worried about how they may feel and react, especially when we love them a lot. Your mother wanted to tell you something about what happened to your father…but knowing how much you love him, she was worried about how it might affect you, so she said he had gone away for a while…she now wants you to know what happened to him…"

In case the child's caregiver is available, explain to the caregiver that children cannot be told an untruth about death—that they need to know, in order to be able to heal and recover. Organize a joint session with the child and caregiver and help to break the news, but ensuring that the credibility of the caregiver. Facilitate the process by helping both of them grieve, also letting the child know that his mother is sad and grieving along with him. Emphasize that his mother did not 'lie' to him (should the child be upset about this) but that such things are sometimes hard to speak about; that she was so upset herself and so worried about him that she had been unable to explain what happened until now.

Can the child be encouraged to keep an object as a memory of her loved one?

Some cultures, believe that the spirit of the dead person could be embodied by an object. For this reason, or simply for sentimental reasons, children may choose to hold on to an object as a memory and representation of a loved one. Such beliefs and rituals may be encouraged but in case of children, this must be done with caution i.e. so as to not create dependency on the object that is invested with remembrance. You may also help the child pick an object that belonged to the dead person, for instance, such as a pen, watch or some personal belonging. But, rather than having the child hold on to it all the time, it is advisable to have him pick a place for it—such as his bedside or his desk: "each morning, when you wake up and each night when you go to bed, you can remember your mother when you see this…and think happy thoughts of her." Holding on to personal belongings such as clothes is a mode difficult issue. If the child is insistent, you may suggest that he places the clothing item in his cupboard (do not encourage carrying this around): "when you want to get dressed each day, and open your cupboard to pick your clothes, you can see your dad's shirt hanging there—and think of the good times with him".

3. The Trauma of Child Sexual Abuse

3.1. Child Sexual Abuse Basics

Objectives

- To understand the ABCs of child sexual abuse from a psychosocial perspective.
- To recognize the dynamics of abuse, including the various ways in which abuse is perpetrated.

Time

2 hours

Concept

A. Definition & Nature of Child Sexual Abuse

Child sexual abuse is the involvement of children and adolescents in sexual activities (usually for adult sexual stimulation or gratification) that they cannot fully comprehend and to which they cannot consent as a fully equal, self-determining participant, because of their early stage of development.

Child Sexual Abuse is…

…an interaction between a child and an adult where the child is used for sexual stimulation.

…exploration of sexuality between a minor, traditionally understood as below 18 years of age, could also be exploitative, depending on age and power dynamics.

…not restricted to rape/penetrative genital contact.

…digital handling of the child's genitalia.

…non-genital forms of sexual touching.

…non-contact forms of abuse for the pleasure of the perpetrator such as exposing the child to pornography or taking nude pictures of the child.

For the purposes of inquiry and intervention, it is important to have a nuanced understanding of child sexual abuse (CSA), over and beyond definitions of abuse. Contrary to what is commonly understood, CSA is not always a one-off act nor is it a series of sexual actions against a child; particularly in cases where abuse is perpetrated by known people, abuse is also process comprising of a series of actions leading up to the act of sexual abuse. Understanding the different methods and processes by which child sexual abuse takes place helps to identify CSA more clearly and thus strengthen the evidence to condemn the perpetrator.

Sometimes, people tend to take a position that 'if he did not touch you and he only said sexual things' it is not actually abuse. It is important to recognize that all sexual acts, and use of a child for sexual purposes, through contact and non-contact methods, with or without penetration constitute sexual abuse and have a certain kind of psychosocial impact on the child. The above-described dimensions on type of abuse, number of abuse episodes and perpetrators of abuse are often used to determine the psychosocial impact that the abuse may have had on a child—and each child would have a unique combination of these variables.

In case of a one-off contact abuse by a stranger, frightening and unsettling as it may be for the child, he/she may heal better than a child whose uncle has not touched her but has been constantly making sexual remarks to her. The fact remains that coercive acts and sexual acts that cause injury and tissue damage carry their own valence in how a child is impacted. Contact abuse, especially in case of coercive and violent processes such as rape, are likely to be more traumatic for a child and make recovery from the abuse experience more difficult; however, it has also been found that children who have been abused through coercive processes and injury, despite their trauma, have (psychologically) recovered better than abuse that may not have been injurious but committed by a known (and trusted) person such as a family member or caregiver.

However, the impact of CSA does not necessarily follow a linear logic based on generic presumptions about what ought to be more severe. Thus, if a rape survivor were to stoically fight back, without any conventional misconception on the honour-stigma dimension, there is a tendency to interpret this as 'so much has happened and look at her…she seems unaffected', whereas the truth is that this person may be more resilient or have better support.

Nature of CSA: Dimensions to understanding the nature of CSA:

Type of Abuse	Non-Contact versus Contact	Non-contact abuse entails offensive sexual remarks /exposing child to nudity or perpetrator's private parts or observes the victim in a state of undress or in activities that provide the offender with sexual gratification or exposing child to pornography. Contact abuse entails touching of the intimate body parts including perpetrator fondling or masturbating the victim, and/or getting the child to fondle and/or masturbate him/her;
	Non-Genital versus Genital	Non-genital contact abuse entails touching and fondling of parts other than the genitals. Genital contact abuse entails touching and fondling of the genitals. This itself can be penetrative or non-penetrative.
	Penetrative versus Non-Penetrative	Using the penis or other objects to penetrate any orifice of the child's body (including vaginal, anal or oral penetration) versus other forms of contact abuse that may not be penetrative.
No. of Episodes	Single versus Multiple Episodes of Abuse	One incident of abuse versus many incidents of abuse (over a period of time…days/ months/ years)
Perpetrator(s) of Abuse	Known versus Unknown Perpetrator	Abuse perpetrated by a family member/ caregiver or some person known to the child versus a stranger; within known people, if the person is responsible for care and protection of the child (such as institution staff, parent, teacher, school attender…), it qualifies as aggravated abuse, resulting in more severe punishment under POCSO, because this person abused the child in a situation or relationship wherein he/she is meant to be caring for and protecting the child.
	Single versus Multiple Perpetrators	Abuse by a single perpetrator versus abuse by more than one or many/ different perpetrators

Thus, the severity of the impact of the abuse depends on only on the type of abuse but also on the duration of the abuse and very importantly, whether the abuser is a known/ trusted person

or a stranger. Thus, CSA is a complex issue, wherein impact and recovery depends on all of the above variables and how they combine together to influence the child's experience of abuse. Finally, even when there are two children, who have been impacted by identical forms and processes of abuse (similar variables), they may still be different in terms of their responses. This difference is accounted for personality and temperament of each child, and social context and circumstances of each child, due to which each child perceives and internalizes the abuse differently, thus resulting in different emotional and behavioural states or responses to the abuse.

Activity for Understanding Child Sexual Abuse Basics

Method: Discussion

Materials: Statements regarding CSA (below)

Process & Discussion:

- Read each set of statements and ask participants in plenary whether they agree or disagree…
- Discuss why they agree or disagree with each of these statements.

Statements

- Child sexual assault is a rare occurrence.
- It can only be considered abuse only if it is violent.
- Most children who are sexually abused do something to cause the abuse to occur.
- Perpetrators are those who…
  - Suffered physical/ sexual abuse themselves as children.
  - Are from lower socio-economic strata, or from difficult or deprived family circumstances.
  - Poor educational level/ not professionals.
  - 'Dirty old men'
  - Always men (never women).
  - Strangers.
  - Mentally ill people.
- CSA is more or most likely to occur…
  - In places where risk of detection is low.
  - In lonely, isolated places that are unfamiliar to the child, or where there are no people nearby.
  - Where there are no CCTV cameras.
  - Anywhere because actual abuse incident can occur quickly (commonly 5 to 15 minutes).
  - Within the home (especially if the perpetrator is a family member).
  - In places the child regularly visits or performs routine activities, such as schools, tutorials, playgrounds and other public spaces.
- Discussions/ information on child sexual abuse will scare children.
- The most common form of abuse suffered by children at home is sexual abuse.
- Children who disclose abuse and later retract their stories were lying about the abuse

B. Sexual Abuse Dynamics and Processes

Thus far we have been using a trauma lens to discuss child sexual abuse experiences. However, not all child sexual abuse is traumatic or at least not traumatic at the time at which it occurs or the in the ways in which it is perpetrated. Let us consider these two examples:

Example 1: A 6-year old child has been inappropriately (sexually) touched in various parts of her body by her uncle, who has over a period of several months, lured her with sweets and toys to spend time with him; his ways of expressing affection towards the child has been to touch and fondle her in various inappropriate ways. He has also invented 'special, fun' games that entail inappropriate touching and imbued the game with an element of excitement and secrecy.

Example 2: A 10-year old boy who lives in a child care institution has been fondled and sexually touched by one of the staff in the institution. An orphan, having never known a family or any sort of love or support system before, this boy has a relationship of deep affection and trust with this staff, who spends time with him, plays with him and ensures that the boy gets additional food, exemption from punishments (that other children may have to bear).

Example 3: A 16-year old girl is lured into a sexual relationship with a 25 year old man, who has told the girl that she is beautiful, that he is in love with her and would even consider marrying her at a later point. Happy with his attention and his love and caring, the girl has agreed to physical intimacy with him [following which she gets pregnant and the man is nowhere on the scene].

If we examine these three examples, we may agree that all of them entail sexual abuse and could be filed as POCSO cases. However, you also notice that in all three instances, there is no use of violence or force, no injuries resulting from the abuse. Consequently, at least at the time of abuse, processed and internalized as trauma by the children. The 6 year old has no idea of sexuality or boundaries and since she was not hurt or

Grooming…A Method of Child Sexual Abuse that Does Not Entail Fear-Coercion Methods

Grooming is a method of manipulation that entails a process of engaging the child/adolescent in sexual acts through:

- Identifying and targeting the victim (especially when children are vulnerable due to difficult circumstances, with little or no family and social support systems)
- Gaining trust and access (through special attention, sympathy to child, playing games/ giving gifts to gain child's friendship and affection).
- Playing a role in the child's life ('no one understands you like I do & vice-versa')
- Isolating the child (from family/ others by telling the child 'I understand you best and love you the most…the others do not…they don't know what is right for you…')
- Creating secrecy around the relationship (through personal contact, letters and phone calls...imbuing the relationship with a certain specialness and excitement)
- Introducing misconceptions about sexual behaviour ('the greater your sexual experience, the more useful for you as you grow up…people will think you are old-fashioned if you have no knowledge and experience of sexuality…'
- Initiating sexual contact (only after a trust and special relationship has been created).
- Controlling the relationship (using age/power/threats/emotional manipulation...making child believe it was her fault i.e. coercive elements may be introduced at this stage)

threatened, but treated with affection/ given rewards, would be unlikely to recognize what was being done to her as abuse, so she is less likely to internalize her experience as being traumatic. The 10 year old, being older, may have some sense of boundaries around his body and may feel some discomfort but the feelings of confusion, given his relationship with the abuser, may be greater than any trauma caused. The 16 year old, on the face of it, may even be accused (by some people) of having 'given consent' and therefore it not even being a case of child sexual abuse; and in fact the girl herself may defend the perpetrator with whom she believes she shares a romantic and sexual relationship.

Thus, the common image of all child sexual abuse as being acts of violence and coercion (by stangers) can be a misconception i.e. while that form of CSA also occurs, that is not the only method by which child sexual abuse occurs. So, what are the (other) methods by which CSA is perpetrated? How do different methods of perpetration of abuse have varying psychological impacts on children? And why would the perpetration method and its and impact be important for a counselor's understanding?

In younger children, the methods of abuse entail i) inducement and lure and/or ii) coercion and threat. As shown in table 1, inducement and lure entails use of sweets and toys to get children to perform or cooperate in sexual acts for adult stimulation. Perpetrators also use attention and affection in exchange for sexual favours i.e. provision of attention and affection when the child complies with the adult on sexual acts and withdrawal of attention and affection when the child does not. These methods are followed by the perpetrator creating excitement and secrecy around the sexual act, often presenting it to the child as a 'special new game', a' secret game' that no one else plays and no one else knows about; and young children, who have no understanding of sexuality are vulnerable to such ruses.

Table 1: Sexual Abuse Processes in Younger Children

Abuse Process	Impact on the Child
• **Inducement & Lure** – Child rewarded for sexual behavior — *'I will give you chocolate/ toy if you…'* – Offender exchanges attention and affection for sex: "*If you don't do this [sexual act], then I will not speak with you or play with you…if you do this, I will love you".* – Creating excitement & secrecy around the act--*'This is our special secret…remember no one should know about it!'*	Confusions regarding sex and love and care getting/care giving Confusion about sexual norms
• **Coercion & Threat** – Threatening the child/ creating fear in the child—'*If you don't do as I tell you/ and if you tell anyone about it…I will kill you/ I will harm your parents.'*	Fear and compliance

Lure & Inducement in Child Sex Tourism

Inducement and lure methods of CSA play out in particularly complex ways in situations of child sex tourism as happens in many places in South Asia, where children are engaged in prostitution. In such tourist places, children who come from extremely deprived backgrounds i.e. with lack of resources, finances, parenting and supervision and opportunities for growth and development, are targeted by tourism pedophiles and other tourists who looking for sexual activity. The dynamics in such abuse and exploitation is such that the above-described needs are satisfied in exchange for sex. These perpetrators, also known as 'sugar daddies' provide children with food, clothes, toys as well as travel, activity and fun experiences which take these children away from their childhoods of deprivation and trauma. Some children recognize the exploitative nature of the relationship but in the balance, (and perhaps legitimately so in their minds) feel that it is better than the life of poverty and misery that they normally lead. The more generous the gifts and opportunities for fun and entertainment, the greater the lure and inducement and unfortunately, the greater the mutual benefit to the child and perpetrator.

However, despite children's lack of knowledge of sexuality issues, even very young children (around the ages 2 to 3 years) can have a sense of discomfort with (sexual) touching of the genitals and private parts. This is because socialization processes (and taboos) have already introduced to children the importance of wearing clothes (especially underwear) and the need to 'hide' and 'not touch' private parts and genitals. Therefore, in many children, methods of abuse that use lure and inducement also create confusions regarding love and caregiving ('only if I do this [sexual acts], he will love me and play with me') and around sexual norms i.e. what is socially appropriate in terms of inter-personal interactions and sexual norms.

Methods of coercion and threat are used to create fear in the mind of the child and force him/her to comply with the perpetrator's requests to engage sexually. These methods are used more effectively with slightly older children, who have more of a sense of the inappropriateness of the perpetrator's actions. It is a key reason for children not disclosing the abuse to anyone else.

Although the two methods of abuse perpetration are different, they are not exclusive to each other. Perpetrators may begin the abuse process through use of lure and inducement and at a later stage, continue by coercing and threatening the child, especially if after a certain period of time, the child realizes the inappropriateness of his/her actions and wants to or tries to stop the abuse.

In older children and adolescents, the processes of abuse are similar but the use of lure and inducement are slightly different (See Table 2 below). Given that adolescents are at a life stage wherein they are interested in issues of love, attraction and sexuality and are also keen to experiment with these experiences, perpetrators tend to use lure and inducements that are more emotional in nature (rather than the more material ones used with younger children). This means that they and smooth talk adolescents about their physical appeal and qualities, making promises of long term emotional and romantic relationships with them. Adolescents from difficult circumstances, those with poor family support, who have been neglected and/or abused, are particularly vulnerable to such attentions from offenders. Following such manipulation and abuse, adolescents experience feelings of tremendous confusion, especially as they have shared 'deep' sexual and romantic relationships with the offender. They find it exceedingly

difficult to discern this as an abuse process and defend the offender, often refusing to accept that this is abuse.

Table 2: Sexual Abuse Processes in Older Children & Adolescents

Abuse Process	Impact on the Child/ Adolescent
• **Use of Lure & Inducement** – *"I will ensure that even if other children are punished, you are not punished…you will always have special privileges…"* [Expressed verbally or through actions]. – "You are so beautiful…you know I love you…no one in the world cares about you the way I do…" [Manipulation of adolescent girls].	Confusions regarding sex and love and care getting/care giving
• **Threat & Coercion** – Conditioning of sexual activity with negative emotions & memories…through violence and coercive sexual acts. – Pressure on child for secrecy through use of threats.	- Negative associations to sexual activities and arousal sensations - Aversion to sexual Intimacy - Fear and compliance
• **Transmission of Misconceptions about Sexual Behaviours & Norms** – *"The more people you sleep with the greater your sexual experience will be…no man wants a girl who is ignorant about sex."* – *"Sexual experience is important…a real man should have tried everything at least once…"* – *"Not had any sexual experience…that is not cool…what will other boys/ girls your age think of you?'*	Confusions about sexual norms and decision-making.
• **Blaming the Victim** – Offender blames the victim – Child infers attitude of shame about activities – Victim is stereotyped as "damaged goods" (this is often used to continue the abuse)	- Guilt, shame - Lowered self esteem - High risk sexual behaviours

Again, given the life stage adolescents are at, often also under peer pressure to experiment with sexuality, offenders have the perfect opportunity to manipulate them into sexual engagement by transmitting all sorts of misconceptions about sexual behaviours and norms. For instance, appealing to adolescents' need to 'fit in' with their peers, perpetrators tell adolescents that it is necessary to gain sexual experience, that it would be 'uncool' if they are ignorant about sexual acts. As a result, adolescents, who are still acquiring life skills such as (sexual) decision-making are negatively influenced, believing in the misconceptions transmitted to them, confused by how they should respond.

