The Building Blocks

Mental Health, Psychosocial Care & Protection for Children & Adolescents

Training Series 1

Developed by

Community Child & Adolescent Mental Health Service Project

Dept. of Child & Adolescent Psychiatry, NIMHANS, Bangalore

Supported by

Dept. of Women & Child Development, Government of Karnataka

"Childhood is measured out by sounds and smells and sights, before the dark hour of reason."

~John Betjeman

Contents

1. Introduction

1.1. Breaking the Ice

Methods: Interactive game

Materials: Music (any that the children may like or want to move to), player

Time: 15 minutes

Process:

- Ask the participants to form a large circle. Tell them that you will play music. While the music is on they have to move around shaking hands with as many children as they can. When the music stops, they have to freeze. (Do it).
- Now ask them, “Who are you?” Tell them to introduce themselves by name, to the participant standing near-by.
- Start the music again and ask the participants to move and shake hands as before. Stop the music and ask another question such as ‘one fun fact about yourself?’
- Repeat the process multiple times, varying the questions each time, starting with ‘who are you?’ and adding a new question such as:
    - What are your hobbies?
    - Your favourite film/ your favourite actor?
    - Why did you choose to work with children?
    - One thing you can’t live without…?
- Tell the participants that they need to ensure that they talk to someone different in each round/ when the music stops and the question is asked.

**You can tell the participants that this is a good ice-breaker to use with children…and the questions can include ‘what makes you angry?’, ‘when do you feel happy?’, ‘one thing you love about your friends?’, ‘One thing you don’t like about school?’…and so on, to get to know a new group of children.*

1.2. Our Learning Objectives and Methods

Method: Discussion

Materials: PPT Slides

Time: 20 minutes

Process:

- Welcome the participants and introduce the objectives of the workshop as follows:
  - Understanding children's psychosocial issues and protection concerns.
  - Practically applying child development concepts in child mental health and psychosocial work.
  - Building counseling and communication skills with a focus on:
    - Getting started with children.
    - Developing basic communication skills to facilitate supportive relationships between the child care worker and child.
  - Understanding common child and adolescent mental health issues, including administering assessments and developing individual care plans.
- Introduce the methods that the training workshop will use:
  - Slides/ materials
  - Do-and-learn (skills) such as role plays and case-study analysis
  - Participatory group activities and discussion
  - Film viewing and perspective-taking
- Explain how this workshop will not use lecture methods (which are boring and tedious)…that creative, participatory methods will be used to enable participants to bring in their experiences and reflect on children's issues and methods for use in child work.
- Emphasize the importance of skill building—how this workshop may be different from others as it not only helps to understand issues and concepts (which are important) but focuses heavily on how issues and concepts need to be translated into skills—without which participants' theoretical knowledge is of no use in the field (i.e. not helpful to children). So, the workshop will entail a lot of practice to learn skills.
- Request the trainees to participate freely—explaining that the workshop is not about 'right' and 'wrong' responses but about sharing, reflecting and also critiquing thoughts and ideas, in order to allow for new learning to emerge as well as to refine existing learning on child work.
- Let the participants know that this initial workshop is NOT going to equip them with depth therapy methods to deal with children's problems (more complex issues pertaining to abuse, trauma and children in conflict with the law will be addressed in later workshops)…that this workshop will be looking at the building blocks of counseling children, for, only when they have these skills can they move on to more complex issues and skills.
- Address any other expectations that the participants may have of the workshop.

2. Children & Childhood

2.1. Setting the Tone: Re-connecting with Childhood

Objectives

- To sensitize participants to children and childhood experiences.
- To enable them to be aware of and alert to children's experiences and emotions.

Time

1 hour 15 minutes (for a group of about 30)

Concept

Let us set aside psychosocial and mental health issues and counseling; let us just think and talk about children and childhood…by re-connecting with our own childhoods and remembering what our lives were about then…people, places and events…how we felt—things that made us happy, sad, angry…who were we as children? How did we perceive the world as children? What did we experience and feel? We are going to do a simple visualization exercise to return to our childhoods.

Activity for Re-Connecting with Childhood

Method: Visualization and sharing

Materials:
None

Process:

- Request participants to set aside their note books/pens (no note taking to be done now).
- Ask them to close their eyes and remember their childhood days. They may revisit people, places, events that occurred then.
- When they are ready (after about a minute or two), ask them to open their eyes and one by one, to share the images that came to their minds.
- Repeat the process (of visualization) asking participants to revisit childhood memories of difficult or traumatic experiences.

Note: Be prepared for some participants to become very emotional (to be crying) when sharing difficult and traumatic experiences. Acknowledge the courage of the participant and thank him/her for sharing his/her experience, credit the group for creating a safe space for difficult sharing…offer comfort (within the group) to the participant in a gentle and reassuring manner—before you move on with the session.

Discussion:

- Ask why this activity was done.
- How did you feel when you re-visited happy memories versus difficult and traumatic ones?
- Who helped/ how did you cope?
- The importance of being in touch with your own childhoods so you know what it is like to be a child, what makes children happy, angry or sad…
- How this sensitivity is essential to working effectively with children…
- The impact of childhood memories—how childhood events and experiences still impact us in adult life and therefore how childhood experiences, especially those of trauma and abuse, can never be undermined.

2.2. Power and Rights

Objectives

- To enable participants to identify and be aware of issues of power hierarchies relating to children.
- To introduce them to child rights-oriented thinking.

Time

1 hour 15 minutes

Concept

Given their physical maturity and age, children are one of the lowest in the social hierarchy. Add to childhood, socio-economic status, gender, disability and HIV status, and some children become meta-minorities—this means groups that are the most vulnerable and also those that are often the most discriminated against and who consequently end up receiving the least access to basic services and other needs.

In a welfare system such as our's, the response of child care service providers to children often tends to be paternalistic. For example, we frequently hear in child care institutions staff telling children 'how we have provided you with everything…and you still behave like this' or in case a child complains that the food is not good, 'what food do you want then? Biryani and kheer??'*[Ask participants to share their experiences of how caregivers or child care staff often respond to children].*

Inherent in these responses is an expectation of gratitude and also the implication that:

i) Children do not actually have the right to access survival needs;

ii) The provision or rather the conferring of these rights is therefore conditional i.e. upon their 'good' behaviour.

This attitude is also discriminatory in that it reflects that children in institutions do not enjoy the same rights as those living with their families with regard to survival needs—for, the latter are not obligated to express gratitude and behave well (at least not on a continuous basis) in order to avail of care and survival needs.

Further, if we really examine the nature of adult-child relationships, we can see that essentially the basis of these relationships are three-fold: expectation, instruction and obedience i.e. as adults, we have a set of expectations that children must fulfill, instructions they must follow and be unconditionally and unquestioningly obedient at all times! If they do not do this, then the child is labeled as problematic. What we are highlighting is that there is little dialogue and certainly no culture of conversations in adult-child relationships. Why is this so? Because of power hierarchies…the belief that adults have the right to take whatever actions they want to, say whatever they want to and that children do not…that children must merely be at the receiving end be accepting (worse still, grateful) of anything they get. For children who come from difficult socio-economic and family circumstances, they are already socially and emotionally disempowered; the response of child care service providers, including counselors, when they come from positions of

power, authority, paternalism or even patriarchy, result in further disempowerment of some of the most vulnerable children.

We therefore need to be aware of the power we hold as counselors or child care service providers and the ways in which we express it. Let us do an exercise to examine our understanding of power and rights, in relation to children.

Activity: Power and Rights

Method: Power walk

Materials:

- Labels/ identities of various persons, including children of different ages/gender/abilities, caregivers, childcare workers, people in authority/decision-makers. (See below).
- A list of statements relating to rights. (See below).

Process:

- Give identities (Power Walk Identities) to all the participants. Allot them randomly and ensure that each person gets only one.
- Ask them to spend a few minutes thinking about their respective identities i.e. the realities of the lives of the person whose identity they have taken. How does this person spend his/her day? With whom? What problems would he/she have and how would he/she cope?
- Organize the participants into a single line (at the far end of the room) and read the list of statements to them one by one—allowing for them to respond as required to each one.
- Tell participants: "For every statement you agree with i.e. can say 'yes' to, take a step forward. For every statement you disagree with i.e. would say 'no' to, remain in your place". (Remind the participants that they have to agree or disagree based on their identities).
- At the end of the statement-reading, participants will be spread out—some will have answered 'yes' to many questions and moved forward; others will have answered 'no' and remained at the back.

Discussion:

- How did you feel as the statements were being read? (i.e. as the person whose identity you were assuming)
- What characteristics can we identify with the people who moved forward? (age, gender, social and economic status etc).
- What are the risk factors associated with the people standing at the back?
- For those standing at the back, should they have been able to answer 'yes' to most statements? Why? (Introduce the issue of rights).
- Who are the groups of people, particularly children, who are deprived of rights? (List them).
- Would these persons/children (whose identities they have assumed) know of these rights or be able to claim them?
- So, how do power hierarchies play out, especially in relation to children? What are some examples of how power and hierarchy play out in child care institutions? (List them).
- Discuss how children, especially children in difficult circumstances (including those in care and protection and children in conflict with the law) are the most disempowered groups…but how even within children's groups, there are meta-minorities such as children with disability, street children…and how they are affected by power play by child care service providers.