After gaining the trust of adolescents, through inducement and lure and transmission of sexual misconceptions, when perpetrators have successfully engaged the adolescent sexually, they then blame the victim with statements such as 'you started this…you wanted this and consented to this…so, it is your fault'. Adolescents then feel 'dirty and damaged', guilty and ashamed.

The Issue of Consent

It is often assumed that adolescents who get involved in sexual relationships, given their age and life stage, have done so by giving their consent i.e. they consented to the sexual relationship and therefore they are to be blamed. Thus, in addition to the perpetrator, other well-intentioned persons, such as caregivers, welfare, legal and medical system personnel, who are meant to be playing a helping role, also end up vilifying the child instead of supporting him/her. It is therefore critical to make the difference between so-called consent and 'informed consent'. Consent on the face of it simply entails saying 'yes' and entering into the sexual relationship. But informed consent assumes that the adolescent has given consent by knowing and understanding the consequences of sexual engagement i.e. with full information on the following:

- Permission and consent: what coercion means and how to recognize direct and indirect methods of coercion
- Relationships: The contexts in which sexual relationships can play out in a happy, healthy and responsible manner, including who the person is, whether the person can be trusted and whether there is an emotional connect with the person
- Health and safety: issues of unprotected sex, pregnancy risks, sexually transmitted diseases
- Protection and abuse: what sexual abuse entails and how to recognize it

It is only if an adolescent knows and makes relationship and sexuality-related decisions based on the above framework can it be considered as informed consent—which is usually not the case in child and adolescent sexual abuse.

C. When to Suspect CSA:

Signs & Symptoms

There are broadly three contexts in which children present for consultation on sexual abuse issues. The first is when child sexual abuse is already established by agencies and individuals and they refer the child to the mental health system. Such referrals may be received from: i) District Child Protection Units; ii) Childline and child care agencies/ service providers; ii) Police; iii) Courts and judicial personnel. Children are brought by such agencies and bodies either for interventions in the wake of trauma and emotional problems and/or for inquiry and evidence gathering for use in court cases. Thus, in this context, the mental health system is not required to establish whether or not CSA has occurred, as it is already known—usually, children would have reported abuse or in case of children in sex trafficking, they have been rescued through a raid on sex work institutions, and so the abuse has come to light.

The second context is one in which the child has reported to his/her parents but they in turn, have not reported the abuse to police or legal systems. However, they seek consultation to provide the child with mental health interventions.

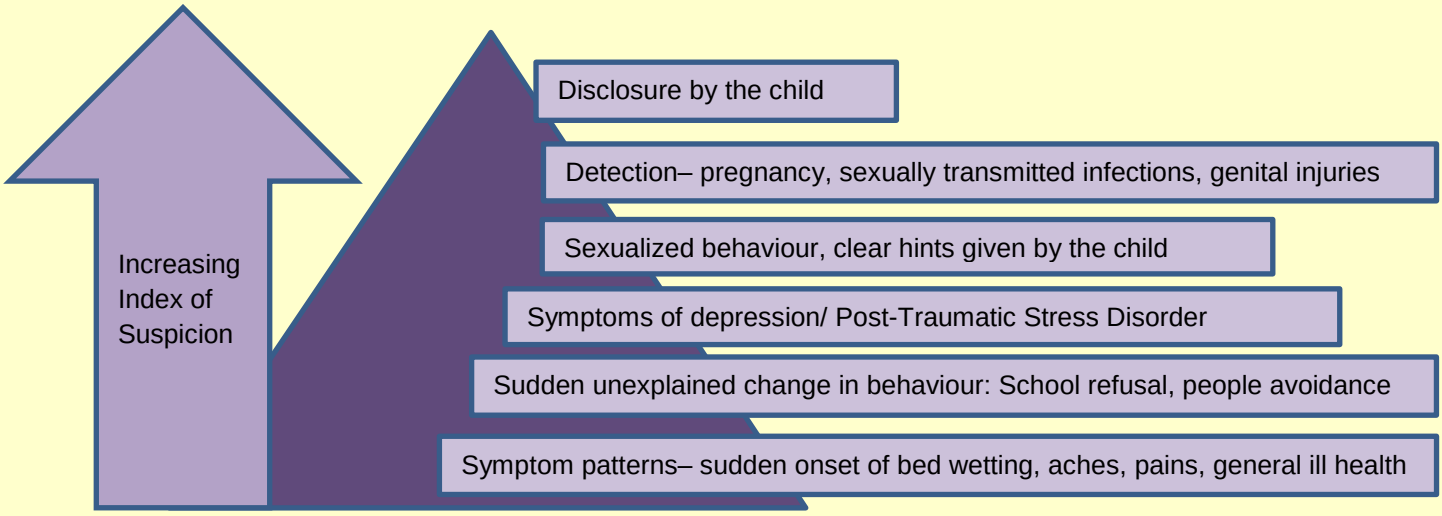
The third context is when it is not (yet) known that he/she has been sexually abused; the child comes to the mental health system for some psychological or psychiatric manifestation, but upon enquiry and examination, CSA issues emerge in one of the following ways:

- The child discloses or reports abuse.
- An adolescent girl is found to be pregnant.

- (Frequent) urinary tract infections in the child are reported by the child/ caregivers and/or genital injuries in the child are reported/ observed.
- Emotional and behavioural issues that are associated with anxiety, anger and depression.

There is what is called an index of suspicion in child sexual abuse i.e. when to suspect child sexual abuse and how true one's suspicions likely to be. Refer to figure below--it diagrammatically represents the index of suspicion in child sexual abuse. At the peak of triangle, the index of suspicion is highest i.e. there is no doubt when a child reports or discloses that abuse has taken place, especially when a child spontaneously reports without particular inquiry by an adult.

Index of Suspicion in Child Sexual Abuse



Equally high on the index is pregnancy (in adolescent girls)—a sure sign that sexual abuse has occurred. Genital injuries and frequent urinary tract infections must lead to suspicion that there is digital handling and sexual abuse is very likely to have taken place. Emotional and behavioural changes observed in the child are important indicators of child sexual abuse, however, they come lower on the index of suspicion because these psychological changes may occur due to a number of reasons (unlike pregnancy or genital injuries which do not have a range of reasons for their occurrence!).

Emotional and behavioural changes observed in the child are important indicators of child sexual abuse, however, they come lower on the index of suspicion because these psychological changes may occur due to a number of reasons (unlike pregnancy or genital injuries which do not have a range of reasons for their occurrence). Emotional and behavioural issues relating to anxiety and depression may occur due to sexual abuse but may also be due to other difficult and traumatic experiences such as parental marital conflict, bullying, learning difficulties and

academic pressures, loss and grief (death-related) experiences…so, while emotional and behavioural changes may lead to CSA suspicion, further examination and inquiry needs to be made (by a psychosocial or mental health professional) to understand exactly what difficult event(s) or experiences they are attributable to in a given child. During inquiry, if sexual abuse is ruled out, then the signs and symptoms may be attributable to other difficult experiences.

Below is a list of signs and symptoms of child sexual abuse i.e. emotions and behaviours that if children show, we must suspect abuse. It is useful for magistrates to know these because they need to read FIR reports provided by the police as well as medical and psychosocial reports provided by health and mental health professionals. When psychosocial reports contain some of the signs and symptoms listed below, the magistrate already has a sense that CSA has taken place and the inquiry and statement recording can proceed accordingly.

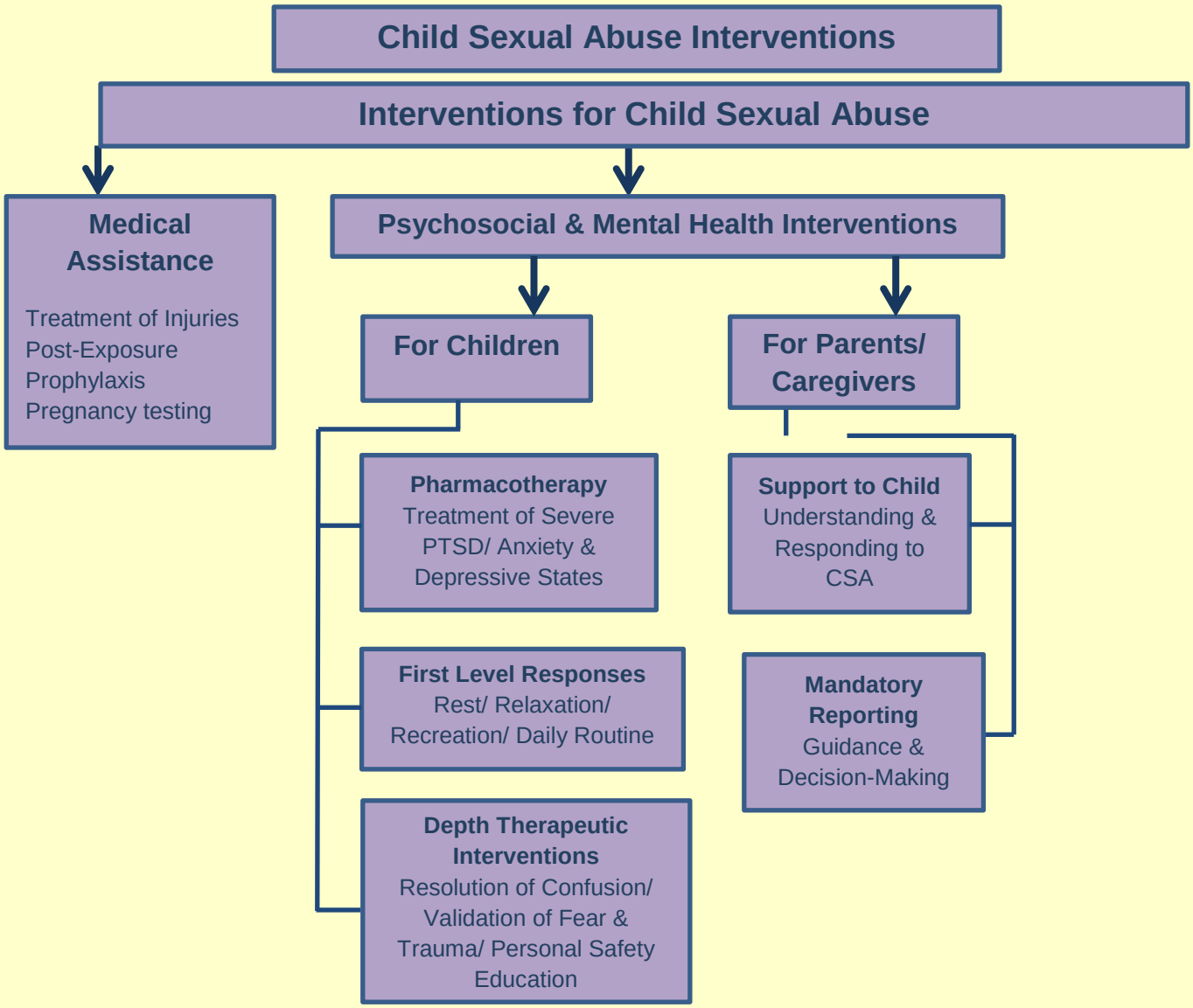
Emotional & Behavioural Signs & Symptoms of CSA	
In Younger Children…	**In Older Children/ Adolescents…**
• Sexualized behaviour • Avoidance of specific adults • Nightmares/ Sleep disturbance • Clingy behaviour/ separation anxiety • Fearfulness and anxiety • Bedwetting • School refusal • Decreased scholastic performance • Medically unexplained body aches and pains	• Self-harm • Depression/ isolation • Anger • Fearfulness and anxiety • Sleep disturbance/ nightmares/ flashbacks • Avoidance of specific adults • School refusal • Decreased scholastic performance • Medically unexplained body aches and pains/ fainting attacks • *High risk behaviours—sexual behaviour/ substance abuse/ runaway.

Adolescents who have been sexually abused may either respond to sexuality and relationship issues with avoidance (i.e. the trauma and negative associations with sexuality cause them to not want to engage in sexual relationships at all) or with high risk behaviours. High risk sexual behaviours such as unsafe sex with multiple partners—these behaviours are either due to sexualization and pre-occupations with sex as a result of the abuse or due to feelings of inferiority and low self-esteem, also due to CSA experiences, which cause an adolescents to feel that ‘I am dirty and damaged anyway…how does it matter what I do now and how many people I sleep with’. Substance use is often a result of the anxiety and depression caused by CSA-- when children do not know how to manage their traumatic experiences, they are likely to resort to smoking, alcohol consumption and other substances to help them cope with difficult emotions.

As also shown in the figure below, psychosocial interventions for CSA can be broadly categorized into two types of responses:

a) Medical assistance
b) Psychosocial interventions
    i) First level responses for children

ii) Depth therapeutic interventions for children
iii) Interventions for parents and caregivers



3.2. Medical Assistance for Child Sexual Abuse

Objectives

- To understand medical interventions that need to be provided to children in the immediate aftermath of sexual abuse.
- To learn the importance of preparing older children for medical examinations.

Time

1 hour

Concept

In case you have come to know of a child who has just been sexually abused i.e. that it is a matter of days or weeks since the event, it is necessary to first proceed with a medical evaluation and requisite medical interventions as a priority. Treatment history and response to treatment (in case the child has already undergone or is undergoing treatment) should be recorded.

- **Preparing the Child/ Adolescent for Medical Tests and Treatment**
  Always prepare children and adolescents for medical evaluations and procedures as these can be frightening and invasive for them; in fact, they can be almost as frightening and feel as invasive as the abuse experience. It is necessary therefore to reassure them on their safety, ensure their comfort during medical evaluations by having known/familiar/trusted people or caregivers with them; and it is important to give children information on the medical tests and procedures in simple, comprehensible ways so that they feel that they have some predictability and control over an otherwise difficult and frightening situation.

- **Physical Examination**
  - Physical examination of child to be conducted including 2 ID marks
  - The child's family or caregiver should be present in the room during the examination.
  - Permission of the child and consent of the parent to be taken before examination
  - What physical symptoms does the child have at present/ (eg: burning sensation during micturition, itching in the perineal area, bleeding, any injury, pain in any area etc.)

Preparing Children & Adolescents for Medical Evaluations and Procedures: What to Tell Them

- "We want to ensure that your health is alright. When children have been in unsafe circumstances and have been hurt/ abused, they may acquire some infections. Testing for this will help us identify if the infection is indeed present and start the appropriate treatment fast".
- "Unprotected sex with known/unknown (or more than one person) can result in injury and disease—especially as we do not know what infections those people have. So, we need to do some tests to check for any possible infection so we can treat it".
- "Since you have been hurt and abused by someone in ways that are physical and sexual, there are chances of your being pregnant. It would be important to do a test and find out if you are pregnant, for a few different reasons: i) doing a test early enough may help you terminate the pregnancy in case you do not want to continue with the pregnancy/ keep the baby i.e. if we delay finding out, it may be hard to implement the medical processes necessary to terminate the pregnancy; ii) in case you wish to keep the baby, then it will be critical for you to maintain your health and your baby's health in certain ways—so finding out early will help us guide you on how to do this. So, finding out sooner about whether or not you are pregnant will help you make some decisions comfortably... and offer you more options in this regard". [For adolescents at risk of pregnancy].

- **Post-exposure Prophylaxis (PEP)**
  If child is within the 36 hour window period (especially in case of penetrative abuse):
  - Has the child received Post-exposure prophylaxis (within 36 hours) in case of penetrative abuse?
  - If not, refer to Pediatric Anti-Retroviral Therapy (ART) ART Centre for Post-exposure Prophylaxis (PEP), especially for HIV prevention ART dose.
  - Even if child is not in the window period for HIV and the penetrative abuse has occurred within a month, refer to the Pediatric ART Centre so that a decision can be taken regarding initiation of PEP.
  - Ensure that the child/adolescent has received oral contraceptive pills to prevent pregnancy.
  - Ensure that child has been medically evaluated by a Registered Medical Practitioner, namely a pediatrician or gynecologist from a government hospital, for sexually transmitted diseases (STDs), urinary tract infection and/or injuries. The STD investigation must be repeated at the end of 4 weeks, 3 months and 6 months.

- **Forensic Examination**
  Check whether an additional specific forensic evaluation has been done (examination requested by police documenting abuse, if swabs have been taken in case of penetrative abuse), and if so, whether the report available. Obtain the report from the relevant source.

- **Pregnancy Tests**
  - Ensure that a urine pregnancy test has been done.
  - In case the results are false negative, it would be best to obtain an additional gynecological opinion.
  - In case the child/adolescent is under 20 weeks pregnant, discussions about abortion may need to be done with the child/adolescent and her caregivers. It is also advisable to liaise with an obstetrician at this time.

Considerations for Medical Termination of Pregnancy…Adolescents' Right to Choose

- Discuss the adolescent's wish or desire/ need to go ahead with the pregnancy and have the child.
- Help adolescent to reflect on her decision to have a child—discuss pros and cons, financial and logistical plans to raise the child (who will pay for the child's upkeep and education/ who will spend time playing with and looking after child?), what are adolescent's life plans and how would a child fit into those (what if adolescent wishes to study or work? What if, in the future, adolescent meets someone and would like to marry? How would she explain the child to him and deal with his acceptance or non-acceptance of the situation?)
- From child rights' perspective, it is an adolescent's rights to finally decide whether or not to terminate the pregnancy…we have no right to impose our views and decisions on her, as valid as those may be and as well-intentioned as we may be!

3.3. First Level Psychosocial Responses for Sexually Abused Children

Objectives

- To develop first level responses to children's confusions and queries about sexual abuse.
- To learn about the types of psychosocial interventions that require to be provided to children in the immediate aftermath of sexual abuse.