Power Walk Identities (to be cut out as separate labels):

Local NGO Fieldworker	Local MLA	JJB Magistrate
Cook of Child Care Institution	House Mother/ Father	Superintendent of Institution
Primary School Teacher (Male)	Police Officer (Male)	District Child Protection Officer (DCPO)
Young Female Single Parent with 2 children aged 4 and 6 years	Uncle, looking after 2 children, 8 and 12 years old, who are separated from their parents	15 year old girl involved in sex work to support family
14 year old with physical disability restricting movement	10 year old boy with intellectual disability, requiring 24 hour care	16 year old daughter of local bank manager, planning to go to college
Child Welfare Committee (CWC) Member	Security Guard of Child Care Institution	13 year old girl in shelter, living on her own with 2 younger siblings
Grandmother caring for two orphaned children	8 year old boy who is orphaned	13 year old boy working on the street
8 year old girl with leg amputated after war injury	17 year old, pregnant	12 year old girl, class leader at primary school
14 year old boy in observation home	4 year old girl abandoned in bus stop	Medical doctor (female)
Disabled & unemployed father of two children	8 year old girl, orphaned and living in institution	10 year old boy, orphaned and living with aunt

Statements relating to Rights (To be read out)

- I can get warm clothes when the weather gets colder.
- I can access primary healthcare services if I need them.
- I can find out the about world around me through newspapers, television and radio.
- I get the opportunity for play and leisure such as going out and spending time with my friends.
- I am in no danger of being sexually abused or exploited.
- I get to see and talk to my parents (or caregiver) about my problems.
- I can pay for my health-related treatment.
- I am in no danger of being physically abused.
- I can influence decisions that affect me at a family level.
- I went to, or expect to go to, secondary school and complete my education.
- I am in no danger of emotional abuse and neglect.
- I will be consulted on issues affecting children or young people's lives.
- I have plenty of information about health issues that concern me.
- I have adequate food to eat everyday.
- I usually get to use a clean toilet and take a shower everyday.
- Clean drinking water is always available to me.
- I lost a limb and can access disability service

2.3. Applying the Child Development Lens

Objectives

- To understand the five key domains of child development.
- To understand how to address children's developmental needs.
- To understand how child development is impacted by deprivation i.e. in children in difficult circumstances.

Concept

Child development refers to the abilities and skills that an average child has at a particular age. There are, broadly-speaking, five domains of child development: physical, social, speech & language, emotional and cognitive development.

Why learn about child development?

- To identify any disabilities, gaps or deficits in development that a child may have and make decisions regarding placements and/or interventions that will help the child to develop optimally.
- To determine how to communicate/ interact with the child, including what methods to use for counseling interventions…how we talk to a 5 year old is different from a 9 year old and different from a 15 year old.
- To understand better the concerns and issues that a child may have as we respond to them—for instance, issues of love, attraction and sexuality form part of normal adolescent development but are not relevant to younger children; similarly, the kinds of stimulation and readiness activities necessary for pre-schoolers have no relevance to adolescence.

Mere knowledge of children's developmental milestones is not useful—what we need to know is how to apply the concepts of child development in our work with children. So, we are now going to do an activity to help us learn about child development in a practical way—to understand the abilities and skill children should achieve at various ages and what activities and opportunities we, as child care service providers, can use to enable the learning of these skills.

Activity: Child Development

Method: Pile Sorting

Materials: Child development cards (see below)

Process:

- Place (spread out) both types of (blue and yellow) child development cards on the floor, on one side of the room, so that they are clearly visible.

- Select 5 corners or spaces in the room and place the title cards i.e. domain, age and 'Abilities & Skills' and 'Needs & Opportunities' for each domain, to form a matrix as shown subsequently.

- Divide the participants into 5 groups assigning each group to one of the five domains of child development.
- Explain that there are 2 types of cards 'Abilities and Skills' cards (in yellow colour) and the 'Needs and Opportunities' cards (in blue colour).

- Now, ask them to look at (read) the cards and sort and categorize them in two rounds:
    - Round 1: Sort cards into 5 domains of development—wherein each group picks up (both yellow and blue) cards relevant to their domain i.e. you pick up the 'needs and abilities' cards pertaining to physical development or social development, depending on which group you belong to; similarly you pick up the 'needs and opportunities cards' that pertain to physical development or social development, depending on which group you belong to.
    - Round 2: Within each domain, each group sorts its cards into the five different age groups i.e. decides whether a card belongs in the 0 to 12 months, 1 to 3 years, 3 to 6 years, 6 to 12 year age group or 13 to 18 year age group, and places them accordingly in the matrix.
    - Blue cards ('Needs & Opportunities') should be placed not only within the requisite age group but also in such a way that they match the yellow/ 'abilities & skills' cards. (What opportunities are required to develop certain abilities/ skills?)

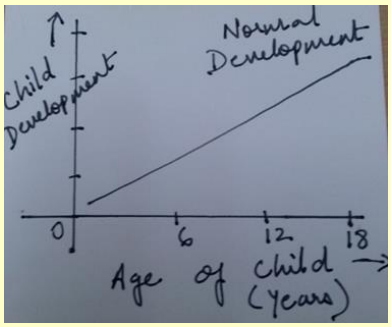
Note: A card generally needs to be read carefully to see which primary domain the skill belongs to (the domain in which the skill applies i.e. the context is the secondary domain) and placed in the domain it belongs to. For example, 'Complex use of language for higher level social transactions' could belong to two possible domains—Speech & Language or Social Development. But since the card focuses on language skills, the primary domain (and therefore where it needs to be placed) is Speech & Language Development, while the secondary domain (where the skill is applied) happens to be 'Social Development'. That said, some skills could belong almost equally in two domains, so the importance of the activity lies in understanding the concepts of development, not in trying to 'get the right answer'.

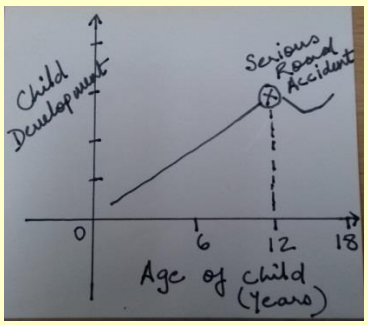
- When each group has completed their task, ask participants to walk around and view others' matrix…and ask for any cards that they feel belong to their own matrix!

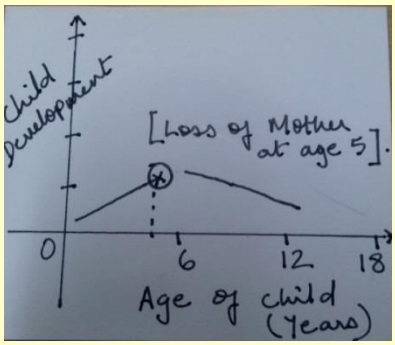
Discussion:

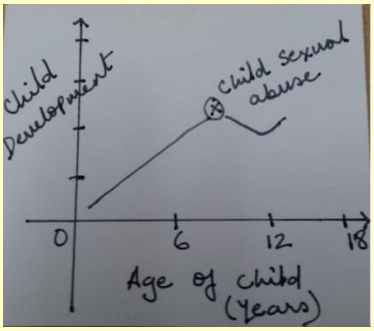
- View the categorization in plenary…by (the whole group) moving from one developmental domain matrix to another.
- Highlight specific skills and abilities; ask questions (and encourage participants to ask questions) of each sub-group about their decisions to categorize the cards.
- When you see some cards in a particular domain when they actually belong to another, discuss why they need to be elsewhere i.e. justifying why they belong to another domain.

- Discuss the following issues:
  - A card could actually belong in more than one domain of development—because the developmental domains are not water-tight compartments…one domain influences another. For example, children who have deficits in cognitive development are also likely to have gaps in social and emotional development; or children who have physical and locomotor deficits and consequently have mobility issues may also have issues with social relationships as they are unable to play and mingle with their peers and/or emotional issues as they may have poor self-esteem due to feelings of inability or inadequacy.
  - Thus, a primary deficit, in a single domain of development, could lead deficits and problems in other areas of development. So, it is important, even when a caregiver complains about a problem in one domain, to evaluate the child in all 5 domains.
  - Most psychosocial problems in children (even when we have diagnosed them using the child psychiatry disorder approach) may be viewed from a child development lens. For example, a child who has been sexually abused is likely to have problems with social skills (due to the anxiety that he/she has developed after abuse), emotional skills (due to low self-esteem issues); cognitive effects (attentional problems and learning difficulties, which in turn are due to emotional problems and anxiety).
- Ask participants to consider the impact of deprivation or life events such as trauma and abuse on child development—such as a young 4 year old who loses his mother, a 6 year old who is neglected, a child who is left in the care of her older sibling as the parents are migrant labourers and have to be at work all day, a street child…how might these events and experiences affect child development? What specific domains of development may be affected and how? (See graphs below) Or if a child has physical disability, how might his/her socio-emotional and cognitive development be impacted?









Let's Talk Attachment…

- Nature of the bond between child and care-giver
- Usually, attachment figure is mother (sometimes there can be extended attachments)
- Strong attachment is related to security and well-being
- Loss of attachment figure (through loss or separation) can give rise to insecurity and related anxiety problems—and later lead to emotional regulation and control problems (excessive anger/anxiety).
- Contexts/ Situations where child is at risk of insecure attachment:
  - Children in intact families: Parental conflict/ Neglect/ Non-response to child's needs/ Physical/ sexual abuse of children/ frequent experiences of separation from caregiver.
  - Other children: Abandoned/orphaned, Suffering loss in conflict areas,
  - Institutional upbringing,
  - Frequent change of care takers

Materials for Child Development Pile Sorting Activity

Make the cards by enlarging, printing and cutting out the cards (below).
It might also be necessary to translate them into the local language (as spoken by participants, particularly if they do not read or understand English)—in which case, keep the translations simple, colloquial and non-technical.

Physical Development	Social Development	Emotional Development	Cognitive Development	Speech & Language Development
0 to 12 months	0 to 12 months	0 to 12 months	0 to 12 months	0 to 12 months
1 to 3 years	1 to 3 years	1 to 3 years	1 to 3 years	1 to 3 years
3 to 6 years	3 to 6 years	3 to 6 years	3 to 6 years	3 to 6 years
6 to 12 years	6 to 12 years	6 to 12 years	6 to 12 years	6 to 12 years
13 to 18 years	13 to 18 years	13 to 18 years	13 to 18 years	13 to 18 years
Abilities & Skills	Abilities & Skills	Abilities & Skills	Abilities & Skills	Abilities & Skills
Needs & Opportunities	Needs & Opportunities	Needs & Opportunities	Needs & Opportunities	Needs & Opportunities

Balances Neck without Support	Crawls Forward On Belly	Looks toward Direction of Sound	Turns Head towards Bright Colours & Lights	Reaches for/Grasps Dangling Objects
Sits without Support if made to Sit	Stands Without Support/ Starts Walking	Reaches for/Grasps Dangling Objects	Grasps Small Objects Using Two Fingers (Thumb & Index Finger)	Screws and Unscrews Jar, Lids, Nuts, & Bolts
Runs Easily	Climbs onto / down from Furniture Unsupported	Walks Up and Down Stairs with Support	Can Drink From Open Cup, With Some Spilling	Puts into /Takes Out Objects from Container
Turns Pages of Book	Makes Vertical, Horizontal, Circular Strokes with Pencil/Crayon	Goes to Toilet during Day Time with Some Help	Fine Motor Skills: pre-writing skills, transfer functions, eye-hand coordination	Gross Motor Skills: Mobility, Ability to Handle Objects
Physical skills necessary self- help: buttoning, brushing, feeding etc.	Fine motor tasks easily achieved.	Full independence in self-care.	Development of secondary sexual characteristics.	Menstruation in girls
Makes Cooing Noises & Reacts to Sound	Babbles “Dadada....” “Mamama....”	Laughing & Squealing	Responds to Simple Verbal Requests, such	Follows Simple, One-Step Instructions

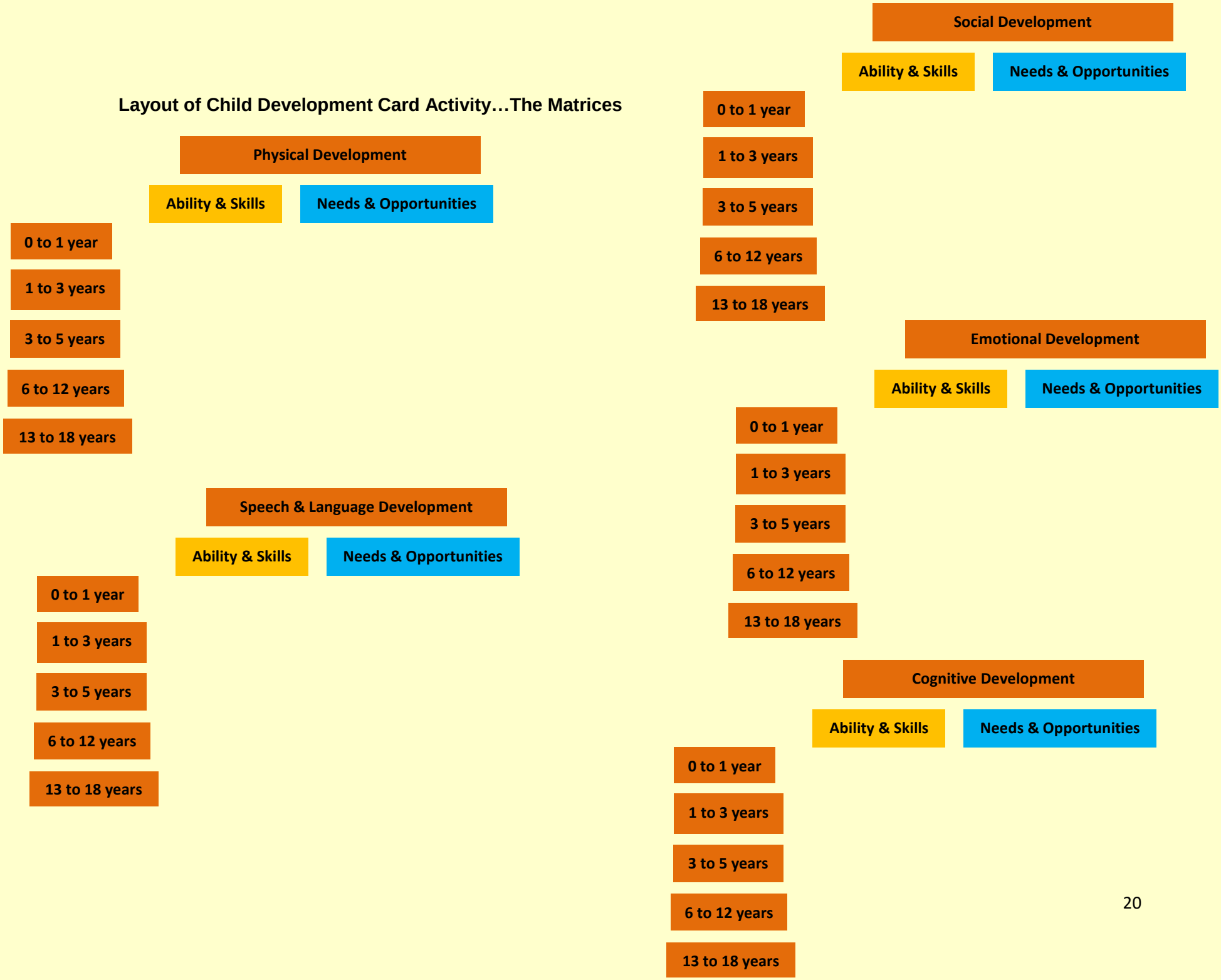
			as “Give Me”	
Repeats Words Overheard in Conversations & Uses Two-Word Sentences	Says 4-5 Meaningful, Single Words	Understands Simple Sentences	Says “No” With Meaning	Expresses needs
Increased Fund of Words	Uses Words to Communicate Wants & Needs	Ability to Construct Short Sentences	Ability to Describe	Language Used For Higher Levels of Communication— To Report Experiences
Language Used for Complex Social Transactions, incl. Life Skills like Refusal Skills/ Assertive Skills/ Negotiation	To Process Complex Feelings & Relationship Dynamics	To articulate opinions and choices	Makes Eye Contact	Smiles at Others When Smiled At
Plays Peek-A-Boo	Shy Of/Anxious About Strangers	Recognizing Familiar People & Places	Enjoys Imitating People in Play	Enjoys Looking at Pictures in Books
Uses the Word “Mine” Often	Likes To Play With Other Children	Understanding of Sequences & Routines	Understanding of Spaces (& What Happens There)	Understanding Rules of Play
Development of Gender Identity	Pretend/ Imaginative Play, Group Play	Same Sex/ Peer-group play	Self-identity/ Individuality	Clarity on Future Orientation
Questioning Parental/ Adult Authority	Peer Group Interactions All Important ('Need to Fit In')	Recognizes bottle or breast	Repeats actions but unaware of ability to cause actions	Learns through sensory experiences
Notices Difference	Understands cause and effect (Pick up a rattle, shake it, makes sound)	Searches for/ can find partly Hidden Object	Recognizes and Identifies Common Objects & Pictures	Identifies Two to Three Body Parts
Imitates Behaviour of Others, Especially Adults & Older Children	Will Listen To Short Story Book with Pictures	Begins To Sort Shapes & Colours	Increasing Fund of information	Ability to understand concepts such as shape, size, distance, directions
Knowledge of Use of Objects	Sequencing and Organizing Abilities	Ability to Form Categories	Understands Concept Of “Two”	Knows Several Body Parts
Completes Puzzles with 3 or 4 Pieces	Learn the Difference between	Ability to Think and Reason from	Less likely to Accept what is Stated	Ability for Self-Introspection,