Time

3 hours

Concept

Asking questions, and attempting to establish depth interventions when the child is facing a crisis i.e. in the immediate aftermath of abuse, is not a useful beginning. This is not the time to for detailed enquiry. If there are serious and disruptive manifestations --like self-harm behaviours, incapacitating anxiety, PTSD symptoms with severe panic, appropriate psychiatric referral at this stage is important (as psychiatric medication may be required for anxiety symptoms to reduce before any counseling work is initiated).

The Importance of First Level Psychosocial Responses to Child Sexual Abuse

If your kitchen pipe bursts, and the water is flowing out, what are some of the things you will do immediately? Turn of the main/overhead water connection tap, try to secure the pipe with some cloth or plastic material…all in order to prevent the water from flowing out and emptying the water tank. It is only at a later point i.e. after immediate damage control, that you will call the plumber, identify the fault within the pipe and get it repaired—all of which will also take time.

First level psychosocial responses to sexually abuse children also entails interventions in the immediate aftermath of the abuse or in the short term—they are aimed at containment (like the water in the pipe). They are different from longer term interventions which are aimed at healing and recovery.

- First-level response is about alleviating immediate suffering and providing initial relief.
- If anxiety is not dealt with, or is very severe, it becomes difficult for the child to carry out daily activities.
- Feelings of unpredictability and lack of control can be debilitating for a child.
- Anxiety becomes the basis for development of depression (and other psychological problems); it can make the child increasingly vulnerable to negative coping mechanisms—such as aggressive behaviours, substance abuse etc.
- Severe anxiety manifesting itself in aches/pains/black-outs can be very frightening and worrying for children and caregivers—therefore immediate reassurance on the cause should be provided.

First level psychosocial responses to sexually abused children consist of a range of interventions from ensuring the child's immediate safety to responding to children's anxieties regarding the abuse, to rest, relaxation, leisure and maintenance of the child's developmental trajectories (as detailed below).

A. Ensuring Child's Safety

Depending on where the abuse occurred and who the perpetrator is, it is essential to immediately take measures to protect the child from further abuse. This is especially applicable when the perpetrator is a family member or a person known to the child, and where the abuse has occurred at home or in places the child frequents on a daily or regular basis (such as school/ tutorials etc). Even in instances where the child and/or family are not willing to file an FIR with the police, it is imperative to take actions the keep the child safe i.e. remove the child from being in contact with the perpetrator. These may necessitate (temporary) measures such as making alternative living arrangements for the child, with relatives/ extended family with whom the child feels safe and comfortable. In case the abuse has occurred at school, the child may be permitted to stay away from school until such time as other processes, legal and psychosocial, are in place; at a later stage, a change in school may also be considered, should the child and family wish not to return to the same school.

However, it is critical to involve children (particularly adolescents) in the decisions regarding these living arrangements i.e. inform them of the risks should they continue to be where they are, explain the imperative to be elsewhere (at least temporarily), offer options where available, to ensure that the child is comfortable. Please note that, despite child care service providers' best intentions about the safety and well-being of the child, when decisions have been made unilaterally and children have been coerced into arrangements that they are not in agreement with, it has resulted in serious issues such as self-harm and suicide.

B. Rest and Recreation

Children who have been sexually abused first and foremost require time to rest and recover from traumatic experiences. They may therefore be encouraged to play, listen to music, do art activities purely for recreational purposes—to keep them entertained but at the same time also occupied (so that they are not sitting idle and constantly thinking about the traumatic experience). Parents and caregivers must be encouraged to spend quality time with children, playing with them and reassuring them about their safety, but not trying to extract details of the abuse.

C. Initial Response to Children's Queries and Confusions

Most sexually abused children's anxieties stem from worries and anxieties that they are internally processing. Thus, in the course of the interview, some responses will be provided to each individual child to allay initial confusions and anxieties that they may be experiencing—whether these pertain to the perpetrator, the law or their future, for instance. Responding to children's questions and confusions is a critical part of first level responses as this helps to stem further distress and anxiety, at least to some extent. Of course, these responses need to be detailed out and reiterated during the course of depth interventions.

Activity for First-Level Responses to Children's Experiences of Sexual Abuse

Materials: Case studies

Process:

- Divide the participants into 4 sub-groups and allot one (of four) cases to each of them.
- Request participants to read the case and do the following:
  - Be the child's inner voice and make a list of questions that would be in his/her mind (focus the questions on the abuse experience).
  - Next, attempt to provide a response to each of the questions on the list developed.
- Remind the participants that they need to consider in their response the truth, comfort and reassurance, the child's developmental stage and the child's experience.

Discussion:

- Ask each sub-group to present their list of questions and responses in plenary.
- Invite the others to attempt responses also and provide comments and feedback.

Case Studies for Discussion:

- **Case 1:** An 8 year old is being sexually abused by the school bus driver. He cries all the time and has nightmares and tells his mother that he does not want to go to school any more. One day, his mother (who does not know about the abuse) has forcibly brought him to school and the child tells you what is happening on the bus daily.
- **Case 2:** A 15 year old girl is suddenly doing poorly in academics and getting into arguments with her peers; when people get upset with her or ask her why she is behaving that way, she just bursts into tears. One day, you call and gently ask what is troubling her…she tells you that her uncle, who visits her home regularly, comes into her room each night and touches her genitals. [She also tells you later that her father's friend has touched her similarly once].
- **Case 3:** A 10 year old is an orphan child residing in a child care institution. He came to the counselor for treatment for behaviour problems, during the course of which he reported sexual abuse by one of the institution staff (other staff deny that this happened in their institution, saying child is lying).
- **Case 4:** A 16 year old girl rescued from sex trafficking is now in a child care institution. She was trafficked by her family. She has been in sex work for the last two years. She is angry and aggressive all the time. She is mistrustful of people and keeps talking about revenge. At other times, she says that her life is over—since her self-respect has been taken away.
- **Case 6:** A 15 year old girl has been sexually assaulted by a 19 year old boy; he first be-friended her, told her that he loved her and then engaged her sexually—she says that the sexual activity was without her consent. However, now she also tells her parents that she does not want a police complaint lodged against him and that she wants to be with him—to move out of home and live with him. She is sad and depressed but also aggressive at times, threatening self-harm if her parents do not allow her to be with the boy.

Responding to Young Children's Sexual Abuse Experiences

Why did he do that to me?

Some people in the world are not good. They are cruel and hurtful. They just do what they want to without caring about other people's feelings. X was one such person…what he did to you was wrong. No one has the right to hurt children (or anyone).

It was my fault…May be I could have prevented or stopped it from happening

Of course it was not your fault. It was his fault and wrong-doing. He was bigger and stronger than you, so it would have been difficult for you to stop him. But you still tried to do your best and that counts for a lot—it shows how brave you are.

I am dirty…

You are not dirty…he is dirty. You are not responsible for what happened, he is. And like I said, he is bad and dirty for doing hurtful things to you.

I am scared…I don't want to go to school, I don't want to go out or play…

I understand that you feel afraid and it is perfectly alright to feel scared and worried—anyone in your place, to whom this happened, would be scared too. But I also think you are very brave for telling me/ mummy about what happened…many other children would not have told anyone what was happening because they would have been too scared—and the bad person would have continued to hurt them. Because you were brave enough to tell us, we could do something to stop it. It is ok to want to stay home and be with mummy for a while…when you feel rested, more relaxed and stronger, you can slowly go to school or to play—when you are comfortable and decided to do so. Until then, no one will force you to go.

Will he do it again? Will he come back to hurt me?

Now that you have told me (and your parents) about what happened, we are going to do everything we can to keep you safe. So, he will not be able to hurt you again. Also, I am going to teach you some ways to keep yourself safe from bad people such as this—so once you know that, I also believe you will feel stronger and more confident, less scared.

(In case child is hesitant to tell parents/ caregivers…) I don't want to tell my parents…they will get angry and punish me…or they may think that I am lying.

I see that you are afraid that your parents might disbelieve you and be upset with you for talking about what is happening. But if you allow me, I can help you explain to them what happened…the reason I feel it is important they know about this is that they can then help to stop the hurt and keep you safe.

Preparing the child to give legal evidence (such as the magistrate's statement as per Section 164, POCSO)…

As we said, no one is allowed to hurt children. If they do, we have rules in our country about how people should behave with children. If someone breaks those rules and harms children, then action will be taken against them—by the police and judges. [Just like we have rules about stealing and breaking into people's houses—where also the police and judges will catch people who do that and take action against them]. So, we need you to tell the judge what this person did/ how he hurt you…the judge may ask you a few questions which you don't have to be scared of. S(he) only wants to know so that s(he) can protect you and other children from bad people who hurt children. I/ your parents will be with you, so you will not have to meet the judge alone…

Responding to Adolescents' Sexual Abuse Experiences

I am so angry…I could kill him.
You should be angry….you have every right to be angry. Would you like to write a letter to your abuser, telling him all you would want to say or do to him, were he in front of you? Sometimes, people feel better when they have written it all out…you can decide whether you want to send it to him. after.

(In case of multiple abusers…) Why do people keep doing this to me? There must be something wrong with me, my body…something that prompts people to behave this way with me.
I understand that when people (repeatedly) make sexual overtures, one can feel self-conscious and uncomfortable about one's body. But I don't think there is anything in you or your body that causes some people to behave this way…these are people who are cruel and uncaring, who have no respect for others' space or feelings. So, they would behave this way with a lot of other people too…and I believe they must have. It is just unfortunate coincidence that this kind of thing happened to you repeatedly, with different people.

Why did they choose me then?
I am not sure that any of these abusers chose you in particular. It could have been any girl…but you just happened to be there…in place and at a time where they were too. If some other girl had been there instead, they would have abused her. It is a matter of convenience and accessibility… abusers targets someone who is easily accessible to them, at a time convenient to them… they does not have to bother to go searching for someone then. They also tend to target children and teenagers because they think that they are too young to know what abuse means or that they will be too scared to tell anyone—that is also a matter of convenience.

Why did it feel good? Why did my body respond?
These are natural physiological responses i.e. normal ways in which the body responds. The body is designed to respond to sexual stimulation…when one's private parts are touched or stimulated, the body responds in certain ways (such as getting wet in the vagina for girls or getting an erection of the penis as in case of boys). It does not mean in any way that you wanted this to happen or that you invited this person to do these things to you.

Why did it feel good? Why did my body respond?
These are natural physiological responses i.e. normal ways in which the body responds. The body is designed to respond to sexual stimulation…when one's private parts are touched or stimulated, the body responds in certain ways (such as getting wet in the vagina for girls or getting an erection of the penis as in case of boys). It does not mean in any way that you wanted this to happen or that you invited this person to do these things to you.

In the future, if I get married, should I tell my spouse about this? Being afraid to tell your spouse is a natural reaction. It is hard to know or predict how people understand the issue of sexual abuse…but people who understand it will also understand that it was not your fault and that you have actually been the victim of someone's criminal act. The issue is what kind of person you want to spend your life with…would it be someone who is understanding, compassionate and supportive towards your experience? In that case, telling him would make no difference to his relationship with you. Or would it be someone who does not believe in equality of men and women's rights, who insensitive to violence and abuse issues—and therefore would be uncaring and unsupportive of you (not only on this issue but others as well)?

D. Relaxation Exercises

Drawing from cognitive behaviour therapy methods, relaxation exercises can be used to help sexually abused children control and manage anxiety or anxiety-provoking thoughts. Essentially, this means getting children to focus on thinking or doing something different, to calm and/or distract the mind at times of high anxiety. Two techniques, deep breathing and guided imagery, may be taught to children—who also need to know when and how to use these techniques i.e. to use them every time they feel the abuse images returning (PTSD) and their anxiety increasing. You can explain to children that focusing on breathing and thinking of pleasant things such as happy events in their lives or imaginary places they would like to visit help the mind to feel calmer and happier. It is useful to demonstrate these exercises to children so they can experience how they work.

Guided imagery is a method of relaxation which concentrates the mind on positive images in an attempt to reduce pain, stress, etc. The activity gets children to use their imagination to leave their present (difficult situation/ thoughts) and think of or 'go to' happier places and situations instead, when they feel anxious or stressed.

Do and Learn Activity on Relaxation (1): Deep Breathing

- **Belly breathing**
  - Sit or lie flat in a comfortable position.
  - Put one hand on your belly just below your ribs and the other hand on your chest.
  - Take a deep breath in through your nose, and let your belly push your hand out. ...
  - Slowly breathe out through your mouth—open your mouth and expel all the air you took in.
  - Do this breathing 3 to 10 times.

- **Calm Breathing**
  - Take a slow breath in through the nose (for about 4 seconds)
  - Hold your breath for 1 or 2 seconds.
  - Exhale slowly through the mouth (over about 4 seconds)
  - Wait 2-3 seconds before taking another breath (5-7 seconds for teenagers)
  - Repeat for at least 5 to 10 breaths

E. Resuming Daily Routine and Developmental Activities

As and when children are ready, it is best for them to resume their daily routines so that their developmental needs continue to be met. Abuse-focused healing interventions alone are insufficient and healing and recovery can also take a long time; in the interim, it is therefore important to recognize the importance of maintaining a children's developmental trajectories—which are (as previously discussed) disrupted by experiences of trauma and abuse. Enabling children gradually to return to daily schedules and activities such as school and play helps to restore:

- Normalcy and balance.
- Predictability (something that is lost in the abuse situation due to the lack of predictability of abusers and of abuse events).
- Control i.e. enables children to feel that they have some control over their time and activities, and decisions on what to do.

All of the above therefore also help reduce anxiety. Helping children to structure and organize their day to accommodate various activities such as daily self-care activities (bathing, eating etc.),school, play, relaxation and recreation, family/ social time also leaves a lot less time for children to be thinking about the abuse events that lead to anxiety.

Do and Learn Activity on Relaxation (2): Guided Imagery

Close your eyes and relax in your chair. Sit in a comfortable position…take your shoes off if you like. Let your hands and legs lose, relax your body muscles. Let slow, relaxed energies flow from your head, down to your neck and shoulders, your arms, your hands and finger-tips…from your neck down to your chest, stomach and abdomen…to your thighs, knees, legs…your feet and toes…until you feel your body relax and quiet. We are now going to leave this therapy room and go on a little journey, away from here…we are walking out of this room, down the steps and out of the building and up the path that leads to the street…and there on the road where the trees are, your feet lift off the ground and you slowly begin to fly…higher and higher and higher, until you pass the branches and are at tree-top level…and then you are above the trees. You move higher until the trees and buildings are far, far below you and they grow smaller and smaller in the distance.

You float along the clouds…you can reach out and touch them, soft and warm and light…feel the sunlight streaming through the clouds to touch you…and so you fly on and on until suddenly you come out of the clouds and find yourself descending, slowly, gradually…you can now see the tree tops again as you pass them by and fly lower and lower until your feet touch the ground. Then you find that you are in a beautiful garden and your feet are on soft green carpet of grass. You walk along a while and see the flowers…roses lilies and some unusual ones you'd never seen before…in colours bright and pale…pink, red, orange, yellow, sunset colours, white, mauve and blue…a lovely mix of sweet fragrances reaches you. You can hear the birds chip and the rustling of the breeze through other fruit trees…mangoes, coconut, chikoo and guava. You decide to sit under the mango tree…your favourite fruit…and you eat a delicious, juicy mango…now you lick the juice that's running down your elbow…and as you look around for a place to rinse your hands, you see a beautiful lake.

You are standing on the soft, white sands by the backwaters of the lake…your feet sink into the sand as you make patterns with your toes. When you reach down to touch the water, it feels wonderfully cool and clean. The water is so clear that as you look down at it, you can see all the way down to the bottom of it…and you can see lots of coloured fish…big fish, small fish, tiny fish…orange, red, spotted, silver and gold, some swimming quickly, others quietly floating or asleep. The water feels so good that you dip your feet in it. Then you slowly begin walking away, back into the garden, letting the breeze dry your feet and hands.

**Note: This is just an example; you can use any narrative that is relaxing for the child.*

F. Explanatory Models of Somatic Pains

As previously discussed, anxiety frequently manifests in sexually abused children as medically unexplained body aches and pains as well as fainting and 'black-outs'. Children express extreme anxiety in this way because they are unable to express their feelings and talk about the abuse event i.e. the pain is actually in their minds but they feel it elsewhere because they are then able to describe it more easily. Or children have fainting spells and black-outs when they feel overwhelmed with anxiety relating to the abuse event and wish to avoid or dissociate from

the event and its memories[1]--fainting and black outs are a mechanism to cope with or avoid situations that provoke high levels of anxiety. It is important to help caregivers understand that children in such situations are not lying or pretending or being dramatic.

With children, two types of intervention are useful, to help them deal with the anxiety:

- Reassure the child that there is no physical health problem.
- Provide children with an explanatory model for somatic pains (see box below).
- Teach them to control and manage anxiety with relaxation exercises.

Caregivers should be advised to:

- Spend more time playing with their child in these situations.
- Reassure the child that there is no physical problem.
- Be considerate and sympathetic when the child expresses these pains but NOT constantly remind the child about them i.e. do not keep asking the child how he/she is.
- Distract the child and do something fun or recreational when these 'pains' occur.

Explanatory Model for Children

- **Reassure the child that he is alright physically**
  "Am happy to tell you that there is nothing to worry about your physical health…so we can all be relieved about that…the doctor has said you have no health problems"

- **Explain the mind-body relationship**

Example 1: What happens when some children become very tense about an exam? They sweat, their hands shake and they have butterflies in their stomach, stomach ache etc. These physical symptoms do not occur by themselves or in isolation…but they also do not occur because these children have any physical ailment (is the child actually sick? No.). They are caused by an emotion—emotions of worry, stress, anxiety.