	‘Right’ & Wrong’	Concrete Visible Events	by Others/ More Likely to Question	Analysis, Judgement
Creative Thinking/Abstract Abilities—Can Generalize from Specific Situations	Attachment and bonding	Cries When Caregiver Leaves	Can Be Soothed When Upset Through Use of Distraction/ Physical Calming	Ability to regulate emotions (responsiveness to soothing/ distress states not prolonged/ separation from attachment figure)
Shows Specific Preferences for Certain People and Toys	Begins to Show Defiant Behaviour	Enjoys Playing With Other People and May Cry When Playing Stops	Objects To Major Changes in Routine, but is Becoming More Compliant	Starts to Show & Identify Emotions
Ability to Identify Emotions	Ability to Recognize Emotional State of another Person and Ascribe Simple Reasons to Causality	Differentiating Between Positive & Negative Emotions	Begins To Separate More Easily From Parents	Ability to Provide Positive Emotional Response (Comfort)
Development of Empathy	Emotional Regulation (Control of Difficult Emotions…Anger, Anxiety…)	Ability to Cope with Stress	Happy, Healthy, Responsible Sexual Behaviour	Dealing with Peer Pressure
Resilient Handling of Role Task, Relational & Emotional Challenges	Developing and Making Decisions about Attraction/ Intimate/ Sexual Relationships	Resilient Handling of Role Task, Relational & Emotional Challenges	Relationship Satisfaction	
Exposing Child to Colourful Objects that also make Different Sounds (Mobiles/Bells/ Rattles/Chimes)	Getting Child to Touch & Hold Small Objects/ Objects Of Different Textures	Placing Objects at a Short Distance from Child to Encourage Reaching Them.	Daily Oil Massages (At Bath Time)	Exercise & Opportunities for Play (Incl. Running/ Climbing)
Sensory experiences (sand, water play, sensory stimulation room…)	General growth and nutrition	Fine-motor activities such as beading, colouring, buttoning, finger painting…	Demonstrate Self-care Activities through Modelling/ Doll play	Hand Exercises (Clay play, Kneading Dough, Squeeze Balls, Soft Sound-Making Toys for Pressing…)

Physical activities/ play/ exercise	**Preparation for bodily changes/ education/ awareness**	**Oro-Muscular Massages (Massaging Cheeks/Jaws/ Areas near Mouth)**	**Talking and Singing to Child; Responding to Child's Sounds.**	**Blowing Bubbles/ Balloons/Whistle**
Naming & pointing games	**Drinking Using Straw**	**Telephone Games**	**Use of Pictures & Flashcards for Descriptive Games**	**Story telling**
Concept Book/ Flash Cards	**Describing Games (Using Pictures/ Observations/ Real Life Events)**	**Freedom to Communicate Needs**	**Story telling & Completion**	**Opportunities to be Disclosive/ Share Experiences**
Opportunities to be to be Heard/ Share Experiences	**Life Skills Training—Assertiveness, Negotiation, Communication**	**Exposure to family and friends**	**Naming & Pointing Familiar People**	**Naming & Pointing Familiar Spaces/Places & Discussion on their Use**
Exposure to play spaces/ interactions with other children (visits to parks/playgrounds)	**Use of Pictures to Explain Daily Routine/ Activities**	**Exposure to common social spaces such as home/school/park/shop**	**Simple Rule Based Games**	**Opportunities for Peer Group Play—Forming Friendships**
Supervised Peer Interaction, Group & Cooperative Play (Exposure to Playgrounds…)	**Comfort/ Security/ Sense of Belonging to Peer Group/ School/ Family & Affirmative Sense of Self-Identity**	**Rules & Healthy Boundaries—With Opportunities to Practice Independent Decision-Making Skills**	**Playing Peek-a-Boo**	**Multiple sensory stimulation using colourful/sound-making objects**
Concept Book/ Flash Cards	**Use of Pictures for Sequencing Events/ Stories**	**Attention Enhancing Tasks (Join the Dots, Spot the Difference, Eye-Hand Coordination Activities…)**	**Naming & Pointing Games (Using Common Objects)**	**Identification of Shape, Size, Colour**
Play to Demonstrate Use of Common Objects				
Use of Simple 4-5 Piece Puzzles	**Categorizing Fruits & Vegetables**	**Use of Building Blocks and Coloured Shapes for Sorting & Categorization**	**Play More Complex, Rule-Based Games**	**Puzzles**

Story-Telling & Completion	**Life Skills Training—Problem Solving, Conflict Resolution, Creative Thinking**	**Picking Up & Holding/ Cuddling Child, Especially When Child Is Distressed**	**Timely Response to Child's Needs (feeding, changing wet clothes, multi-sensory stimulation…)**	**Providing Frequent/ Timely Responses of Love, Affection + Positive Verbal & Non-Verbal Feedback**
Pictures and stories reflecting common emotions such as joy, sadness, anger, excitement	**Story Telling**	**Identifying Emotions through Pictures**	**Use of Visual Analogue (Emotion Scale)**	
Listing Situations in Which Emotions are Felt ('I am happy when…sad when…)	**Opportunities to Acknowledge & Process Intense Emotions (Anger/Fear)**	**Family, School Social Support**	**Appreciation & Encouragement**	**Opportunities for Pro-Social Behaviour**
Storytelling, Drama (Complex Themes for Adolescents—Gender, Sexuality, Risk Behaviours, Conflict Resolution…)				

Layout of Child Development Card Activity…The Matrices



Physical Development

	Abilities & Skills	Needs & Opportunities
0 to 12 months	Balances Neck without Support Crawls Forward On Belly Looks toward Direction of Sound Sits without Support if made to Sit Stands Without Support/ Starts Walking Turns Head Towards Bright Colours & Lights Reaches for/Grasps Dangling Objects	Exposing Child to Colourful Objects that also make Different Sounds (Mobiles/Bells/ Rattles/Chimes) Getting Child to Touch & Hold Small Objects/ Objects Of Different Textures Placing Objects at a Short Distance from Child to Encourage Reaching Them. Daily Oil Massages (At Bath Time)
1 to 3 years	Grasps Small Objects Using Two Fingers (Thumb & Index Finger) Runs Easily Screws and Unscrews Jar, Lids, Nuts, & Bolts Climbs onto / down from Furniture Unsupported Walks Up and Down Stairs with Support Can Drink From Open Cup, With Some Spilling Puts into /Takes Out Objects from Container Turns Pages of Book Makes Vertical, Horizontal, Circular Strokes with Pencil/Crayon	Exercise & Opportunities for Play (Incl. Running/ Climbing) Sensory experiences (sand, water play, sensory stimulation room…)
3 to 5 years	Goes to Toilet during Day Time with Some Help Fine Motor Skills: pre-writing skills, transfer functions, eye-hand coordination Gross Motor Skills: Mobility, Ability to Handle Objects Physical skills necessary self- help: buttoning, brushing, feeding etc.	Hand Exercises (Clay play, Kneading Dough, Squeeze Balls, Soft Sound-Making Toys for Pressing…) Fine-motor activities such as beading, colouring, buttoning, finger painting… Demonstrate Self-care Activities through Modelling/ Doll play
6 to 12 years	Fine motor tasks easily achieved. Full independence in self-care.	General growth and nutrition Physical activities/ play/ exercise
13 to 18 years	Development of secondary sexual characteristics. Menstruation in girls	Preparation for bodily changes/ education/ awareness

Speech & Language Development

	Abilities & Skills	Needs & Opportunities
0 to 12 months	Makes Cooing Noises & Reacts to Sound Babbles "Dadada...." "Mamama...." Laughing & Squealing	Oro-Muscular Massages (Massaging Cheeks/Jaws/ Areas near Mouth) Talking and Singing to Child; Responding to Child's Sounds.
1 to 3 years	Responds to Simple Verbal Requests, such as "Give Me" Follows Simple, One-Step Instructions Says 4-5 Meaningful, Single Words Says "No" With Meaning Repeats Words Overheard in Conversations & Uses Two-Word Sentences Understands Simple Sentences Expresses needs	Blowing Bubbles/ Balloons/Whistle Drinking Using Straw Naming & pointing games Telephone Games
3 to 5 years	Increased Fund of Words Uses Words to Communicate Wants & Needs Ability to Construct Short Sentences	Use of Pictures & Flashcards for Descriptive Games Story telling Concept Book/ Flash Cards
6 to 12 years	Ability to Describe Language Used For Higher Levels of Communication—To Report Experiences	Describing Games (Using Pictures/ Observations/ Real Life Events) Freedom to Communicate Needs Story telling & Completion
13 to 18 years	Language Used for Complex Social Transactions, incl. Life Skills like Refusal Skills/ Assertive Skills/ Negotiation To Process Complex Feelings & Relationship Dynamics To articulate opinions and choices	Opportunities to be Disclosive/ Share Experiences Opportunities to be to be Heard/ Share Experiences Life Skills Training—Assertiveness, Negotiation, Communication

Social Development

	Abilities & Skills	Needs & Opportunities
0 to 12 months	Makes Eye Contact Smiles at Others When Smiled At Plays Peek-A-Boo Shy Of/Anxious About Strangers	Exposure to family and friends
1 to 3 years	Recognizing Familiar People & Places Enjoys Imitating People in Play Enjoys Looking at Pictures in Books Uses the Word "Mine" Often	Naming & Pointing Familiar People Naming & Pointing Familiar Spaces/Places & Discussion on their Use Exposure to play spaces/ interactions with other children (visits to parks/playgrounds)
3 to 5 years	Likes To Play With Other Children Understanding of Sequences & Routines Understanding of Spaces (& What Happens There) Understanding Rules of Play	Use of Pictures to Explain Daily Routine/ Activities Exposure to common social spaces such as home/school/park/shop Simple Rule Based Games
6 to 12 years	Development of Gender Identity Pretend/ Imaginative Play, Group Play Same sex/ peer-group play	Opportunities for Peer Group Play—Forming Friendships Supervised Peer Interaction, Group & Cooperative Play (Exposure to Playgrounds…)
13 to 18 years	Self-identity/ Individuality Clarity on Future Orientation Questioning Parental/ Adult Authority Peer Group Interactions All Important ('Need to Fit In')	Comfort/ Security/ Sense of Belonging to Peer Group/ School/ Family & Affirmative Sense of Self-Identity Rules & Healthy Boundaries—With Opportunities to Practice Independent Decision-Making Skills

Cognitive Development

	Abilities & Skills	Needs & Opportunities
0 to 12 months	Recognizes bottle or breast Repeats actions but unaware of ability to cause actions Learns through sensory experiences Notices Difference Understands cause and effect (Pick up a rattle, shake it, makes sound) Searches for/ can find partly Hidden Object	Playing Peek-a-Boo Multiple sensory stimulation using colourful/sound-making objects
1 to 3 years	Recognizes and Identifies Common Objects & Pictures Identifies Two to Three Body Parts Imitates Behaviour of Others, Especially Adults & Older Children Will Listen To Short Story Book with Pictures Begins To Sort Shapes & Colours	Concept Book/ Flash Cards Use of Pictures for Sequencing Events/ Stories Attention Enhancing Tasks (Join the Dots, Spot the Difference, Eye-Hand Coordination Activities…)
3 to 5 years	Increasing Fund of information Ability to understand concepts such as shape, size, distance, directions Knowledge of Use of Objects Sequencing and Organizing Abilities Ability to Form Categories Understands Concept Of "Two" Knows Several Body Parts Ability to Form Associations Completes Puzzles with 3 or 4 Pieces	Naming & Pointing Games (Using Common Objects) Identification of Shape, Size, Colour Play to Demonstrate Use of Common Objects Use of Simple 4-5 Piece Puzzles Categorizing Fruits & Vegetables Use of Building Blocks and Coloured Shapes for Sorting & Categorization
6 to 12 years	Learn the Difference between 'Right' & Wrong' Ability to Think and Reason from Concrete Visible Events	Play More Complex, Rule-Based Games Puzzles Story-Telling & Completion
13 to 18 years	Less likely to Accept what is Stated by Others/ More Likely to Question Ability for Self-Introspection, Analysis, Judgement Creative Thinking/Abstract Abilities—Can Generalize from Specific Situations	Life Skills Training—Problem Solving, Conflict Resolution, Creative Thinking

Emotional Development

	Abilities & Skills	Needs & Opportunities
0 to 12 months	Attachment and bonding Cries When Caregiver Leaves Can Be Soothed When Upset Through Use of Distraction/ Physical Calming	Picking Up & Holding/ Cuddling Child, Especially When Child Is Distressed Timely Response to Child's Needs (feeding, changing wet clothes, multi-sensory stimulation…)
1 to 3 years	Ability to regulate emotions (responsiveness to soothing/ distress states not prolonged/ separation from attachment figure) Shows Specific Preferences for Certain People and Toys Begins to Show Defiant Behaviour Enjoys Playing With Other People and May Cry When Playing Stops Objects To Major Changes in Routine, but is Becoming More Compliant Starts to Show & Identify Emotions	Providing Frequent/ Timely Responses of Love, Affection + Positive Verbal & Non-Verbal Feedback Pictures and stories reflecting common emotions such as joy, sadness, anger, excitement Story Telling
3 to 5 years	Ability to Identify Emotions Ability to Recognize Emotional State of another Person and Ascribe Simple Reasons to Causality Differentiating Between Positive & Negative Emotions Begins To Separate More Easily From Parents	Identifying Emotions through Pictures Use of Visual Analogue (Emotion Scale) Listing Situations in Which Emotions are Felt ('I am happy when…sad when…)
6 to 12 years	Development of Empathy Ability to Provide Positive Emotional Response (Comfort) Emotional Regulation (Control of Difficult Emotions…Anger, Anxiety…)	Opportunities to Acknowledge & Process Intense Emotions (Anger/Fear) Family, School Social Support Appreciation & Encouragement
13 to 18 years	Ability to Cope with Stress Happy, Healthy, Responsible Sexual Behaviour Resilient Handling of Role Task, Relational & Emotional Challenges Dealing with Peer Pressure Relationship Satisfaction Developing and Making Decisions about Attraction/ Intimate/ Sexual Relationships	Opportunities for Pro-Social Behaviour Storytelling, Drama (Complex Themes for Adolescents—Gender, Sexuality, Risk Behaviours, Conflict Resolution…)

2.4. Identifying Problems & Contexts: The Child's Experience & Inner Voice

Objectives

- To identify psychosocial contexts of children's problems and understand and analyse problems in accordance with their context.
- To make the link between children's context and experiences, and emotions/behaviours.
- To understand how children perceive and internalize their experiences i.e. their inner voices, and how this manifests in emotional and behavioural issues.

Time

2 hours

(*Note: This time is based on the fact that it usually takes participants a while to grasp the concept of the inner voice as well how long it takes to discuss and analyse 5 to 6 cases—it is recommended that sufficient time be spent on this exercise as it lays the basics of counselling response).*

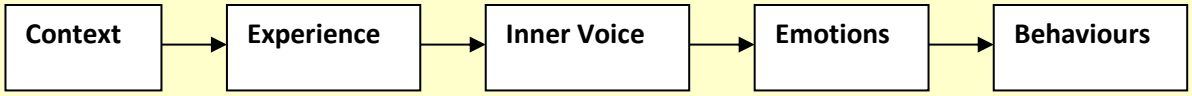
Concept

A child's behavioural (or emotional) problem seldom occurs in isolation; there is always a reason why it occurs, a place where it grew out of. In other words, there is a context to every child's problem. A specific type of behaviour problem may arise out of many possible contexts: for example, there may be four children, all of whom have anxiety; but the context of anxiety may be different in each child—for one is may be due to parental marital conflict, in another, it may be due to child sexual abuse, in the third, it may be because of bullying experiences at school; in the fourth, it may be due to learning disabilities and pressure from school teachers. Similarly, a single context may lead to different behaviours in different children: for example, there may be 3 children all of whom have been sexually abused; but despite the same context and experience, they may have very different behaviours—one child may show aggressive behaviours (due to anger); another may have self-harm/ suicide behaviours (due to depression); and the third child may have frequent headaches and stomach aches (due to anxiety). Even when the behaviour is the same, the contexts vary, thus necessitating different interventions i.e. how we respond to a sexually abused child (with anxiety) is going to be different from how we respond to a learning disabled child (with anxiety).Similarly, we cannot have identical responses to children who are from similar contexts because their behaviours are entirely different i.e. a child with self-harm issues (due to sexual abuse) requires different interventions from a child with aggressive behaviour (also due to sexual abuse).

Thus, merely looking at the behaviour tells us nothing unless we know the context out of which this behaviour developed. Consequently, addressing only the behaviour will be of no use, because unless we understand the context and address the processes that then led to that behaviour, the behaviour itself cannot change. Understanding contexts is therefore critical to identifying the nature of the problem and developing a response. In order to develop interventions accurately, we need to understand the context and the processes leading from the context to the behaviour. So what are

the processes or elements between the context and behaviours, that we also need to unpack, in order to analyse the child's problem fully, and plan appropriate interventions?

Below is a framework for analysing children's behavioural issues. It comprises of 5 key elements, and most information available about the child, including the child's history and current state including emotional and behavioural issues, can be fitted into this framework to analyze the child's context and behaviour.



i) Context: This refers to the child's location, living arrangements and family situation, which is where the primary experience of the child comes from i.e. it refers to the child's universe, which then gives rise to certain experiences, emotions and behaviours. For instance, is the child at home or in an institution? Is the child orphan/ abandoned or living with caregivers? Is it a single parent family or is an aging grandmother taking care of the child? Are the parents/ caregivers HIV+ and/or have other illnesses? Are there family and marital conflicts (or alcohol dependence) at home? Has there been a death in the family?

ii) Experience: This refers to the child's experience of the living arrangements and family situation/ institutionalization and events thereof. For instance, is the child's experience one of physical neglect (not receiving basic survival needs), or of emotional neglect (not receiving love, support, encouragement) in a situation of being orphan/ abandoned or in a single parent family or in a situation of parental HIV/illness? Is the child's experience of separation or loss in a situation of institutionalization or death in the family? Is it an experience of sexual abuse? Is it an experience of emotional abuse due to stigma and discrimination practices of the family/ school? It is important here to make the distinction between context and experience—two children from similar contexts do not always have the same experience. For example, the death of a parent, on the face of it, may lead us to view it as a loss experience to child X (and indeed it may be); but the death of a parent may not be as serious a loss experience for child Y because he disliked his parent and had a very poor relationship with him. Thus, each child's experience of a given situation is unique, and while there may be similarities, there are also differences, which is why we must not assume that a child's experience is or must be a certain way. So, how do we understand this experience? This brings us to the third element of the conceptual framework, that of the child's inner voice.

iii) Inner Voice: This refers to the child's internalization of the experience. Between a traumatic event (experience) and its consequence (behaviour), what is critical is how child internalizes it. Often we try only to manage the behavioural manifestations of the problem without understanding the internalization.

The internalization or the inner voice of the child is basically how the child understands and processes the traumatic event. For example, a common inner voice in a child who has experienced sexual abuse is "I am damaged" and "I am powerless"; or the child's internalizations may be "I am responsible for what happened/ it is my fault". It is the thought or feeling in the child's mind that may

or may not be verbalized. When it is still at a non-verbal stage, as a thought, it is called the 'inner voice'.