Example 2: If you have pizza, coffee, ice-cream, sandwich and then tea, all together, one after another, what would happen? Your stomach would hurt. Similarly, if we put a lot of things into your head…think excessively about things…what would happen to it? It would hurt.

- **Teach the child to practice relaxation exercises.**

" So now that you know that it is the worry and tension that is causing these aches and pains/ fainting fits, if we help you do something to reduce the worries and tensions, the aches/pains/fainting fits will also reduce…I will now teach you some relaxation exercise to do when you start feeling very anxious…"

***Suggested Activity:** Ask participants to get into pairs with one person

G. Identity Exercises

Often, children who have been sexually abused perceive themselves not only as being weak but also incapable of doing things i.e. the helplessness felt in the abuse situation tends to become

[1] Somatic pain and dissociation can also occur in many other anxiety-provoking contexts, other than abuse, such as when children have learning disabilities, when they are bullied, when they are witness to severe marital and family conflicts…the intervention and explanatory model remains the same in other contexts too.

generalized or spill over into other areas of life as 'I can't…I am not good at…' Additionally, these children also tend to view their identity and selfhood through an abuse lens: I am equal to my abuse experience. Consequently, both in the present and future, their worldviews and decisions stem solely from the abuse experience. For example, when children make decisions about inter-personal relationships from a purely abuse perspective, they are likely to view the world as a hostile place, wherein people are not to be trusted and intimate relationships (in the future) are to be avoided. It is therefore essential to ensure that the abuse experience do not form the entirety of children's identities.

See diagram alongside: figure 'A' shows a child's identity when it is fully occupied by abuse and the child thinks 'I am the girl who was sexually abused'; figure 'B' shows a child's identity when interventions are provided to transform the child's identity and the child is able to think 'Sexual abuse is one life experience—and a very difficult one but I am more than my abuse…I am a sister, a daughter, a student, a citizen of the country…I am a good singer, a helpful friend…a girl who is interested in sports and dance, a lover of animals…' Thus, figure B shows the child's identity as it is when she is able to see herself as much more than a person who has been abused…and recognize that her identity is made up of roles, qualities and talents, interests, wherein abuse is just one part of her life and identity. If interventions are provided, a sexually abused child's identity moves from A to B i.e. the abuse experience which occupied the whole identity in A gradually shrinks (it may not completely go away as it cannot always be forgotten) to become what it is in B.

Do & Learn Identity and Selfhood Activity for Child: Who am I?

- Explain the idea of identity: What or how we think of ourselves makes a difference to how good we feel about ourselves. What we think about ourselves is based on what people tell us or our experiences. Identity is our sense of who we are. However, people's impressions and some experiences do not make one's entire identity. Here we will learn to do activity to experience ways of seeing oneself, which will make our identities strong and capable.
- Give the child a paper cut out of a boy/girl and explain that 'this is you' (or ask the child to draw himself/herself).
- Divide the paper cut out or figure into 3 parts, telling child that this represents different parts of you.
- Ask him/her to write in the following (on different parts of the paper cut-out—for example: roles on the head. Qualities on the upper body and fears and worries on the lower body):
  i) Your roles (as a student, as a family member, citizen of the country, friend…)
  ii) Your qualities and talents (things you are good at, special gifts you have, characteristics)
  *Abuse can be marked as one experience (in case the child wishes to mention it).
  (If the child is unable to write, you could do the writing or ask child to use symbols).
- Discuss with the child:
  - Identity is how you perceive yourself.
  - Identity is not just what you don't manage to do i.e. your worries, fears and failures or your bad experiences. Similarly, X (child's name) is not equal to his/her abuse experience…abuse is not the only thing that makes you who you are…it is one experience in your life.
  - Identity is also your roles, your gifts, your talents, your efforts, your perseverance…
  - You can also use the above explained visual/ figures A and B to explain identity and abuse to the child.

3.4. Longer Term Healing Interventions for Child Sexual Abuse

Objectives

- To learn methods to address longer term healing and recovery from child sexual abuse experiences.
- To enable children to overcome abuse trauma and empower them to develop coping & survivor skills.

Time

2 hours

Concept

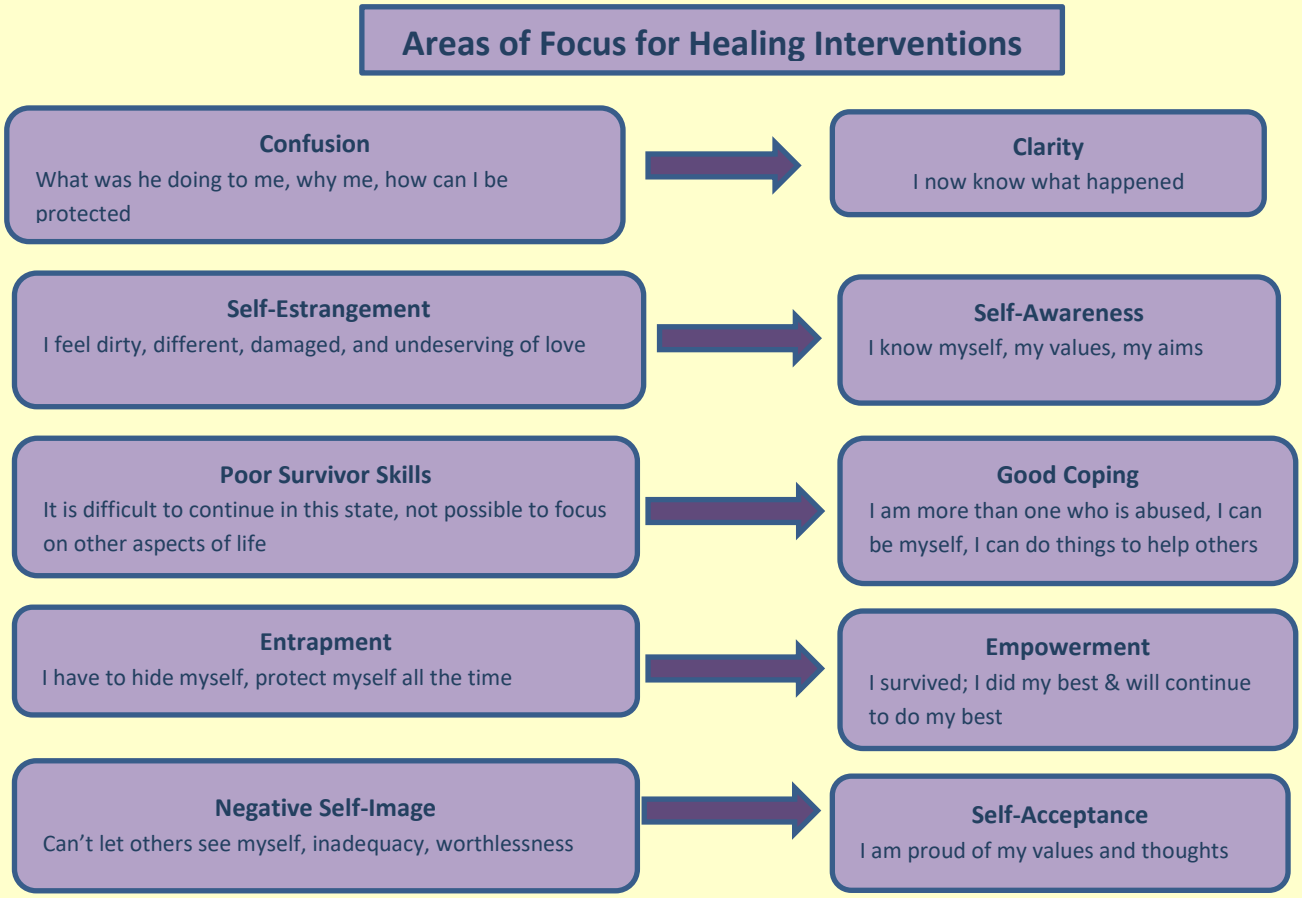
Longer term therapy entails regular sessions between a trained therapist or mental health professional to engage the child in reflection and dialogue to process and resolve the abuse experiences. It is only after the first level responses that healing interventions are undertaken. They are longer term processes, entailing in-depth work with the child. The purpose of therapy with a sexually abused children or adolescents is NOT to help them 'forget' the experience and 'get past it'.

The objectives of depth therapeutic interventions for sexually abused children and adolescents are:

- Inquiry: Helping child to detail/provide a narrative on sexual abuse experience in a gentle, non-threatening manner.
- Healing & Recovery: Enabling child to overcome abuse trauma and move from confusion to clarity; empowering child to develop coping & survivor skills.
- Personal Safety & Abuse Prevention: Identifying ways to cope/respond in case abuse is imminent or after abuse has occurred (for children); acquire life skills such as decision-making, assertiveness, negotiation (for adolescents).

Therapeutic methods need to be innovative and age-appropriate. Thus, multiple creative methods that allow for children & adolescents to understand and reflect on situations and experiences require to be used (versus mere information and instruction giving). Below is a framework for designing activities and interventions to assist children with the trauma of sexual abuse (see figure below).

Various types of creative methods, ranging from art and story-telling to theatre, and cognitive-behaviour therapy methods for containment and emotional regulation may be used. The figure below shows the areas of focus for longer term healing interventions.



Activities & Interventions for Focus Areas of Healing:

i) Containment & Emotional Regulation (Poor Survivor Skill to Good Coping):

- Relaxation techniques
- Guided Imagery/ music/ deep breathing
- Maintenance of a Mood Diary
- Normalization—going back to school/play/routine activities

ii) Memory Work (Confusion to Clarity):

- Helping the child detail the event: who, when, what (narratives—using art if required)
- Helping the child make sense of what happened, including feelings/emotions/behaviours

iii) Skill Training (Self-Estrangement to Self-Awareness; Poor Survivor Skills to Good Coping Skills, Entrapment to Empowerment; Negative Self-Image to Self-Acceptance):

- Assertiveness skill building
- Self-esteem enhancing tasks
- Re-gaining control and mastery
- Affect (emotion) regulation

iv) Vision for the Future (Self-Estrangement to Self-Awareness; Poor Survivor Skills to Good Coping Skills, Entrapment to Empowerment; Negative Self-Image to Self-Acceptance):

- Who am I/ Identity establishment activities
- What do I want to be

Activity: Healing Interventions for Child Sexual Abuse—Let's Try it Out…

Method: Art (Note: These methods are drawn from Butler & Carp's Workbook 'Treatment Strategies for Abused Children')

Materials: Paper and (colour) pens or pencils

Process:

- Divide participants into pairs.
- Explain that while the exercise is being done, one person can act as counselor and the other as the (abused) child and discussions had accordingly; the roles may then be reversed in the next part of the exercise—so that each person gets to play the counselor role and conduct the activity/ carry out the discussion.
- Tell them that for now, you as facilitator will give the main instruction i.e. what is to be done/ drawn and the participants should do it; the questions and statements within the parentheses[ ], are to be used by the counselor participant to conduct a brief conversation with the child (for 2 to 3 minutes—as we are doing this only to get an idea on use of methodology).
- Activity Implementation:

i) Draw a picture of yourself
(Can I help you, can I do shading, long/short hair, will you draw dress, if you can't draw, I will do it-you tell me)
(after drawing...please describe, anything missing?...)

ii) Draw a happy/sad/scared face
(How we make sad face, I wonder why people are sad sometimes, I am scared when I have to go to exams…when do you feel scared/ sad/happy…?)

iii) Draw a picture of yourself and colour your personal space
(what have you coloured as personal space, why, how you decided that, what do you understand by personal space…?)

iv) Draw your safe spaces
(Shall we divide it into 4 sub-spaces- home, neighborhood, school, city?...what is safe here?.... How is it safe here, what do you mean by safe space…which spaces are not safe and why?)

v) Draw your safe people.
(Who can you share things with, secrets even…easy to tell?...feel better when sharing?...why do you trust these people? What does trust mean?)

vi) Draw your cartoon hero(ine) who can help you
(Why is this character your hero(ine)? What qualities does he/she have...can he/she help you to reduce your bad memories..)

vii) Complete these sentences…
(It was not my fault because… I'm not to blame because… I now know that…)

viii) Write a letter to your abuser/family

ix) Draw a picture of yourself now
(…how have you changed? things you have learned…?)

Discussion:

- The above activities are merely a glimpse into how to implement healing activities, using a particular method (art).
- These activities are excerpts from: Karp, C.L, Butler, T.L, Bergstrom, S.C (1996). Treatment Strategies for Abused Children: From Victim to Survivor. Sage Publications
- You may also draw activities from the following books:

– *Activity Book for Treatment Strategies for Abused Children, From Victim to Survivor by Cheryl L. Karp & Traci L Butler*
– *Activity Manual for Adolescents by Cheryl L. Karp & Traci L. Butler & Sage C. Bergstrom*
– *The Courage to Heal Workbook for Women and Men Survivors of Child Sexual Abuse by Laura Davis*
– *Child Sexual Abuse Prevention and Personal Safety (for Children aged 4 to 7 years)**
– *Child Sexual Abuse Prevention and Personal Safety (for Children aged 7 to 12 years)**
– *Life Skills for Adolescents Series (II): Gender, Sexuality & Relationships**

*(The last 3 activity books for use with children/ adolescents, are developed by Community Child & Adolescent Mental Health Service Project, Dept. of Child & Adolescent Psychiatry, NIMHANS, and are available on the Community Project website).

- It is strongly recommend that these activities and others from the Butler, Karp and Bergstrom workbook be used along with the NIMHANS-DWCD Community Child & Adolescent Mental Health Service Project's 'Child Sexual Abuse Prevention and Personal Safety Activity Book for Children' or Life Skills Series II for Adolescents on 'Gender, Sexuality and Relationships' because the NIMHANS project activity books:
    - Provide (age-appropriate) methods for children/ adolescents to detail out and understand abuse as well as introduce ideas of safety and prevention.
    - Are adapted to Indian culture.
    - Use multiple creative methods unlike Butler and Karp's workbooks which primarily use art and paper-pencil tasks (not all children are interested in art and not all have the ability to write).
    - Address not only adolescent sexual abuse (risk) issues but also enable adolescents to acquire life skills in the context of relationships and sexual decision-making; such life skills are closely related to abuse issues and also prepare adolescents in non-abuse contexts to navigate sexuality and relationship needs and issues.

3.5. Linking Sexual Decision-Making to Sexual Abuse

Objectives

- To understand the dynamics of adolescent sexual abuse.
- To learn methods to enable adolescents to cope with the pressures and confusions of with sexual decision-making.

Time

2 hours

Concept

Thus far, we have been talking about child sexual abuse in terms of how to respond when children and adolescents are distressed and traumatized by it—and such distress and occurs in contexts where children and adolescents were (and usually admit to being) coerced. Certainly, where younger children are concerned i.e. those below the age of 12 years (or before they have reached puberty/ adolescence), coercion may be assumed as there is no question of obtaining consent.

So, our learning in this session pertains only to adolescents—wherein sexuality work must consist of two aspects…i) abuse and ii) decision-making. Earlier, we talked briefly about the dynamics of adolescent sexual abuse and the concept of grooming…how adolescents are manipulated into giving consent (this could also be called 'manufactured' consent). Let us explore adolescent sexual behaviour and its implications a little more in this session—and take some perspective on adolescent sexuality and learn how we can more effectively work in the area.

In some contexts, abuse and decision-making issues may play out independently, while in others, they are linked. For instance, if a 16 year old girl runs away with a 30 year old man, she might say that it was her desire and decision to be with him, however, it is highly likely that there has been grooming and sexualization processes involved (given the age of the man)—which then means that there was 'manufactured' consent, consequently making the man's act one of child sexual abuse. In another instance, however, a 16 year old girl and a 17 year old boy may fall in love and decide to physically intimate/ run away/ live together etc. Here, they are both adolescents, and given that they are of similar age, probably are in a mutually consenting relationship; however, in such instances, the Prevention of Child Sexual Offences (POCSO) Act 2012, is applied and the boy in question, is accused of alleged sexual abuse.

The POCSO Act does not consider the above-described dynamics in a relationship, while deciding whether or not it is a case of child sexual abuse—any case of an individual below the age of 18, who has been involved in sexual activity, is automatically considered as having been sexually abused. Interestingly, the law plays out with a very clear gender bias: in the latter case, of two adolescents, despite the involvement of both the boy and girl in decisions of sexual intimacy, it is only the boy who is held accountable and may be punished (or sent to the Observation Home). What happens then in case of a 17 year old girl who might coerce/ abuse a 14 year old boy?

Thus, there are many complexities of the issues of consent and gender. There are many cases which we receive of romantic relationships and runaways for love, to which the law is applied. We are therefore compelled to find ways to work with adolescents on issues of sexual decision-making—through which they can also protect themselves against sexual abuse.

But first let us examine our own perspectives on adolescent sexuality…what do you think…? *[Engage in a discussion with the participants].*

- Adolescents have no sexuality/ sexual needs or rights.
- They may have sexual needs but no rights; they cannot gratify needs.
- They have sexual needs and rights and are allowed to gratify them.

[Many participants often respond from socio-cultural contexts that are against sexual intimacy before marriage/ in adolescents. Some of the reasons for their viewpoints are 'adolescents are not physically and emotionally ready…', 'they are not mature enough at this age to make decisions about love and relationships, so they should not engage in sexual relationships…', 'this is the age to be studying and doing other things—if they get into relationships, they will not concentrate on school and academics…']

Let us enter into some more discussions (use gentle humour to challenge some of the emerging thinking!):

- What is the 'right' age for love? If 15 is too young, what about 20? 40 years? 90 years is too old then?? (Encourage participants to name the 'right' age).
- How do we know that love at age 15 is not 'real' love?
- When people make decisions at age 30 to fall in love and enter a relationship, have many of these relationships not broken? What does that say about adult decisions then?
- Many of you are married and presumably in sexual relationships…so, because you are in a sexual relationship, does it mean that you are not performing other roles and responsibilities in your life…such as going to work, taking care of family etc?
- Let us return to the age issue…most of you feel that individuals below the age of 18 (in accordance with the law), cannot give consent and should not enter into sexual relationships. If I am 17 years old today, and tomorrow is my birthday i.e. I turn 18 at midnight, can I run out and have a sexual relationship? *[Participants usually disagree with this].* Why not? Legally, I am permitted to do so…why can't I then?

What we are essentially saying then is that sexual decision-making is not, or not entirely, an age issue. There are several other issues or factors we need to consider when making decisions about sexual intimacy. So, with adolescents too, decisions are not about 'yes' or 'no'—in answer to questions about whether or not to engage in sexual intimacy. Some of us come from an adolescent sexual rights position i.e. we believe that adolescents have the right to engage in sexual relationships. But this is not absolute—this does not mean that adolescents can have sex whenever, wherever, with whomsoever they choose. We would still ask the questions when, where, with whom, under what circumstances—and these are the questions to consider for adolescents (or anyone!) while making decisions regarding sexual intimacy.

Thus, based on the above, the framework for sexual decision-making is as below—and requires to be used when working with adolescents on such issues (explain):

1. Acknowledgement of love/ attraction and needs/pleasures:
"There is nothing wrong with feeling love and attraction for someone…everyone does and love and physical intimacy are wonderful…they are important aspects of human life. We cannot deny

the need for love and sexual intimacy—and must make space in our lives for them. The question is can we set aside everything else (such as education, everyday activities and life plans) and only focus on love and sex?"

2. Privacy

"What does privacy mean? Why do windows have curtains? Why do we close the door and take a bath? Where can we engage in sexual activity? There are public spaces such as parks, market places…can you think of some private spaces? Are facebook and other social media public or private spaces? It is not that it is wrong to put certain type of (intimate) pictures there…but once you put a picture out there, do you have any control over who sees it i.e. your privacy? Can we control what some people may think and act if they see a certain kind of picture? For instance, if a girl puts a picture of herself in a sexual position with her boyfriend, some of us may think it is her right to do so and think no more of it; however, some of her male classmates may see it and think...? That if she can do that with that guy, then why not me? What if they then approach her and coerce her to do the same…? While many of us are supportive of women's rights and women's safety, and believe that women should be able to wear what they please and go out at any time, in the confidence that they won't be harassed, what are the realities of the world we live in?"

3. Consent and Boundaries

"What does permission and consent mean? In what situations do we ask for permission? For instance, if I want to enter your room, how do I do so? If I do not knock or ask, and I walk right in, how would that make you feel? What happens when consent is refused and we still go ahead and do something…whether we take someone's belongings or enter their space…? It is likely that there will not be much trust or respect or liking left in a relationship where people feel coerced. Violence is an extreme form of force or coercion…what are others? Suppose you asked someone out for a movie and he says 'no' and you buy tickets and tell him that he must come…? When he continues to refuse, if you say (in a sweet tone of voice)—'please, please…aren't you my friend? Don't you love me? If you really loved me, then you would come…' would this be a form of coercion? So, not all use of force is angry or violent; it can be done in ways that are softer, but it still means coercion—when one pushes a person to do what he/she does not want to do. And when we coerce someone we are breaking boundaries..."

4. Relationships

"Who is the person that one is considering having sexual intimacy with? Is it a young child—in which case it may be problematic because it is not possible for a young child to give consent…since she does not understand sexuality issues. (There are also laws against sexual engagement with children). Is it someone within the family… like an uncle—and that may also be difficult, considering boundary issues/ family relationships? Is it a friend—if so, how long have and how well have you known him/her? How do we get to know people and establish trust…? What are your plans/ expectations of the relationship and what are his/hre plans and expectations?"

5. Health and Safety

"Risks of unprotected sex? Unwanted pregnancy…HIV and other sexually transmitted diseases. What is protected sex? How to use a condom?"

6. Abuse

"When a person engages with another person, without taking into consideration the issues discussed above i.e. he/she does not take into account issues of privacy, goes against consent, uses coercion and breaks boundaries, disregards relationships."

[The above-described framework has been used to develop the Life Skills Series for Adolescents on Gender, Sexuality & Relationships—life skills methodologies are discussed later in this workshop].

The above framework is applicable to anyone (not just an adolescent), who is making decisions about sexual engagements. In other words, sexual decision-making is actually a life skill, to be used whether one is aged 15 years, 45 years or 65 years!
The beauty of this framework is that it can be used with:

- Adolescents who have not been sexually abused (for awareness on personal safety and abuse prevention purposes)
- Adolescents who are victims or have been sexually abused (in order to be able to understand and recognize abuse and thereby prevent it or report it in the future i.e. personal safety in the future)
- Adolescents who have violated boundaries and manifested sexual abuse behaviours (so that they understand what constitutes abuse and why, and can make decisions not to engage in such behaviours).

This framework is also referred to as the 'window approach' by the NIMHANS team who developed it—because this stage by stage discussion, is also akin to opening each (new) window of thought. When we want to talk to children and adolescents about abuse, we do not directly speak about abuse—because not only is it a sensitive issue with which children can be uncomfortable, but also a complex one and one that is hard, particularly for younger children, to understand. A window approach therefore allows for discussions to gradually proceed, so that knowledge and understanding on relevant and related themes are transferred sequentially.

Finally, through the processes of reflection and engagement this framework entails, an adolescent (or any person) might arrive at completely different decisions regarding sexual engagement: one person might decide to engage sexually only within the context of a marriage, in which case issues of privacy, consent and health-safety still matter; another person might be more liberal and decide that sexual intimacy is ok as long as there is a relationship context and commitment; a third may decide that a one-night, casual encounter is acceptable. But whatever the decision and the context, the factors discussed are applicable—for a **'happy, healthy, responsible and safe'** sexual engagement. All four components need to be addressed in adolescent sexuality education—sex education programs in school often leave out the emotional and relational context of sexuality, focusing only on the biological and physiological issues (i.e. health risks). Such approaches are incomplete and ineffective as they end up in preaching abstinence—is that realistic?—and/or presenting sexuality from a negative (disease) perspective only—is that what sex is? Is that a fair perspective?

Furthermore, we need to make a distinction between our personal viewpoints and opinions and the counseling process with the adolescent. We are entitled to hold our beliefs and opinions, whatever they might be, pertaining to sexuality and sexual behaviour. However, these beliefs and opinions come from our personal life experiences—which may be completely different from the life experiences of the child you are assisting. It would therefore be problematic for us to impose our beliefs and opinions on the child—who needs to make his/her decisions based on his/her experiences. We are only there, through the use of the above frameworks, to facilitate and guide the child as he/she develops certain ideologies or makes sexual decisions.

<u>Important Note for Facilitators:</u> The issue of sexuality and decision-making is a sensitive one in many cultures, particularly those that are more rigid and patriarchal in nature. It is important to therefore be gentle and humorous as you challenge people's thoughts and perception on the matter. Do not ever be aggressive or insistent or coercive in your persuasions. Remember that these are difficult issues and people's thoughts and opinions are deeply entrenched in socio-cultural norms that cannot be changed over-night. It is therefore best to tell people that these are perspectives and ways of working that we have found useful and effective with adolescent sexuality and that you are presenting them for their consideration…that you understand that they need time to reflect on some ideas and approaches that are both new and complex.

Activity for Linking Sexual Decision-Making to Sexual Abuse

Method: Role Play

Material: None

Process:

- Ask participants to divide into pairs—with one person playing the role of counselor and the other playing the role of the adolescent.
- Each pair may select any one of the situations for their role play:
    - A 16 year old girl ran away with a 17 year old boy; she has been found and is in the institution now. The boy is from a different religious community than her and her parents are against this relationship. The girl is therefore insistent that she goes and lives with the boy, that she is in love with him and will only marry him. (Your client is the girl).
    - A 17 year old boy is now in the institution as he ran away with a 17 year old girl. He says that she threatened suicide if he did not run away with her and marry her. The girls' family, however, has filed a complaint against him. (Your client is the boy).
- They need to then apply the window approach/ the above-discussed sexual-decision-making framework as they have a conversation with the girl/boy.
- Invite some of the groups/ pairs to present their role play in plenary.
  *Remind participants of the non-judgmental skill they learnt in workshop 1.

Discussion:

- Invite participants to comment on the role plays, with particular attention to the sexual decision-making framework and the counseling skill of non-judgmental attitude.

<u>Note:</u> this activity may appear similar to the one in workshop 1—on acceptance and non-judgmental skills. It would be useful to repeat it because such cases are increasingly becoming common and more practice in the area would be useful to participants; also, both the non-judgmental skill as well as the sexual-decision-making framework are complex and require much reiteration and practice—and revision and reiteration never hurt anyone!

3.6. Introducing the Practice of Life Skills Methodologies

Objectives

- To introduce the concept of life skills.
- To learn methods to enable adolescents to cope with trauma as it pertains to loss and grief or sexual abuse.

Time

3 hours (if only 1 life skills series is used for practice and demonstration; could be longer if facilitator and participants wish to try out more activities—in which case, it can even extend to a day).

Concept

What Life Skills are About

Skill Domain	Sub-Skills	Specific Skills
Communication and Interpersonal Skills	Interpersonal communication	• Verbal/Nonverbal communication • Active listening • Expressing feelings; giving feedback (without blaming) and receiving feedback
	Negotiation/Refusal	• Negotiation and conflict management • Assertiveness skills • Refusal skills
	Empathy	• Ability to listen and understand another's needs and circumstances • Express that understanding
	Cooperation and Teamwork	• Expressing respect for others' contributions and different styles • Assessing one's own abilities and contributing to the group
	Advocacy	• Influencing skills & persuasion • Networking and motivation skills

Decision-Making and Critical Thinking Skills	Decision making /problem solving	• Information gathering skills
		  ◦ Evaluating future consequences of present actions for self and others
		  ◦ Determining alternative solutions to problems
		• Analysis skills regarding the influence of values and attitudes of self and others on motivation

	Critical thinking	• Analyzing peer and media influences • Analyzing attitudes, values, social norms and beliefs and factors affecting these • Identifying relevant information and information sources
Coping and Self-Management Skills	Increasing internal locus of control	• Self-esteem/confidence building skills • Self-awareness skills including awareness of rights, influences, values, attitudes, strengths and weaknesses • Goal setting skills • Self-evaluation / Self-assessment / Self-monitoring skills
	Managing feelings	• Anger management • Coping skills for dealing with loss, abuse, trauma
	Managing stress	• Time management • Positive thinking • Relaxation techniques

The World Health Organization (WHO) defines Life Skills as "*'adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life.'* Core life skills for the promotion of child and adolescent mental health include: decisions-making, problem-solving, creative thinking, critical thinking, effective communication, inter-personal relationship skills, self-awareness, empathy, coping with stress and emotions[2].

The reasons for developing this Series are two-fold. First, in terms of sheer numbers, there is a tremendous challenge in reaching out to address the psychosocial care needs of children in difficult circumstances. Every child comes from difficult and traumatic circumstances; each child is unique in that he/she has his/her own story, is impacted again, in unique ways. This series takes into consideration the fact that children in similar contexts have different processes and outcomes and conversely, children with the same manifest issues come from different contexts. This series helps recognizing this 'equation' to effectively construct interventions.

Second, given that all children in difficult circumstances require psychosocial assistance and, that resources are scarce, providing individual interventions to each child is not possible. Trained personnel, with the knowledge and skills on how to deal with children's issues, especially with complex and difficult problems, are especially scarce and have resulted in inappropriate and unhelpful responses to children, on the part of caregivers and child care agency staff. As a result, many children requiring assistance to deal with the difficult psychosocial contexts they are in and come from, do not receive it.

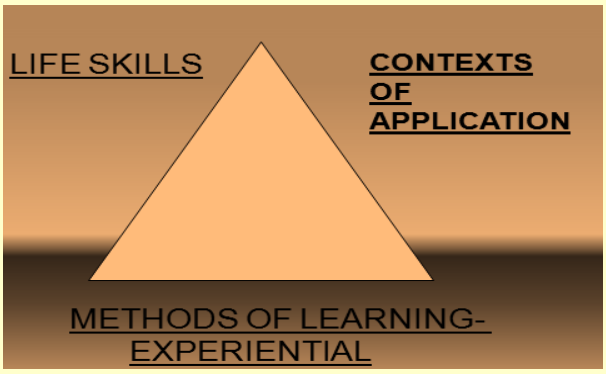
Further, most mental child health problems (except for those such as psychosis and those caused by organic factors or physiological problems) may also be viewed as life skill deficits. For instance, violent and abusive behaviours result from children's inability to regulate emotions, negotiate inter-personal relationships and/or resolve conflicts in alternative or creative ways; thus, the objective of any therapeutic work with such children will be to enable them to acquire the life skills to manage anger and aggression—in other words, to manage emotions, develop creative thinking, problem-solving and conflict resolution (life) skills. Children in difficult circumstances (as discussed above), exposed to experiences of deprivation and abuse from early childhood, develop emotional and behaviour problems which may also be viewed as being created by life skill deficits i.e. due to their difficult circumstances, children have not learnt certain life skills, and that results in emotional and behaviour problems. These life skill deficits, if not addressed, then exacerbate emotional and behaviour problems, increasing the risk for more serious and chronic mental health disorders. The Life Skills Series, as it uses group intervention approaches, therefore ensures that larger numbers of children receive psychosocial assistance to address their emotional and behaviour problems by helping children build the life skills that they may lack.

Thus, life skills series for children and adolescents have been developed by the NIMHANS Project to address socio-emotional and child sexual abuse/ sexuality-related issues in children and adolescents:

- Nurturing Social & Emotional Development (Life Skills for Children aged 8 to 12 years)

[2] WHO, *Life Skills Education for Children and Adolescents in Schools: Introduction and Guidelines to Facilitate the Development and Implementation of Life Skills Programs*. 1997, World Health Organization: Geneva.

- Child Sexual Abuse Prevention & Personal Safety (Activity-Based Awareness & Learning for Children aged 7 to 12 years)
- Children aged 8 to 12 years: Social Emotional Development
- Adolescent Life Skills Series I: Social and Emotional Development
- Adolescent Life Skills Series II: Gender, Sexuality & Relationships



Many manuals and approaches exist for conducting life skills sessions for adolescents. They are all based on the WHO definition and listing of life skills[3]. However, based on our understanding of what various agencies tell us about how life skills sessions are conducted, the content of these sessions are usually very broad and general i.e. they teach skills such as interpersonal relations or communication is a generic sort of way without contextualizing the content to address the needs and daily realities faced by institutionalized children. Further, they do not take into consideration the traumatic nature of many children's experiences—nearly all institutionalized children have experienced some form of trauma in the form of loss, grief and abuse—and these experiences have shaped their emotional and behavioural responses, and resulted in the nature and type of life skills (or survival skills and responses) they have developed (whether positive or negative). The Project felt therefore that life skills sessions that either ignore the (present) daily realities or (past) experiences of children would not be effective.

The specific objectives of the Life Skills Series are:

i) To allow for sharing of experiences and narratives children's daily realities and past experiences so as to take perspectives on them for the future.

ii) To address life skills domains (as outlined by the WHO) covering the broad areas in which children need to acquire skills in order to address their situations and experiences.

iii) To enable children to develop specific skill sets through the various creative and process-based activities.

iv) To thus triangulate life skills, contexts of application (situations/ experiences) and methods of learning (experiential activities)--as shown in the figure above.

Activity for Introducing the Practice of Life Skills Methodologies

Method: Practice and demonstration

Material: Life Skills Series (Printed along with the materials required)

Process:

- Divide participants into sub-groups (of 6 per group depending on the number).
- Select any 1 life skills series on socio-emotional development—either the one for children or adolescents.
- Allot one thematic area from the series (such as anger or anxiety or loss…) to each sub-group, asking them to do the following:
    - Read the activities one by one (pertaining to the theme allotted to them).
    - Discuss how they would execute it with a group of children.
- Request each sub-group to come forward in plenary and briefly do the activities allotted to them—they may use the larger group as the child group.
  [The idea is just to familiarize themselves with the methodologies and the practice].

Discussion:

- Invite participants to ask questions about the activities and methods, and to anticipate challenges they may face while working with children—so that these may be discussed.

*Similarly, the other life skills series pertaining to adolescents (on gender, sexuality and relationships) may also be demonstrated and discussed—this one has several film clips, which could be played, either in full or selectively, depending on the time.
Alternatively, the facilitator may also demonstrate some activities.
The number of activities you decide to do will determine the time required—you could actually spend a whole day looking at the materials and trying them out!

3.7. Family & Systems Responses to Child Sexual Abuse

Objectives

- To know some basics of how to work with other systems that come into play in the context of child sexual abuse.
- To understand and respond to mandatory reporting dilemmas.

Time

2 hours

Concept

So far, we have discussed individual responses to child sexual abuse i.e. how we engage with and assist the child. However, since CSA is a medico-legal issue, medical/health facilities as well as legal systems need to be involved in the psychosocial assistance processes; last but not least, families and school systems need to be part of the healing and recovery process, both in the immediate and long term context. Below are some guidance notes on the role of various systems in assisting sexually abused children i.e. what they should do and how they can respond to children to aid recovery and healing.