Even if the experiences are similar for two given children, i.e. that of sexual abuse, their internalizations may be very different: while child X's inner voice may be 'I am damaged and powerless', child Y's response may be 'this is not fair…how dare he do that to me.' Thus, the nature of internalization or what a given child's inner voice says is what leads to the development of certain emotions, which in turn lead to certain behaviours.

iv) Emotions: These refer to a child's feelings or psychological states, usually derived from certain contexts and experiences, which lead to a set of internalizations. For example, internalizations such as 'I am damaged and powerless' lead to emotions of frustration and hopelessness while those such as 'this is not fair…how dare he do that to me' lead to anger. Again, it is therefore not just contexts and experiences that determine children's emotions but the inner voice that does so. Examples of emotions are love, hate, anger, trust, joy, panic, fear, and grief.

v) Behaviours: These refer to the response to emotions or to the final consequences of context, experience, internalizations and emotions. Unlike emotions, which are internal in origin and nature and not always observable, behaviours refer to actions that are observable on the outside. For instance, hitting someone, throwing things, crying, being silent, not engaging socially are all behaviours—and the emotions behind them may be anger, sadness, anxiety etc.

It is important to understand events of trauma in children's lives, using such a conceptual framework because:

- Interventions commonly focus on behaviours without seeking to understand the emotions behind them, and without consideration of how those emotions came about.
- Behaviour is only the end result of an entire process that includes context, experience, internalization and emotion. Therefore, if the intervention focuses on the behaviour consequence (such as telling the child not to hurt herself) fails to focus on the internalization ('I am damaged and powerless') that lead to the behaviour consequence in the first place. But if the intervention focuses on creating experiences of empowerment and agency for the child so as to make her believe she is not damaged, it addresses the internalization that has occurred; and the behaviour consequences will, as a result, also be altered.
- It is essential to understand children's emotional and behaviour problems in a nuanced context-specific manner, duly considering individual children's perceptions and experiences and most importantly, how they internalize these or what their inner voices are with regard to their life situations and experiences.

Tell the participants that we will now do some preliminary exercises to be clear as to what the inner voice means and about the differences between emotions and behaviours, before we move onto practising problem analysis (using case studies). [*Note: The information provided in the 'Concept' sub-section requires to be explained alongside doing the activities detailed below. The idea is to do each activity and follow it up with some conceptual understanding].*

Activity for Understanding the Inner Voice

Method: Simulation

Material: None

Process:

- Provide the following situation to the participants: “In a Bombay local train, some years ago, a young girl with intellectually disability was sexually abused by a man. There were 7 other people on the train, in the same compartment but they did not respond or do anything to help.”
- Tell them that each one of them is one of the 7 people on that train.
- Ask them to state what their internal voices would be. (What would they be thinking at that moment, about the situation at hand?)
- Ask them to share (in plenary) their internal voices.

Discussion:

- Remind participants that:
  - They need to be the person or put themselves in the other person’s shoes and speak (not in 3rd person but in first person).
  - The internal voice is not ‘they were insensitive or they were worried’…internal voice begins with ‘I…’ or pertains to the person in first person. So, it would be ‘It is not my problem’ (suggestive of some insensitivity) or ‘I am scared about what might happen to me…I am worried I will be harmed.’

Activity for Differentiating between Emotions & Behaviours

Method: Naming game

Material: None

Process:

- Explain that: it is important for us to make the distinction between emotions and behaviours (the two often tend to be confused). Emotions are how we feel… usually internal or not visible to the outside world unless we show them through behaviours. Behaviours are external…actions we perform that are visible to the outside world, to others.
- Go around the room and ask each participant to name an emotion.
- Next, go around the room and ask each participant to name behaviour.
- Ensure that participants are clear about the difference between the two words/ concepts: for example, anger is an emotion and the (corresponding) behaviour would be verbal abuse, breaking things etc; love is an emotion and hugging/ kissing are behaviours; possessiveness is an emotion and being clingy may be a related behaviour. Thus, you can enable participants to also link emotions with behaviours—by asking what emotion lies behind a behaviour they have named or vice-versa.

Activity for Identifying Problems, Contexts & Child's Inner Voice

Method: Case study analysis

Material: Flip chart sheets and markers; case studies (see below—or use any case studies that the group brings).
Note: For a group that deals with all types of children, you can give a mix of cases from sections A, B and C sections; for a group that is being trained specifically on child sexual abuse or HIV/AIDS & children's issues, you can use more cases from sections B and C (to enable them to apply problem analysis in a very specific area).

Process:

- Tell the group that now that we have done a round of practice on inner voices, emotions and behaviours, and have some clarity on these concepts, we will proceed to doing the case study analysis in which they will apply these concepts.
- Divide participants into sub-groups of 3 to 5 members each and assign 1 (or 2 in case there are fewer participants) case studies to each sub-group.
- Ask participants to read each case study and analyze it using the concepts in the overview that you just provided and fill out the matrix below (concepts already discussed) i.e. to include the context, experience, inner voice, emotions and behaviours of the child in each case. (They may work backwards from behavior and/or forwards from context).

Context	Experience	Inner Voice	Emotion	Behaviour

Discussion:

- Ask each sub-group to share their analysis in plenary, inviting others to comment and provide additional viewpoints.
- Emphasize how a single context can lead to multiple behaviours and how multiple contexts can lead to a single type of behavior. So a context and behavior need be understood by focusing on the inner voice of the child i.e. what meaning the child makes of her context and experiences, how this leads to the development of certain feelings or emotions and how then she chooses to express her inner voices and emotions through her behaviours.
- How interventions therefore need to focus on changing the inner voice of the child, for, this is what will lead to changes in emotions and consequently, changes in behavior…so the crux of problem analysis lies in being able to accurately identify or listen to the child's inner voice.

Case Studies for Context-Inner Voice Activity

A. Miscellaneous

Case 1: A 14 year old girl, was rescued by Childline team from the streets where she had lived for about 2 years. Her mother had died when she was 5 yrs old; although she was sent home, her father refused to take her in (he was re-married) when the family was tracked and none of her relatives wanted her. So she ran away again. This time around she lived with a transgender person (who was in sex work) for a year. This person wanted to keep the child safe and brought her to CWC/ institution. The child now shows a lot of anger/ aggression behaviours; she does not obey anyone; she has lying and stealing problems. No institution is able to manage her & they don't want her.

Case 2: A 14 year old girl is always angry and aggressive, but also has a tendency to be very clingy i.e. if a person she has befriended someone, she does not like her to engage with any other children/ people. Her mother died when she was about 10 years old. She was on the streets from the age of 8, begging, as parents were alcohol dependent and did not take care of the child. She still misses her mother very much and says that had she known about her mother's hospitalization, she could have saved her (it's my fault that my mother died).

Case 3: A 14 year old boy is often angry, gets into fights with other children, breaks window panes, and does not adhere to the rules of the institution. Previously, he was part of gangs and into smoking. The child had lost his father; his mother re-married and he was physically abused by his step father—who also made him discontinue school and work at a cycle shop. The step-father is also into gangs and physically abuses the child's mother.

Case 4: A 11 year old boy was reported by the institution to have anger issues --hitting and biting other children—as well as runaway behaviour. The child was sent to a hostel by his grandmother and he ran away from the hostel twice because he was beaten there. There is marital discord in the family : mother has re-married and she resides in Hassan, the child does not wish to stay with his mother as he reports that beats him and makes him sleep outside the house/ does not give him food. The child's biological father resides in another town with his family , the child has better relationship with his father but the father has alcohol dependence and he does not wish to take the responsibility of the child.

B. Cases on Child Sexual Abuse

Case 5: A 15-year old girl has suicidal thoughts, refuses to eat and has disturbed sleep, she is often seen crying, has recurrent disturbed images of her past. She lost her mother a year ago, after which her father has re-married. He no longer wanted to be responsible for her, so she was married off to a 30-year old man, who sexually abused her multiple times; she was also beaten/ burnt on various parts of her body by her mother-in-law.

Case 6: A 10 year old girl spends all his time alone, does not eat properly and has sleep problems. She has no friends and is often 'in his own world' ('lost'). She also has academic problems. She was sexually abused by her father and brother; her father killed her mother.

Case 7: Mamata, a 14 year old girl, had her 25-year old cousin come to stay at her home. When her family was in another room, he touched her private parts and told her he loved her. Some days later, he left and did not stay in contact with Mamata, who is now not able to concentrate on her classes, finds it difficult to fall asleep and talks rudely to her family.

Case 8: Saira is a 6 year old girl who was sexually abused by the school attender. She now refuses to go to school and clings to her mother all the time; she wakes up crying at night; she refuses to leave the house to play with her friends too.

C. Cases on HIV Infected-Affected Children

Case 9: Sharadha is a 10-year old girl who is a double orphan & HIV+. She is studying in 5th standard and is staying with her grandparents . She lost her mother 4 months back due to AIDS. A month ago, the doctor said she also needs to start ART. She has now stopped playing with other children and refuses to go to school, complaining of stomach ache/ headache at school time; she also refuses to take her ART medicines.

Case 10: Veena is 15-year old orphan child and staying in an institution from the past 8 years. Recently child is showing lot of anger towards staff and friends even under slight provocation. When she gets angry, she bangs her head against the wall and shouts at people/ uses bad words; she hits herself, lies on the floor for hours doesn't listen to anyone. When she goes home from the institution for holidays, her aunt does not allow her to touch anything at home and she is asked to sit on the floor (and not on the sofa); her aunt buys her cousins toys and things but refuses to do so for Veena.