The Need for Child-Centric Systems' Response

A critical aspect of child protection, CSA warrants systemic approaches that are uncompromisingly child-centric. When an event occurs, it is addressed by systems of criminal justice, police, schools, families, and healthcare. However, in attempting to conduct inquiry, interrogation and detailing of the event to verify it and then bring the perpetrator to book, the child's best interests cannot be compromised. The balance between the need for justice and empowered recovery of the child becomes precarious. There is thus an urgent need to develop a protocol-based systemic response ensuring that the child's agenda i.e. healing and recovery, is at the core of it. Processes involving medico-legal systems for the child and the family must be devised in a manner as to avoid further traumatization of the child. In fact, inquiry with the child should be conducted once instead of multiple times, and only by mental health professionals and/or police personnel/SJPU trained in CSA work and forensic interviewing with children (to avoid re-traumatization)—again, as part of the psychosocial and healing processes.

B. Guidance for Families and Caregivers

- Do not ignore or undermine a child's statements and innocuous remarks.
- Believe what your child tells you.
- Do not to blame the child.
- Contact Childline (1098) for assistance on how to report to police, Child Welfare Committee and medical/ psychological help systems.

- File an FIR or police report.
- Ensure that the child is provided with emergency medical services (EMS) (within 24 hours of filing the FIR) provided by state Registered Medical Practitioners (RMP) in government hospitals.
- Seek counselling from child mental health experts in government institutions to ensure that psychosocial assistance and healing interventions are provided to the child; and that evidence gathering and other legal processes are embedded within the healing context.
- Tell the child that the abuse was not the child's fault. Explain to the child about the measures that are being taken to make the child feel safe at home and at school.
- Show openness to the child sharing his/her experiences by saying," When you want to tell me about what happened, how you feel about it, I am ready to listen."
- Get the child back to maintaining regular home (mealtime, bedtime) and school routines. (Normalizing process is essential to recovery)

Mandatory Reporting Dilemmas

The purpose of mandatory reporting, under POCSO, is to ensure that sexual offence comes to light and gets punished, to ensure that the child (especially when abuse takes place within the family) is safe and does not continue to suffer abuse, to provide justice to the child concerned and prevent abuse of other children. As justified as it is in its intent, the stipulation of mandatory reporting is ridden with dilemmas and is often difficult to implement. Parents and caregivers are often reluctant to report child sexual abuse for reasons ranging from stigma and discrimination associated with sexual abuse to fear of legal procedures and systems.

It is recommended therefore that mandatory reporting is not a one-off procedure but that it follows a process which entails the following:

- Written documentation of the child's (or family's) report/ account of sexual abuse in an official manner i.e. there should be nothing loose or informal about documentation, which must also be done in a clear and meticulous way.
- Explaining to the child and family that there are laws about child sexual abuse (POCSO) and that it is recommended that they report the abuse—with reasons for how and why it could be advantageous to them i.e. how it would ensure safety of the child/ other children, get the perpetrator to be punished etc.
- Reassuring the child and family that there would be no pressure or coercion—that ultimately no report would be made without their consent and that were they to choose, in due course/ after due consideration, to report, we will assist them to do so.
- Understanding the child and family's hesitancy to report i.e. to elicit the reasons and fears they have not to want to report, and then to try and address these fears and concerns one-by-one. (Should their concerns be addressed, they might be more willing to go ahead with the reporting process).
- Assuring the child and family that confidentiality would be maintained through the processes of reporting i.e. the press/media/ school/general public would not be aware of the identity of the child.

- Explaining all processes involved in reporting, to child and family i.e. to guide and assist them through the gamut of agencies involved, from the police to child welfare committee and the magistrate; preparing the family and child about the sequence and type of reporting that would be necessary at each stage gives them greater clarity and reassurance and increases the likelihood of their reporting abuse.
- To start with healing interventions and tell the child that we can re-visit the reporting issue at a later point, when he/she feels ready to do so.

Thus, it is recommend that reporting be embedded in the process of psychosocial interventions for the child and family rather than a disconnected, stand-alone process that needs to be done immediately—and which then only serves to exacerbate the confusion and trauma that the child and family is already experiencing soon after the abuse incident/ disclosure or discovery.

Activity for Mandatory Reporting

Method: Role Play

Material: None (You can introduce the guidance/concept as outlined above)

Process:

- Ask half the participants to form groups of 3—in which 2 of them play the parent and one of them the counselor.
- Ask the other half of the participants to form pairs—in which one of them plays the child and the other one plays the child.
- Request them to play out a scenario in their groups/ pairs wherein the counselor has to introduce the POCSO mandatory reporting clause and discuss it with the parents/ child (attempting to persuade them to report).
- Invite some of the groups/ pairs to present their role play in plenary.

Discussion:

- Invite participants to comment on each sub-group's role play.
- Explain that:
  - Mandatory reporting is a process.
  - POCSO does not state a time frame within which the reporting has to be done.
  - What is critical is to document (formally) that discussions with the child and family have been had, regarding the law/ mandatory reporting, including their response and hesitancies, should they be unwilling to report.
  - While the law makes reporting of abuse mandatory, how we implement it also depends on our own individual and personal ideologies and positions vis a vis children and child rights—some of us may decide that children's views and feelings cannot be over-looked, no matter what the law says, so we may not proceed with mandatory reporting (in this case formal documentation is exceedingly important); others may feel that they must follow the law, irrespective of what the child and family feel or decide. There is no 'right' way in this—it is about our own positions, as child care professionals.

B. Guidance for Schools & Child Care Institutions

- Whether the Act…occurs within or outside the school/ institution premises, is done by school/ institution staff or others, reported by the child to anyone in school or not…it is the institution/school's responsibility to support and help the child.
- The institution/ school's Position… should be one of acknowledgment that the incident occurred and one that is absolutely, unquestioningly supportive of the child.
- The institution/ school's response (there should be a pre-set response plan) …
  - Identification of a person at school known to the children, and who can respond in a sensitive and gentle manner to alleged instances of abuse reported by the child.
  - Identification of a next-level reporting authority (such as the principal) who will inform the parents.
  - Provision of guidance and help to parents to access the first level medical and other facilities, including reporting to the Child Welfare Committee (CWC).
  - Referral to trained counsellors/ child mental health experts to provide psychosocial support and assistance to the child.
  - Adoption of a proactive stance with the concerned parents and other parents (in case of school), by addressing their fears and reassuring them that the necessary actions will be taken to help the child.
  - Organization of de-briefing sessions for students and teachers following an incident.
  - Preparation to receive the child back at school in natural and non-stigmatizing ways so that the child re-integrates comfortably.

In case of child care institutions, there are guidelines for **'Identifying Abuse and Maltreatment in Child Care Institutions'**. Refer to Annex III for a copy of the guidelines developed by the Community Child & Adolescent Mental Health Service Project, NIMHANS. These may be shared and discussed with the participants. Generally, in case abuse is suspected or reported by someone to an authority such as the child welfare committee or to the District Child Protection Officer (DCPO), an inquiry would need to be organized to assess the situation in the institution. Such inquiries may be conducted by teams put together by the concerned government department and/or DCPO.

Activity for Systemic Responses to Child Sexual Abuse

Method: Simulation Game

Material: None (You can introduce the concept/ guidance as outlined above)

Process:

- Divide participants into sub-groups of 7 to 8 members.
- Give them a child sexual abuse at it plays out in a school or child care institution (depending on whether the participants are teachers or child care institution staff/ counselors). One of the children has just come to you (as teacher/ counselor) and reported that he/she has been sexually abused by a staff member in the same institution. You inform the head of the institution…who is confused about what to do and how to make decisions regarding reporting to the police. Meanwhile, the trustees/ board members come to know and they are pressuring the head to suppress the matter because the reputation of the institution is at stake; information has leaked to the media who is now calling and demanding to know what is happening; the Ministry of Education/ Child Welfare is calling and pressuring the institution to suppress the issue and say that such a thing has not happened at all. The parents of the concerned child are upset and anxious and blaming the school/ institution for being careless, and demanding justice and action. Other parents/the public are outraged and staging a protest outside.
- Ask each sub-group to play out the situation along with how they will deal with the situation i.e. what position will they take regarding the abuse incident, how will they respond to the various people pressuring them, including media, politicians, government officials and general public?
  [Hint: The resolution should be such that the child ultimately receives justice and assistance].
- Allow about 30 to 40 minutes may be provided for preparation of the role play—remind the participants to draw guidance from the hand-outs.
- Invite each sub-group to play out the situation, including how they would go about resolving it.

Discussion:

- Invite participants to comment on each sub-group's role play and resolution.
- Was the situation resolved? Were people assuaged? Did the child receive justice? Were the positions taken by the institution child-centric?
- Based on this simulation, what are some critical elements of engaging with systems?

4. Field Practice

4.1. Supervised Field Practice

Objectives

- To enable participants to apply the knowledge and skills gained in the workshop.
- To enable them to translate theoretical knowledge into practice and action.

Time

Half a day

Concept

The last few days of training have been classroom-based i.e. although heavily skill-based, all the learning was still done through discussion and simulation processes. Theoretical knowledge now requires to be translated into practice by actually working with children and attempting to use all the conceptual frameworks and skills learnt in the workshop. Participants will also gain considerable confidence when they are able to apply their learning in the field, and also realize what their gaps in knowledge and skill are, to return for further clarification. Such a process makes learning both relevant and iterative, thereby strengthening the actual field practice of each participant, and consequently ensuring that children are served. Else, a lot of training workshops are conducted…there is little monitoring or follow-up in terms of its use and impact, consequently making training and capacity building initiatives acts of tokenism!

As Safdar Hazmi said, 'the limit of your capacity is the limit of your experience'. The concept of praxis differs from practice in that it is the manifestation of the relationship between theory and practice. Thus, all the concepts detailed in this manual need to be practised over repeated trials for the transformation to occur into effective field praxis.

Activity for Field Practice

*To be done by all participants on the last day of the training workshop.

Material: (Relevant) Assessment proformas

Method: Practical implementation of individual assessments in a child care institution/ school

Process:

- Select (with the support of the organizing agency) a child care institution/ school.
- Ask the institution staff to provide a group of about 10 to 15 children of similar age group (it could be children between 8 and 12 years or an adolescent group).
- The facilitator of the workshop then does one life skills activity (as a demonstration).
- Next, another life skills activity is done by some of the participants—with the support and supervision of the facilitator, as required.
- Re-assemble (in a separate space) and discuss in plenary the experience of the participants—what went well? What did they feel confident doing? What part of their group work with the children was challenging? Provide suggestions accordingly—encourage participants to also assist each other with solutions.

**Note 1: It would be useful to make plans for this field practice session the previous day, during the workshop i.e. when the life skills methodologies are being discussed.*

***Note 2: If the trainee group is large (like 30 participants), it would be preferable to divide into two groups—and run the session with two groups of children in the institution. If the number of trainees far exceeds the number of children, the space could become uncomfortable over-crowded and/or the children could become distracted and intimidated.*

4.2. Homework Assignment

Objectives

- To enable participants to continue to apply the knowledge and skills gained in the workshop.
- To enable them to translate theoretical knowledge into practice and action on a sustained basis.

Concept

Participants need to apply and experiment with methods learnt in the workshop, to work with and assist children with trauma, in their field settings.

Activity for Homework Assignment

*To be completed by all participants who attended the training workshop, in the weeks following the workshop.

Material: (Relevant) Assessment proformas/life skills activity materials

Method: Practical implementation of individual assessments and interventions; and of group sessions/ life skills training activities in a child care institution/ school

Process:

Assignment 1: Case Work on Loss & Death Issues

- Select 1 child in your institution who has undergone the trauma of loss/ death.
- Use the assessment format and take a detailed history of the child, including problem summary and care plan.
- Next, use the matrix discussed in the workshop (Context/Experience/Inner Voice/Emotion/Behaviour) to analyze the child's psychosocial issues—you need to use the information collected through the assessment form/ interview and plug it into the matrix.
- Do the interventions using the methods you learnt in the workshop and list/explain your interventions as follows:
    - Social and systemic interventions (such as placement/ school and other such arrangements you made for the child)
    - Psychological inputs/ counseling
- Challenges you faced while doing the counseling interventions.
- You will need to present your case at the next workshop.

Assignment 2: Case Work on Child Sexual Abuse

- Select 1 child in your institution who has undergone child sexual abuse experiences.
- Use the assessment format and take a detailed history of the child, including problem summary and care plan.
- Next, use the matrix discussed in the workshop (Context/Experience/Inner Voice/Emotion/Behaviour) to analyze the child's psychosocial issues—you need to use the information collected through the assessment form/ interview and plug it into the matrix.
- Identify (based on your assessment), what method of sexual abuse the perpetrator used with the child. (Was it lure-inducement-manipulation or coercion-threat…?)
- Do the interventions using the methods you learnt in the workshop and list/explain your interventions as follows:
    - Social and systemic interventions (such as placement/ school and other such arrangements you made for the child)
    - Psychological inputs/ counseling
- Challenges you faced while doing the counseling interventions.
- You will need to present your case at the next workshop.

Note: *Since you are expected to do depth interventions, you will require a minimum of 6 to 8 sessions with the child. Even if you do not complete the intervention process, you should have done at least some of the interventions/ used some of the methods taught.*

Assignment 3: Life Skills (Group) Sessions

- Select a group of 10 to 15 children in your institution.
- Use the life skill manual given to you to implement sessions for the children.
- You should aim to do at least one session per week (4 to 5 per month) with each session being an hour long.
- You may either follow the order of the life skills activity book and start at the beginning and proceed…or you may select particular themes (such as anger, conduct…) that are especially relevant to your institution/ children.
- You need to document EACH session you do as follows:
    - Target Group
    - Session objective
    - Activity implemented (process)
    - Discussion of the activity
    - Observations & challenges (Children's responses/ your observations about the children and how the methodology worked…)
- You will need to present your work in the coming months (time to be decided).

Note: The next workshop (on Working with Children in Conflict with Law) should be scheduled about 3 months after this one. It would be useful to spend half a day before starting that workshop to discuss and review the homework assignments done—so that the facilitator is aware of how much learning and practice has taken place following the previous two training workshops. Any emerging gaps and challenges may be plugged before proceeding to new content.

Tough facilitators, with serious commitments to training and child work, would generally not permit participants to move onto the next workshop (i.e. the next level of learning) unless the homework assignment is done! This is really to ensure that participants are ready to proceed to higher and more complex levels of work with children.

Annex I

Guidelines for Psychosocial and Mental Health Assessment for Child Sexual Abuse

A. Demographic Details:

Name, Gender, Age, Date of Birth, Gender, Place of Residence/Address, Who the Informant is and how he/she is related to the child

B. Referral

- Agency Referral (Child Welfare Committee/ National & State Commissions for Protection of Child Rights, other medical specialists such as GP/Paediatrician/Gynaecologist): A letter from referral service/agency should be requested/filed, including the date and time of referral and the time lag between this and the initial consultation with the mental health/ other medical services; the Letter from the referral agency should state circumstances of referral, whether a case has been filed, and the current status of the case. If a case has been filed a copy of the First Information Report (FIR), Sexual Offence Report is required for our case file.
- Self-referral—by child's parents: whether parent or primary caregiver is present at the time of initial and subsequent consultations should be noted; in case only one parent is available, information about the other parent and his/her absence, possible parental martial conflict/ separation/ divorce issues, or the fact that the alleged perpetrator of CSA could be one of the parents, need to be documented; relevant identification and contact numbers of persons accompanying the child/adolescent should be noted. [Again, if parents/ caregivers have filed an FIR, a copy of this must be placed in the file].

C. Initial Account of Abuse Incident(s)

Documentation should include information (obtained from persons accompanying the child and/or child if child is willing to provide the information) regarding:

- Circumstances of the alleged abuse
  - Who was the alleged perpetrator?
  - What happened?
  - Where it happened?
  - When it started, the number of times abuse occurred?
  - How disclosure came about and circumstances following disclosure?
  - Where and with whom is the child living now? Is he/she safe there?
- Agencies that the child and family have been in contact with prior to the referral to mental health establishment/ pathway to referral to mental health establsihment (e.g.: Police, Child Welfare Committee (CWC), National/ State Commission for Protection of Child Rights, Child Protection Services, Other hospitals, NGO)
- Collateral information from other sources (e.g.: Police, CWC)

D. Medical Examination and Tests

- In case of penetrative and/or abuse that caused physical injuries, check if requisite medical examinations and tests have been conducted and ask for the reports/ documentation on these tests.
- Medical tests and examinations include physical examination for injuries, HIV testing and pregnancy testing (the last depends on the age/sex of the child).

E. Mandatory Reporting Query

In case CSA was not the primary context of consultation and that it emerges in the course of the mental health assessment from caregiver/child i.e. it is not a case referred by any government/ welfare/legal authority:

- Explain to caregivers and older children/ adolescents the mandatory reporting clause in POCSO Act 2012.
- Offer assistance if they wish to report to police/ legal authorities.
- Do not coerce child or caregivers if they do not wish to report at this stage.
- Ensure that you have documented the discussion on mandatory reporting.

F. Assessing for CSA-Associated Psychiatric Morbidity:

Children need to be assessed for common mental health disorders resulting from CSA are Post-Traumatic Stress Disorder (PTSD), Depression and Anxiety. Below are some suggested scales and checklists for use with children:

- Child Depression Rating Scale (CDRS-R)
- Screen for Child Anxiety Related Disorders (SCARED)
- Children's Impact of Traumatic Events Scale (CITES)

Ask the parents/caregivers about emotional and behavioural responses and changes in the child following the abuse incidents; older children and adolescents may be interviewed directly to understand emotional and behavioural changes.

G. Academic and School History

This includes the child's educational and school status, the child's academic performance (both current and past) and any learning issues/ disabilities the child may have.

H. Family History

This includes basic demographic information on the child's parents/ caregivers (in terms of their educational qualification, occupation and income level) as well as the child's living arrangements, parental relationships, child's emotional relationship & attachment to parents, illness & alcoholism in parents, parental marital conflict, single-parenting, any loss experience suffered by child of primary caregiver.

I. Institutional History

This includes information on places the child has lived in other than the family home (if applicable)--which institutions child has lived in or is living in currently, for what periods of time, reasons for institutionalization.

J. Mental Status Examination

Upon first contact or during the first meeting with the child, he/she should be assessed for:

- General appearance
- Speech, mood, thought, suicidal ideation, perceptual disturbances, orientation
- Signs of subjective distress, clinging, crying, reactions to touch

Developmental Assessment for Sexually Abused Child

The developmental assessment requires to be completed before any forensic interviewing processes and/or interventions are entered into with children for eliciting abuse narratives. The purposes of conducting a developmental assessment in the context of CSA are two-fold:

- To make decisions about the feasibility and use of methods to elicit the abusive narrative in accordance with the developmental abilities of the child, for treatment and intervention purposes and/or as part of evidence gathering for court cases/ legal processes.
- To be able to design and/or deliver age-appropriate interventions; this includes the use of communication and methodologies that are comprehensible to a child in the course of treatment, including to provide personal safety education and awareness (which forms a part of the treatment interventions).

There are 5 specific domains of development that children require to be assessed in: physical or locomotor, speech and language, cognitive, social and emotional development. If the abilities and skills in these domains are not age-appropriate, then there are implications for forensic interviewing and evidence gathering for court cases and legal processes.

Box 3: Applying Child Development Assessment to Child Sexual Abuse Inquiry & Intervention

- Narration (or statement provision) is a function not only of speech & language abilities but also of social, emotional and cognitive skills/ abilities of a child. Thus, exceptions to recording statements for legal and mental health processes must be made for:
  - very young children (ages 0 to 3.5 years)
  - children with intellectual disability
  - children with speech and language delays/ problems
  - children (of any age) with severe trauma/ post-traumatic stress disorder and associated dysfunctionality

*In such cases, statements from parents and caregivers and/or mental health professionals should be recorded.

- At a minimum, a child has to be about 3.5 years of age, to even attempt taking a statement.
- Children with intellectual disability including speech & language delays will need to be assessed by mental health professionals, to understand what their developmental abilities and deficits are…and whether or not they will be able to provide a narrative.
- The child's emotional state of readiness needs to be considered before engaging in child sexual abuse inquiry processes. If the child is recovering from serious injury or medical issues and/or PTSD, adequate time must be allowed for recovery before broaching inquiry regarding the abuse incidents.
- Additional/specialized assistance from translators, and sign language professionals should be sought in case the child has speech and language disabilities.
- Play, art and other creative methods should be used to elicit narratives from young children and/or children with intellectual disability.

Annex II

A Perspective on Child Sexual Abuse Prevention

Some Thoughts on Child Sexual Abuse Prevention

Can CSA really be prevented from occurring?

- Limitations of human nature will always exist.
- Those motivated to engage in CSA will always find ways to do so.
- Child safety policies (CCTVs/ background checks etc), though useful, as they act as deterrents, cannot totally prevent abuse.
- Coercive/ violent acts of sexual abuse are not preventable i.e. children cannot be expected to protect themselves in the wake of brute force.
- Non-coercive forms of CSA (contact and non-contact) occur due to the nature of child adult relationships i.e. hierarchical/ authoritative…in a culture of obedience, where it is not acceptable for children to say 'no'…protecting themselves from CSA is difficult.

Thus, CSA cannot actually be prevented—a motivated abuser will always find ways of perpetrating abuse.

So then, what does CSA prevention really mean? How can preventive activities help?

Doing awareness and prevention programs help as they ensure…

- Early reporting by children and caregivers (to prevent further/ continued abuse).
- Increased alertness and ability of child to resist (further) abuse. Therefore, awareness and prevention activities need to be implemented both with children who have not been abused to protect them, as well as children who have been abused, so that they have greater clarity and understanding and can be protected from abuse in the future.
- Reduced psychological morbidity (greater awareness and understanding of abuse will mean that there are less chances of shame/ guilt and negative self-thoughts in children).
- Children and adolescents at risk (such as those from difficult family situations, those with poor social skills, learning problems all of which lead to poor self-esteem/ need for attention and affection) can be better equipped to protect themselves from abuse.

Thus, *Prevention= Response=Prevention or prevention is a part of CSA response.

You may refer to the Community Child & Adolescent Mental Health Service Project's activity books on personal safety and child sexual abuse prevention, to design and implement preventive programs with children and adolescents. There are 3 activity books, designed for varying age-groups:

- Child Sexual Abuse Prevention and Personal Safety (for Children aged 4 to 7 years)
- Child Sexual Abuse Prevention and Personal Safety (for Children aged 7 to 12 years)
- Life Skills for Adolescents Series (II): Sexuality & Relationships

These activity books use creative methods and techniques such as movement games, body mapping, art, board games, adaptations of traditional children's games (such as hopscotch), story-telling and narratives, and film clips.

Finally, while sexual abuse cannot be prevented, what can be prevented is the mental health morbidities that sexual abuse can give rise to in children and adolescents. Adult mental health problems that find their roots in child sexual abuse is well-documented. Awareness amongst children, and timely reporting can also ensure that children receive the psychosocial care and mental health assistance they require, to prevent serious mental health morbidity both in the present and future.

Annex III

Identifying Abuse and Maltreatment in Child Care Institutions

Community Child & Adolescent Mental Health Service Project
Dept. of Child & Adolescent Psychiatry, NIMHANS

Supported by Dept. of Women & Child Development, Government of Karnataka

September 2018

1. Background & Rationale for Monitoring Child Care Institutions on Abuse and Maltreatment Issues

Following the alleged sexual abuse and assault of children in a shelter home in Muzzafarpur, Bihar, the Dept. of Women & Child Development, Government of Karnataka proposed to take tighter measures and formulate systemic methods to ensure the safety of children within the state Juvenile Justice system. Upon request of DWCD, the NIMHANS team has developed this document to enable relevant authorities, including DWCD personnel, child welfare committees, juvenile justice boards and indeed all other stakeholders engaged in care and protection of vulnerable children, particularly those housed in child care institutions, to better understand and monitor children's safety from abuse and exploitation. This document lays out standards and methods that are for use to identify abuse and maltreatment in CCIs; it is meant to complement (not substitute) other monitoring tools and formats that individual states may have already developed, in order to monitor the general functioning of CCIs. While abuse may be physical, sexual or emotional in nature, this guideline focuses primarily on identification and response to on physical and sexual abuse in child care institutions.

1.1. Current Issues & the Context of Juvenile Justice

In recent years, there have been increasing reports of child sexual abuse (in all likelihood, always prevalent but under-reported) across the country. In the context of children in care and protection, or children in institutions, most incidents of child sexual abuse are known to have occurred before the child is placed under state care i.e. when the child was living with family/ in the larger community and/or in the street. Thus, the child is then afforded protection through

child welfare committee services and state care, in institutions run by government and non-government agencies.

When a child is placed in a child care institution (CCI)[4] registered under the Juvenile Justice Act or the Dept. of Women and Child Development / Dept. of Social Justice and Empowerment or other relevant state departments, the child is automatically assumed to be safe and protected. While this assumption is not an incorrect one, there unfortunately continue to be instances where such vulnerable children are abused and exploited, even in child care institutions designated for their care and protection. For instance, in 2007, a PIL was filed at the Supreme Court based on a media report drawing attention to alleged sexual exploitation of children in orphanages in Mahabalipuram, Tamil Nadu; most recently, there have been cases of alleged sexual abuse of girls at shelter homes in Muzzafarpur, Bihar and Deoria, Uttar Pradesh. In fact, the Supreme Court has taken *suo moto* cognizance of the Bihar incident, and has since, directed the Ministry of Women and Child Development to place before it the data of social audit and survey conducted in shelter homes across the country

While it is the incidents of sexual abuse in CCIs that have often made news headlines, the fact is that other forms of abuse are also rampant in these institutions. The Tata Institute of Social Sciences report on shelter homes in Bihar (through which the Muzzafarpur home incidents came to light) also describe other forms of abuse that are perpetrated against the children, from serious physical violence to being forced to work in the houses of the institution staff, and emotional and verbal violence. According to this report, such maltreatment of children has also led to them resorting to self-harm and suicide behaviours.

Alas, what we know of the above-mentioned child care institutions is perhaps only the tip of the iceberg. Some of the main reasons for the enactment of the Juvenile Justice Act were to *'impose on the State a primary responsibility of ensuring that all the needs of children are met and that their basic human rights are fully protected'* and that *'children are given opportunities and facilities to develop in a healthy manner and in conditions of freedom and dignity and that childhood and youth are protected against exploitation and against moral and material abandonment'*. It therefore becomes doubly ironic and against the mandate of the JJ Act when children within the care and protection systems are abused and maltreated. If the very agencies and systems that are responsible for providing protection to some of the most vulnerable children in the country i.e. children who are orphaned/abandoned/(previously) abused/ HIV infected or affected and disabled, are abusive and exploitative instead, it is a serious concern—in fact, the POCSO Act 2012 terms (sexual) abuse by a caregiver of a child as 'aggravated abuse'. In the light of the above, it is critical to devise monitoring systems that will ensure the continued safety, care and protection of vulnerable children, especially those in institutions.

1.2. Definitions of Child Abuse and Maltreatment

[4] CCIs include children home, observation home, special home, place of safety, specialized adoption agency and open shelter, which also house children in need of care and protection, and those in conflict with law.

Childhood abuse and maltreatment refers to any interaction or lack of interaction by adults, whether families, caregivers or others, that results in harm to physical, mental and developmental states of children. Child abuse can be broadly categorized as follows:

c) Acts of omission:

- Consist of things caregivers *should do* to children but do not do—which amounts to neglect.
- Comprise of psychological neglect, sustained parental non-responsiveness and psychological or physical unavailability.
- For instance, parents/ caregivers who do not respond to children with love, affection and caring; or do not take care of the physical/medical/ nutritional needs of children.
- It also entails depriving children of educational, play and recreational and other opportunities they require for optimum growth and development.

d) Acts of commission:

- Things caregivers *should not* do to children but do them, and so hurt children.
- Involves actual trauma directed toward the child in the form of acts of abuse, whether physical, sexual, or emotional/psychological.

More specifically, child abuse may be of the following types:

Neglect & Physical Abuse

- Entails inadequate parenting or caregiving where there is potential for injury resulting from omissions of caregivers.
- Involves poor hygiene, lack of compliance with medical therapy, malnutrition that occurs due to lack of proper feeding practices by caregivers.
- Any non-accidental physical injury to the child and can include striking, kicking, burning, or biting the child, or any action that results in a physical impairment of the child.
- Includes corporal punishment—which refers to use of physical punishment, force or threat to decrease the frequency of child misbehavior, but that results in (risk of) injury to the child.

Sexual Abuse:

- Is an interaction between a child and an adult where the child is used for sexual stimulation.
- Entails exploration of sexuality between a minor, traditionally understood as below 18 years of age, could be exploitative if the age difference between them is more than 5 years.
- Includes but is not restricted to rape/penetrative genital contact (whether by using the body or any other external object).
- May involve digital handling of the child's genitalia, non-genital forms of sexual touching as well as non-contact forms of abuse for the pleasure of the perpetrator such as exposing the child to pornography or taking nude pictures of the child.

Emotional Abuse:

- Behaviors, speech, and actions of parents, caregivers, or other significant figures in a child's life that have a negative mental impact on the child or seriously damage the emotional health and development of a child.
- Examples of emotional abuse include:
  - name calling
  - insulting or humiliating

- discriminating against a child based on caste, gender, (lack of) abilities/talents or any other issue
- threatening violence (even without carrying out threats)
- allowing children to witness the physical or emotional abuse of another
- withholding love, support, or guidance

- Children who are neglected, or physically or sexually abused also suffer emotional abuse.

1.3. Consequences of Child Abuse and Maltreatment

Depending upon the age of the child, immediate impacts of child abuse can range from post-traumatic stress disorder, anxiety and depression, to confusions and mistrust about interpersonal relationships; children's developmental trajectories (i.e. their achievement of milestones) can be adversely impacted with disruptions in their day-to-day functioning resulting from the psychological trauma.

- **Adverse Impact on Developmental Trajectories**

- Direct injuries resulting from abuse could adversely affect children's physical and loco-motor development.
- Trauma impairs children's daily functioning in terms of feeding and sleep patterns, thereby impacting their nutritional and health status, which in turn, affect growth and development.
- Severe trauma interferes with the usual acquisition of self-capacities and developmentally appropriate skills in children.
- Both due to pre-occupation with the trauma event and related anxieties, as well as developmental impairment, it becomes difficult for children to acquire and process new information, develop family, social and peer relationships.
- Due to the impact on socio-emotional development, there is likely to be impairment of functions relating to self-identity, social and cognitive skills.

- **Negative Assumptions about Self**

- Negative assumptions refer to how the child makes inferences based on how she is treated.
- Example: "I must be basically unacceptable/ bad"; "something must be basically wrong with me to deserve such punishment".
- Consequently, the child perceives herself as weak and inadequate.
- Child also views others as dangerous or rejecting or hurtful.
- Negative assumptions about self can lead to poor self-esteem and difficulty in forming or maintaining healthy inter-personal relationships.

- **Trauma Flashbacks**

- Trauma flashbacks refer to re-experiencing trauma at a later time (weeks, months or even years after)—as flash backs.
- Thoughts can be triggered or 'switched on' by exposure to some environmental stimuli or experience that is similar to the trauma.
- Children remember the details of event, especially sights, sounds, touch and other sensations—and these often cause distress and anxiety that impair functioning.

- **Interference in development of emotional regulation skills**

- Emotional regulation refers to the ability to manage and control emotions, particularly difficult emotions such as anger and anxiety, in the wake of provocative situations.

- Children who have been abused are at risk of being more easily overwhelmed by emotional distress
- They tend to use maladaptive ways to cope with stress, such as dissociation (fainting/ black-outs) and other methods of avoidance.
- They have difficulty in responding in a 'balanced' way, within a moderate range of emotions: the slightest provocation, even if unrelated to the event may produce extreme reactions of extreme fear or anger—which create difficulties for them in social and inter-personal situations.
- Preclinical and clinical studies have shown that repeated early-life stress and trauma experiences lead to alterations in central neurobiological systems leading to increased (mal) responsiveness to stress; this in turn increases the risk of psychopathology in both children and adults.

There is also considerable evidence on how adult survivors of child sexual abuse are at high risk of developing various types of mental health morbidities: anxiety, depression, self-harm, and substance abuse, which may have their roots in childhood and adolescence, following abuse trauma, are known to continue into adulthood, affecting individuals' sense of self-efficacy and identity, long-standing interpersonal difficulties, as well as distorted thinking patterns, emotional disturbance, and continued posttraumatic stress.

2. Objectives of Monitoring Abuse and Maltreatment Issues in Child Care Institutions

- To ensure that child care institutions are places of care and protection, in accordance with the provisions of the Juvenile Justice Act 2015.
- To monitor protection concerns in child care institutions through (early) identification of abuse and maltreatment issues.
- To provide speedy and timely assistance to affected children found to be in situations of abuse and harm while residing in child care institutions.
- To enable relevant authorities and child services to undertake timely and appropriate actions against caregivers and other functionaries and stakeholders in the care and protection system for protection violations committed by them.

3. Role of Child Welfare Committees & Juvenile Justice Boards

The Juvenile Justice Act 2015 has adequate provisions for addressing child protection issues both within and outside the state child care and protection system. It is therefore suggested that as the child welfare committees (CWCs) and juvenile justice boards (JJBs) are already vested with the powers/ functions to monitor child protection issues and visit child care institutions to do so, it would be most suitable for these bodies to undertake the abuse monitoring function in child care institutions. In fact, some of the specific roles and responsibilities ascribed to CWCs and JJBs make clear their functions relating to child protection of institutionalized children.

Amongst others, there are three CWC functions outlined in Chapter V of the JJ Act that have particular reference to monitoring (and responding to) abuse issues in child care institutions:

- *Conducting inquiry on all issues relating to and affecting the safety and well-being of children under this act'.*
- *Ensuring care, protection, appropriate rehabilitation or restoration of children in need of care and protection, based on children's individual care plan, and passing necessary*

directions to parents or guardians or fit persons or children's homes or fit facility in this regard.

- *Taking suo moto cognizance of cases and reaching out to children in need of care and protection, and who are not produced before the committee, provided that such decision is taken by at least three members.*
- *Taking action for rehabilitation of sexually abused children who are reported as children in need of care and protection to the committee, by Special Juvenile Police Unit or the local police, as the case may be, under the Protection of Children from Sexual Offences Act 2012.*

The JJ Act also states that *'a visit to an existing child care institution by the Committee, to check its functioning and well-being of children shall be considered as a sitting of the committee'.*

Likewise, according to the JJ Act, the functions of the JJB includes *'Conducting at least one inspection visit every month of residential facilities for children in conflict with law and recommend action for improvement in quality of services to the District Child Protection Unit and the State Government'.*

Thus, drawing from the Juvenile Justice Act and its provisions relating to children in institutions, whether they are children in need of care and protection or those in conflict with the law, it would be essential for CWCs and JJBs, as part of their child protection function, to undertake monitoring of child care institutions, including identification and reporting of abuse. However, other child protection staff, such as the District Child Protection Officer (DCPO) and officers of the District Child Protection Units (DCPUs) who frequently visit and monitor child care institutions and their functioning, must also be equally alert to identify and report abuse issues.