Case 11: Jyothy is a 7-year old HIV+ girl. Both her parents are HIV+ and bed ridden. She has a younger brother who is HIV affected. She is looking after her parents and doing all the household work . She and her brother are forced to go school for the sake of mid-day meal which is the only way they can access food. But Jyothy finds it hard to concentrate and has difficulty with reading and writing. She is easily angry, verbally abuses others and also appears sad.

Case 12: Ananth is 16-year old boy studying in class XII and staying with father who is an auto driver. Recently, Ananth came to know that he is HIV+ from his aunt; she also told him that his mother committed suicide because his father used to blame his mother daily for being HIV+. Now Ananth has stopped talking to his father and started drinking alcohol every day.

Case 13: Pallavi is 5 year old girl who lives with her mother. Her mother is HIV+ and takes the child with her to hospital each time she goes for ART. Some neighbours have told the child her mother is sick; they have also said that people who go to the hospital do not come back. Recently, the child clings to the mother a lot and refuses to go anywhere without her.

D. Cases on Children in Conflict with the Law or with Conduct Issues

Case 14: Srini is a 15 year old boy from low socio-economic background. Father has severe alcohol abuse due to which there is domestic violence and parental marital conflict at home; the child was also continually physically abused by his father. The child was regular at school until 8th grade. Then he came in contact with a group of boys in the neighbourhood/ school, he started missing school to hang out with his peers. They would steal wires from newly constructed buildings and use the money for food; they also engaged in substance abuse, mainly beedi-smoking and solution. Eventually, the child came into conflict with the law when he, along with his group of friends were caught stealing a vehicle.

Case 15: Som is a 16-year old boy from a low socio-economic background, and very difficult financial circumstances. His father has a heart problem. The child dropped out of school to work as a day labourer in construction, and support the family. The child happened to tell one of his friends that his father was very ill and the mother was exceedingly anxious about gathering resources to arrange for the necessary medical treatments. His friend asked him to meet with him later that day, saying he would be able to help with some money. When the child went to the place of meeting, he was not aware of his friend's plans and was at first shocked when his friend took him to an empty house and broke into it. However, the child then helped his friend search the house for money and valuables which they split between them. The child went home and gave his mother the money for his father's treatment. Later, the police, who had caught the friend, also came and arrested the child for robbery.

Case 16: Praveen is a 14 year old child from a single parent family. He never went to school and was a child labourer. He usually spent time with his neighbourhood friends who were mostly older than him. One time, they had shown him pornographic videos after which the child was curious about sexual relationships. The next day, the child took one of the young boys in his neighbourhood, an 8 year old, to an abandoned building nearby and touched the young child inappropriately in his genitals, following which he came into conflict with the law when the young child complained to his parents.

Examples of How to Use the Inner Voice Analytic Framework

Below are some examples of how to use the Inner Voice Analytic Framework to understand a child's emotions and behaviours.

Case 3: A 14 year old boy is often angry, gets into fights with other children, breaks window panes, and does not adhere to the rules of the institution. Previously, he was part of gangs and into smoking. The child had lost his father; his mother re-married and he was physically abused by his step father—who also made him discontinue school and work at a cycle shop. The step-father is also into gangs and physically abuses the child's mother.

Context	Experience	Inner Voice	Emotion	Behaviour
Loss of father Mother's re-marriage (New) father into criminal activity	Loss, grief Rejection Physical abuse Legitimacy of violence/ antisocial activity	If my father had not died, things would have been different. My mother did not ask me before she married this man (new father)…why did she do this? I wish she had not… May be she does not really love me…may be she only cares about this man (new father)… How dare this man (new father) beat me? He is not even my ('real') father, so how dare he…? If he can beat me, why I can't I beat and hurt others?	Sadness, depression Anger Resentment Hostility	Gets into fights with other children (possibly also because he is unable to express or vent his anger and frustration at home--displacement) Breaks window panes, and does not adhere to the rules of the institution (due to anger and also because his learning from his house/ circumstances that violence and abuse are legitimate ways of response.

Case 7: Mamata, a 14 year old girl, had her 25-year old cousin come to stay at her home. When her family was in another room, he touched her private parts and told her he loved her. Some days later, he left and did not stay in contact with Mamata, who is now not able to concentrate on her classes, finds it difficult to fall asleep and talks rudely to her family.

Context	Experience	Inner Voice	Emotion	Behaviour
Adolescence Sexual abuse within a family context	Love/ attraction Sexual Abuse	Why did he do that to me? What am I supposed to feel about him? May be I was a little attracted to him…may be I liked what he did to me…but was I supposed to like it? He said he loved me…then why didn't he stay in touch with me? If he didn't care about me, why did he touch me? Should I have allowed him to touch me? What if my family comes to know? What might they think or say?	Confusion Anxiety Sadness Betrayal Rejection (Some) Anger	Not able to concentrate on her classes Finds it difficult to fall asleep Talks rudely to her family

Case 13: Pallavi is 5 year old girl who lives with her mother. Her mother is HIV+ and takes the child with her to hospital each time she goes for ART. Some neighbours have told the child her mother is sick; they have also said that people who go to the hospital do not come back. Recently, the child clings to the mother a lot and refuses to go anywhere without her.

Context	Experience	Inner Voice	Emotion	Behaviour
Chronic illness in parent HIV affected child	Illness of primary caregiver	Why does mummy have to go to hospital so often? What is the matter with mummy? What if she is really sick and does not get better? The neighbours say people who go to hospital don't come back…why not? What is Mummy does not come back one day? What will happen to me? Who will look after me…I would be all alone… I better stay with Mummy all the time…I don't want to be away from her, in case something happens to her…and I become alone.	Confusion Anxiety Fear	Clinging to the mother a lot and refusal to go anywhere without her. (Also called Separation Anxiety)

Case 16: Praveen is a 14 year old child from a single parent family. He never went to school and was a child labourer. He usually spent time with his neighbourhood friends who were mostly older than him. One time, they had shown him pornographic videos after which the child was curious about sexual relationships. The next day, the child took one of the young boys in his neighbourhood, an 8 year old, to an abandoned building nearby and touched the young child inappropriately in his genitals, following which he came into conflict with the law when the young child complained to his parents.

Context	Experience	Inner Voice	Emotion	Behaviour
Single-parent family Never schooled Child labour	Low levels of adult supervision No structured, age-appropriate daily routine/ tasks Exposure to (older) peers and peer pressure as well as high risk behaviours including through pornography	Wow, all that stuff my friends showed me on the video and mobile phone seem so interesting…it looks dirty…but I wanted to watch it. May be I wasn't supposed to watch that stuff…but everyone at my work place is and they seem to think it's quite normal. As they said, I guess I need to learn about all that stuff… Some of them have even done some of those things they were showing videos of…and said I should try them too. As they said, if I don't try it out and experience, it how will I learn? I don't want to be girly…I want to be (cool) like the other guys in my group…I should try it to see what it's really all about, how it feels…	Curiosity Anxiety (to understand/ do what his peers were talking about) Need to 'fit in' (with peers)	Sexual experimentation (with younger child) *Viewed and understood by others/ law as sexual abuse

2.5. Representations of Childhood

Objectives:

- To reflect on images of childhood.
- To take perspective on multiple childhoods and emerging psychosocial themes and narratives.

Time

2 hours (1.5 hours for film screening and 30 minutes for discussion)

Concept

Childhood is not a unitary phenomenon. No two children are the same and no two childhoods are the same. Two children from the very same context may have completely different emerging narratives. Two children with completely different contexts may have very similar challenges. It is this complex inter-play of factors that constitute the nature of multiple childhoods.

One of the ways in which we get people to reflect on issues of children and childhood is through use of films--films in which lives of children on children's issues, which have many psychosocial contexts and themes, are represented. Films about (and for) children explore various themes such as attachment, friendship and relationships, children's interests, motivations, dreams and aspirations. They enable us, in essence, to view the world through the eyes of children, thereby getting us to adopt a child-centric approach to dealing with young people.

Films can similarly be used with children also—to generate discussions and get children to reflect on various themes and issues relevant to their lives and to take perspective on these (instead of instruction and lectures). So in this session, we are also introducing a creative methodology that you can use with children. Experiential methodologies have both appeal and effectiveness. Children love films and the visual/ moving image. This methodology, however, has a strategic component. It creates a safety and distance for children to engage more actively as opposed to addressing an issue directly with them, which can perhaps cause discomfort and defensiveness. The methodology also involves the critical components of experience, process and meta-processes. Watching the film is itself a primary experience; imbibing its content and relating to it is the process. The discussion that follows and linking of it to the child's own life is the meta-process. Through this, alternative ways of thinking and responding are generated, giving rise to healing and transformation processes.

Activity for Representations of Childhood

Method: Film screening and perspective-taking

Materials: Any film that is about children, including films made for children.
Suggested films:
'Children of Heaven'(Iranian with English Sub-titles/ Directed by Majid Majidi);
'Colour of Paradise'(Iranian with English Sub-titles/ Directed by Majid Majidi);
'Stanely Ka Dubba' (Hindi/ Directed by Amole Gupte);
'Kaisale Kamsale' (Kannada/Directed by T. S. Nagabharana)
'Shwaas' (Marathi with English Sub-titles)

Process:

- Screen the film.