4. Indicative Guidelines for Identification of Abuse & Maltreatment in Child Care Institutions

A. Basic Information:
Agency Name & Registration:
No. of Children:
Age/ Gender of Children:
Staff Details (No. and Designations):

B. Establishing Abuse
In order to detect and monitor incidence of child abuse in institutions, a conceptual framework comprising of various strategies, at several levels, has been developed as follows:
Level 1: Observation of Signs & Symptoms of Abuse
Level 2: Discussions with Children
Level 3: Medical & Psychiatric-Mental Health Records
Level 4: Individual Interviews with Institution Staff

The levels are based on an index of certainty, with levels 1 and 2 representing the highest index of certainty of abuse i.e. where it may be presumed that abuse has occurred; and levels 3 and 4 are used to corroborate information from levels 1 and 2.
The framework and questions below can be used in the following situations:

- For routine monitoring purposes, during child protection staff visits to an institution, to detect abuse in case it is incident;
- In the aftermath of any reports regarding child abuse within an institution, to facilitate inquiry and investigation on abuse-related issues.

Level 1: Observation of Signs & Symptoms

When child protection staff visit an institution, they need to be alert to certain observable signs of physical and sexual abuse. This forms the basis of suspicion of abuse and consequent investigations into child care services and facilities within that institution. While the physical signs and symptoms of child abuse, both physical and sexual, and neglect may differ somewhat, the emotional and behavioural consequences are largely similar or over-lapping.

Identifying physical signs of abuse and neglect through observation is particularly important in the context of institutions providing care to children between 0 to 6 years and to children with intellectual and other disabilities. This is because many of these children are non-verbal and/or because of their developmental stage (or developmental disability) will be unable to articulate their experiences or express their discomforts. Thus, young children and those with disability are particularly vulnerable to various forms of abuse and neglect, and other child rights violations—and particular alertness and care in required when monitoring institutions housing such children.

Level 1: Observation of Signs & Symptoms

Physical Signs	**For Physical Abuse** **• Bruises, welts, black eyes or other injuries that can't be explained or don't match with the child's story.** **• Burns that cannot be explained.** **• Injury marks that have a pattern, like from a hand, belt, or other objects.** **• Injuries that are at different stages of healing (bruises change colour over time)** **• Fractures and dislocations.** **• Wear clothing that doesn't match the weather -- such as long sleeves on hot days -- to cover up bruises.**
	For Sexual Abuse **• Pregnancy** **• Sexually transmitted infections** **• Genital injuries** **• Physical injuries**
	For Neglect **• Skin infections and sores** **• Appears dirty and has severe body odour** **• Has poor dental hygiene** **• Lacks sufficient clothing for the weather** **• Signs of Malnutrition:** **- Respiratory and other infections/ illness** **- Skin is thin, dry, inelastic, pale, and cold**

	- Cheeks appear hollow and the eyes sunken, as fat disappears from the face **- Hair is dry and sparse**
Emotional & Behavioural Signs	**• Sudden unexplained change in behaviour: School refusal, people avoidance** **• Sudden onset of bed wetting, aches, pains, general ill health** **• Symptoms of depression and Post-Traumatic Stress Disorder** **• Appear dull, listless and inactive.** **• Avoidance of any kind of touch or physical contact.** **• Fearful appearance always seeming to be on high alert.** **• Withdrawal from friends and activities.** **• Marks of self-harm/ self-injury (especially on arms/ wrists).** **• Sexualized behaviour (applicable only to sexual abuse).**

*****_Time-lines to be checked with child and in medical records, to establish whether these signs occurred during the child's stay in the institution or before admission to the institution._

Level 2: Discussions with Children

One of the highest levels of certainty is when children themselves disclose that they have experienced abuse. Frequently expressed concerns in this regard are: 'how can children be believed?' or 'what if they are not telling the truth?' At the outset, it is important to understand that it is unlikely that children lie about abuse-related issues—firstly, they have little to gain from such lies, and secondly, abuse is too complex a matter to concoct stories around, especially given the developmental abilities of children. In case of institutionalized children, generally drawn from exceedingly vulnerable backgrounds of abuse, neglect and family dysfunction, they are even less likely than their counter-parts from intact homes/ families, to 'make up' stories about abuse; this is because institutionalized children have no other security and support systems to fall back on, and so, on the contrary, tend to be reluctant to disclose abuse, for fear of losing what little support and facilities they have.

Another perspective on the (dis)belief issue may be taken by considering the following situations:

- We believe the children(who report that there has been abuse), and it is found later on, that it is untrue/ there has been no abuse, there are no harmful consequences per se—at least not to the children.
- We believe the children (who report that there has been abuse), and it is found later on, that it is true/ there has been abuse, then the children receive assistance and protection.
- We disbelieve the children (who report that there has been abuse), and it is found later on, that it is untrue/ there has been no abuse, there are no harmful consequences. (We are lucky that it actually did not happen!)
- We disbelieve the children (who report that there has been abuse), and it is found later on, that it is true/ there has been abuse, then children receive no assistance or protection…in fact, they continue to be abused.

So, whilst taking a position on (dis)belief, it is better to err on the side of belief than on the side of disbelief. In other words, if one were to make an error of judgement, it is better to believe and be wrong (since there will be no harmful consequences to the children) than to disbelieve and

be wrong (in which case the children will seriously suffer). In short, always believe—at least at first instance, and proceed with further investigations as necessary.

Some general guidance on Interviewing Children on Abuse-Related Issues:

- ✓ Be gentle and reassuring.
- ✓ Never hurry, harangue or force or threaten children to disclose their experiences.
- ✓ Remember that it is difficult for anyone to be disclosive about abuse experiences, and that you are a relatively new, unknown person to the children.
- ✓ Bear in mind that particularly for children who have experienced abuse, they are afraid and confused, no longer sure of who to trust—and that includes you.
- ✓ -You might, therefore, not be able to get the requisite information in a single interview/ discussion, and so may have to come back multiple times to the institution, for further discussions with the children
- ✓ Do not use the law as an argument in your persuasion i.e. talking about police and legal procedures (as true as those aspects are) only serve to intimidate children rather than encouraging them to be disclosive.
- ✓ Focus instead on the children's difficulties (in the wake of abuse), their right not to be hurt, and your commitment to assisting them.
- ✓ Reiterate issues of permission and confidentiality (outlined in the *'Introduction'* section of the discussion guidelines (below).

In interviews with children, it may be preferable to start with a group discussion, so that children do not feel threatened or singled out, as might happen if inquiry started with individual interviews. Also, the general questions are likely to yield generic information, that all children should have a chance to feed into.

Level 2: Discussions with Children

Introduction	***My name is……. You may have seen me here sometimes. My job is to work with children and ensure that they feel safe and protected…and to help them if they have any difficulties or are hurt in any way. Part of my job is also to make sure that children's institutions are run well and that children are looked after. I am here today to talk to you about your views and experiences—which are really important for me to understand. Also, whatever you share with me, will not be shared with the caregivers of the institution. If I feel that something needs to be done about the issues you share with me (in case there are difficult issues), I will first consult you, tell you whom I will speak to and only do so with your permission. [I would not do things without your permission as I do not want you to get hurt in any way].***
General Questions	***- Tell me about how you spend the day…what activities do you do from the time you wake up…?*** ***- Tell me about the different rooms and spaces in your institution…where do you eat? Where do you sleep? Where do you play/ do your homework?*** ***- What time do you eat dinner? And what happens after that…? What do you all do?*** ***- What are some of the things you like best about being in this***

	institution? ***- What are some things you find difficult about being in this institution?*** ***- Tell me something about each of the caregivers who are in this institution…we can name them one by one and you can tell me what they do here/ how they help you/ what activities each of them do with you…*** ***- In many institutions, children help out and do things around the place…like some chores related to cleaning and cooking. Tell me a little about what chores you do in this place…or if you do chores in any other place too (although you live here).*** ***- Has anyone forced you to do work/ chores that you don't want to do? Tell me about it…***
Questions about observable physical and emotional-behavioural signs of abuse	***- I see that (some of) you have hurt yourselves…I notice that you have marks on your arms/face…Can you tell me how these injuries happened?*** ***- Did you meet the doctor about these injuries? What did he/she say?*** ***- (Some of) you look a little sad and afraid (or dull)…is there anything that make you feel sad/ afraid/ angry?*** ***- Has anyone said or done anything that has made you feel upset or uncomfortable during the time you have been here?*** ***- Has anyone forced you to do anything that you don't want to do or that makes you uncomfortable? Tell me about it…***

As shown in the box above, there are three parts to the discussion, whether had with children either in a group or individually:

- An introduction of the child protection staff/team, so that children know and understand who they are speaking with and what the purpose of the discussion is; ideally (and time permitting), this stage should include a simple game and a round of introductions of the children too.
- General questions about the children's daily routine including places they go to and activities they do. In case children do not go to school or go to places/engage in activities that seem inappropriate, there must be a suspicion about abuse. It is also important to observe children's body language and non-verbal cues as they respond to questions—do all children respond? Do all agree or corroborate what some say about their routine and activities? Do several children appear silent and non-responsive? Do some children have a different response in terms of what they do? It is critical to wait for children to respond, listen for dissenting voices and gather information that is different from even what the majority voice may be, in order to identify abuse.
- Questions in relation to observable physical and emotional-behavioural signs of abuse may be asked in a group, especially if many children have observable signs of abuse; however, these questions may also be met with silence or resistance, by several children, who may be uncomfortable making disclosures in a group situation. Therefore, these questions, which elicit information that is very sensitive in nature, are better used in individual interviews with children in whom child protection staff observe signs of abuse and/or children who volunteer information and seem more ready to be vocal.

Level 3: Medical & Psychiatric-Mental Health Records

Level 3 of the inquiry entails correlation between observed signs and medical records/ reports and correlation between observed signs and psychosocial/ psychiatric records/ reports. Child protection personnel need to ask the child care institution superintendent and staff for the children's files and medical records to check whether and what types of treatment children have received for illness and injury and/or emotional and behavioural problems. If the medical records do not contain (adequate) reports of children's treatment or fail to corroborate children's accounts or do not adequately explain children's injuries and problems, it is indicative neglect and/or of abuse—and the matter may be reported to the relevant authorities for action.

As erstwhile mentioned, medical records are particularly important indicators for children in institutions providing care to children between 0 to 6 years and to children with intellectual and other disabilities. Since most of these children may be partially or completely non-verbal, it would not be possible to implement Level 2 of the inquiry with them.

Level 3: Medical & Psychiatric-Mental Health Records

Medical records explaining the injury marks/fractures/burns	**- Date of injury** **- Name/ details of agency that conducted assessment/ treatment *** **- Nature of the injury** **- How and when the injury/ illness occurred** **- Treatment child is under**
Psychiatric assessments and records explaining emotional & behavioural signs and symptoms:	**- Date of assessment** **- Name/ details of agency that conducted assessment/ treatment*** **- A detailed account of child's emotional and behavioural issues, including explanations on the context of the child's problems** **- Treatment inputs child has received**

***Credibility of individual and non-governmental organization assessments are likely to be suspect as monitoring and accountability of such entities is limited.

Level 4: Individual Interviews with Institution Staff

Considering that the objective is to identify abuse taking place within child care institutions, some or all child care institution staff are likely therefore to be responsible and/or involved in any child abuse that occurs in these spaces. They are also likely, therefore, like most perpetrators of abuse, to either completely deny abuse or to provide conflicting/ contradictory reports on

children's injuries/ health problems. In the light of this, interviews with caregivers are the last level of inquiry, and also lowest on the index of certainty.
Given the uncertainty of the role and positions of different institution staff, it would be inadvisable to conduct a group discussion as it would be critical to get different observations and viewpoints to understand the situation, especially in situations where some but not all of them may be involved in perpetration of abuse. A group discussion may not allow staff who have certain observations or information about abuse incidents to report these matters freely. It is therefore necessary to conduct individual interviews with each of the staff and with all of them—including part-time and full time staff, and those involved in direct care of children as well as those involved in administrative and cleaning tasks.

In case it is reported (by children or other sources) that the institution caregivers are involved in abuse perpetration, and/or in case there is denial or caregiver is unable to account for it or gives conflicting/ contradictory reports on children's injuries/ health problems, no further questions should be asked of them. The matter should be immediately escalated to the relevant authorities.

Level 4: Individual Interviews with Caregivers

Introduction	***My name is……. You may have seen me here sometimes. [or you know that I visit the institution/ work on child welfare issues]. Part of my job is also to make sure that children's institutions are run well and that children are looked after. I am here today to talk to you about your views and experiences of the children and the staff in this institution—I will be talking to each of the staff independently, as different people may have different views on how this institution is run…and so that each person can express his/her views freely. I will not share your viewpoint with any of the other staff members I talk to and interact with.***
Questions	***- Have you noticed any injuries/ health issues in the children? Tell me more about it?*** ***- Have you observed injuries?*** ***- Have children reported any injuries/ health problems to you?*** ***- Any sudden or unusual behavioural changes in the children? Sleep patterns/ feeding patterns/ socialization/ daily activity/ sudden onset of bed-wetting?*** ***- What measures have you taken to help children access treatment for injuries/ health problems and/or psychological problems?*** ***- Have children reported any misbehaviour to you about any staff here? Or have you observed any staff behaving in ways that you feel are not child-friendly?***

5. Response to Abuse & Maltreatment in Child Care Institutions

In case physical abuse and maltreatment is identified in a CCI, the CWC or JJB members may report the matter to the concerned personnel, such as the Project Director, ICPS, Director and/or Principal Secretary in the Dept. of Women and Child Welfare (or the concerned state department under which CCIs and care and protection of children fall).

In case of sexual abuse, the CWC/ JJB members would not only be required to bring the matter to the notice of the concerned government department, but also, as per the POCSO Act 2012, report the matter to the police.

Furthermore, after the concerned administrative and legal authorities have been informed and due processes are set in motion, the CWC/JJB members (along with the administrative authorities) need to ensure continued support to the children as follows:

- Removal and re-location of children to safe spaces or alternative child care institutions.
- Medical examination and treatment for injuries/sexually transmitted diseases/ tests for pregnancy (and related decisions for medical termination of pregnancy).
- Mental health assistance, with a focus on providing assessments and interventions for post-traumatic disorder and other anxiety and depression-related issues common in children who have undergone traumatic experiences, to ensure healing and recovery of abuse-related trauma, both in the immediate and longer term.
- Enablement of (institution) caregivers to provide psychosocial support to the children.
- Assistance to children and relevant legal personnel for facilitation of legal/mandatory processes, with particular focus on sensitive methods of child interviewing i.e. forensic interviewing undertaken in collaboration with mental health professionals.
- Medium to long term rehabilitation of the children, ensuring continued access to care and protection, education and mental health assistance as required.

Additionally, the concerned authorities need to ensure that assistance to children is provided in accordance with the following issues, so as to maintain child rights and child's best interests:

- ✓ The children cannot be subjected to multiple questioning by multiple agencies as victims of sexual abuse or sexual offences should not be required to re-live the trauma.
- ✓ The children's physical and mental health is best addressed by agencies that have the expertise in these areas.
- ✓ The police and other legal authorities will need to proceed with the investigations but such investigations should be conducted (keeping in mind the interest of the children) with the assistance of qualified medical and child mental health professionals (ideally from a government hospital or institution, so as to ensure adequate monitoring and accountability).

Annex II

Suggested Training Workshop Schedule

DAY 1		
9:00—9:30 am	Introduction	
9:30—10:15 am	**Trauma Basics**	The Experience of Trauma
10:15—11:15 am		Impact of Childhood Trauma
11:15—11:30 am	**The Trauma of Loss**	*Tea Break*
11:30 am—1:00 pm		Introducing Loss, Grief and Death Work with Children
1:00 –2:00 pm		*Lunch*
2:00—3:15 pm		Understanding How Children Experience Loss & Grief
3:15—3:30 pm		*Tea Break*
3:30—4:30 pm		First-Level Responses to Children's Loss & Grief Experiences
4:45—6:30		Film Screening & Discussion (Stanely Ka Dabba)
DAY 2		
9:00—10:30 am	**The Trauma of Loss**	First-Level Responses to Children's Loss & Grief Experiences
10:30—10:45 am		*Tea Break*
10:45 am—12:15 pm		Depth Interventions on Childhood Loss & Grief
12:15—1:15 pm	**The Trauma of Child Sexual Abuse**	*Lunch*
1:15—2:45 pm		Child Sexual Abuse Basics
2:45—3:00 pm		*Tea Break*
3:00—3:30		Medical Assistance for Child Sexual Abuse
3:30—5:30 pm		First Level Psychosocial Responses for Sexually Abused Children
DAY 3		
9:00 pm —10:30 am	**The Trauma of Child Sexual Abuse**	Longer Term Healing Interventions for Child Sexual Abuse
10:30—10:45 am		*Tea Break*
10:45 am—12:30 pm		Linking Sexual Decision-Making to Sexual Abuse
12:30—1:30 pm		*Lunch*
1:30—3:30 pm		Introducing the Practice of Life Skills Methodologies
3:30—3:45 pm		*Tea Break*
3:45—4:45 pm		Family & Systems Responses to Child Sexual Abuse
DAY 4		
9:00 am—3:30 pm	**Field Practice**	Supervised Field Practice
		Homework Assignment