Discussion:

- Let us reflect on the film through 3 levels of processing:
  i) Do an primary 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?
  iii) How might we use the understanding of these themes to inform our work with children?
- What kinds of questions and themes would you discuss if you were using this film with a group of children?

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 of children and childhood.

3. Basic Communication & Counselling Techniques

3.1. Skill 1—Getting to Know the Child

Objectives

- What to say and do when you first meet the child.
- To build a rapport with the child.
- To set a context for further interaction and work with a child.

Time

1 hour

Concept

10 year old X sits before the counselor not saying a word. The counselor keeps asking her questions but the child withdraws further and remains silent. This is a common phenomenon, especially in case of children who might have had difficult experiences. They are confused and frightened and unsure of whether to trust and what to respond. They may also be unable to verbalize their feelings or respond. It is therefore important to make the child comfortable and establish a relationship before proceeding to discuss his/ her problem.

Rapport Building is the first stage towards building a relationship with children. It involves 3 broad steps: introducing yourself; preliminary establishment of context; getting to know the child. These should be done in the first or at least first two sessions with the child--they pertain to first or initial contact with the child.

How to build rapport and get to know the child:

a) Introducing yourself

While this might sound obvious, many counselors and child care professionals either forget or do not think it is necessary to introduce themselves to the child. The question is, when a child does not know who you are, why should they talk to you, that too, to tell you about their difficult issues? Also, many children, by this time have been compelled to be a part of various enquiry processes, answering the same sort of questions over and over again (such as in cases of child sexual abuse or children in conflict with the law). How do you, as a counselor (or any other child care service provider), establish your identity as being different from others the child may have encountered (such as police, doctor, superintendent…)?

Introducing yourself (first) also helps to create a more equal platform for interaction versus only asking children to introduce and talk about themselves.

Explaining your role…

In many contexts, the word counselor has taken on negative connotations—especially as people threaten to 'send' a child to a counselor for bad behavior. So you may want to re-consider the use of the term 'counselor' nor is it useful to use your position or designation in the organization --these are meaningless to children and only serve to amplify power hierarchies that intimidate children. Perhaps you could consider using an introduction such as 'I am someone who works with children…many children have some difficulty or problem they are not sure how to deal with, they may have questions and confusions about things that have happened…I work with children to help them to resolve some of these issues and make things better and easier for themselves.' Essentially, children have to be able to make sense of who you are what your role is, including how you may be helpful to them.

- **Greeting**
    - Greet the child.
    - Shake hands (or not) as appropriate.
    - Tell the child your name and say who you are…then ask his/her name.

- **Clearing Misconceptions about Counseling and Alleviating Fear**

Children may be fearful about talking to a counselor. Explain what you will be doing with them and provide them with reassurance, in ways that are age-appropriate.

Example: "I am not here to give you medicines or injections, I am not the police or lawyer… am only here to talk to you and play with you when you feel like it…to talk about some things that you may find difficult or feel confused about…to ensure that you are comfortable and relaxed…and able to cope with any difficulties you might have."

- **Normalizing the phenomenon of getting help**

As mentioned, may children have negative associations with the role of a counselor as they think that 'only bad children' are sent to counselors or that they are strange in some way because they have some problem (that others do not). It is therefore essential to de-stigmatize or normalize the phenomenon of getting help.

Example:

- 'When you have fever or tummy ache, you go to a doctor to help you. In the same way, when you are feeling sad and upset about many things, I am here to help you feel better and see how to solve some of the problems you might have. We can play or talk about the things that are worrying you and we can see how best to make them better.'
- 'At school, you have a foot-ball/ sports coach who helps you play games better. I am a bit like that…I am here to help you feel stronger and happier…to help you with any troubles you may have…help you think about things and think about how best to solve some of your troubles.'

b) Preliminary Establishment of Context

- **Establishing child's knowledge and understanding**

Many children come to counselors or child care workers without really knowing what they are being asked to see the counselor for; caregivers are often silent and do not tell the child what issue they want to consult the counselor about. Establishing a context for interactions and work with the child is therefore critical i.e. if the child is not aware what issues need to be addressed or does not agree that he/she has a problem, then, there is no basis for counseling interventions! So how do we establish the problem context so that we have a consensus with the child that there is a problem so that we can work towards addressing it?

Example:

- 'Do you know why you are here with me? What were you told?'
- 'Tell me a little about why you were asked to come and see me…'

- (If the child states the concerns or complaints of the caregiver/ institution staff), 'Do you also feel that this is a problem that is creating difficulties for you? Or do you think that it is just others who see it as a problem…when it really is not?'
- (If the child does not know), 'I have been told a little bit about why you are here…you can tell me if what I have been told is correct. Your mother's concern (not complaint) is that you tend to be upset and angry these days. Do you agree? And do you want to tell me something more about it?'
- (If the child is silent and refuses to acknowledge the problem), 'We have only just met, so perhaps we need some time to get to know each other better…and it may be easier to talk about what is troubling you at a later time. That's fine…maybe we can play something instead today…'
- (In case of abuse and if the child is silent), 'I am given to understand that you have had some difficult experiences lately…I know it is hard to talk about them and you may not feel ready as yet to talk about them…but there is no hurry. I am here everyday and we will be spending time together to play and do stuff…whenever you feel ready and comfortable, you can tell me.'

Establishing the context does not mean that a child should be forced to talk about the problem right away, especially in case he/she is not ready to do so. But it still means that the counselor needs to allude to the problem in as much as he/she knows about it—because when the counselor and child are both silent about the problem, the child is left wondering (sometimes over several sessions/ days) about why he/she is coming to meet the counselor and what the purpose is! So, while the counselor may lay the problem context in session 2 (and not in session 1), note that this cannot be done in session 4 or 6—because a lot of time has gone by and the child is wondering what these sessions and activities are for.

- **Universalizing the child's experience**

An extension of normalizing the phenomenon of getting help, this technique helps the child feel less stigmatized or labeled; it is about conveying to the child that what happened to him/her or the problem he/she has, has happened to others or been experienced by others—so that the child feels more comfortable about talking about the problem or experience. It helps the child to know that the counselor 'has heard of this problem before and so I am not going to be telling her something that is weird or shocking'.

Example:

'Like you, lots of children, who now live here (in the shelter) have left their homes and had difficult experiences. So many children are sad and upset and need help with what they are feeling and experiencing. None of these children, nor you, are bad people or crazy people.'

- **Individualizing the child's experience**

Universalizing children's experiences should not come across to them as trivializing or minimizing their experiences i.e. that 'this happens to many children, so there is nothing special about you'! In order to ensure this, it is also important to individualize the child's experiences—to assure that child his/her experiences and problems are unique and warrant a serious consideration.

Example:

'While many children may have gone through experiences and troubles similar to yours, your experience is still different and special—and unique to your situation. Everyone needs help in different ways. I am here to understand and support you.'

Thus, universalizing and individualizing the child's experiences should be done in tandem as they are related techniques.

- **Ensuring Confidentiality**

Children have the right to privacy. In order to build a relationship of trust with children, it is important to assure them of confidentiality i.e. tell children that whatever they share with the counselor, will not be told to the caregiver or others. However, confidentiality cannot be absolute: it is not a matter of telling the child 'I will never tell…no matter what…' because a situation may arises at some point, wherein the counselor needs to disclose some of the child's issues usually in order to ensure the child's safety or best interests. An example of such a situation is child sexual abuse—a child may disclose about sexual abuse based on the fact that the counselor has assured confidentiality; but the counselor then finds himself in a position wherein he has to disclose the child's report in order to ensure that the child is safe and protected from abuse. If he discloses after giving absolute assurance of confidentiality, the child's trust will be broken and she will never want to work with the counselor again. So, how to assure a child of confidentiality in a manner wherein the counselor can negotiate a space in which to disclose if ever necessary?

Example:

'I want you to also know that when we talk or play, whatever we share will be between us. I won't tell anyone about your feelings or upsets. If there is a time/ a need to have to tell some of it to other people, I will only do it after consulting you and getting your permission—never without.'

So, what is of key importance (as per the example) is the child's permission. The counselor assures the child of confidentiality but tells the child that he will only disclose information if and when it is absolutely necessary—and that too, never without her permission. This means that the counselor will first discuss with the child what needs to be disclosed, to whom and why and only if the child agrees, they will, together, plan how the information will be disclosed (which parts to tell and to whom)—so that it is done in a manner that is comfortable to the child.

<u>Note:</u> We will return to a more detailed discussion on confidentiality issues in the context of child sexual abuse and mandatory reporting as well as when working with children in conflict with the law, when the child may want certain issues not to be disclosed to the legal personnel.

c) Let's get to know each other…

This technique refers to play and activities and further conversations that enable the child to feel relaxed and comfortable with the counselor. It is also a way to establish what the child's interests and hobbies are (such as art or story-telling, dance etc) so that these methods can be incorporated into the counseling process i.e. used to work with the child in counseling and therapy sessions.

- **Ask child neutral, non-threatening questions to elicit information about his/ her likes/ dislikes and interests:**
    - What did you eat today? What have you been doing all morning?
    - Flip a coin: The counselor and the child each choose 'heads' or 'tails' of a coin. When the coin is flipped, depending on what comes up, the person has to reveal a personal detail i.e. if the counselor chose 'heads' and heads comes up, she must reveal a fact about herself; if 'tails' comes up, it is the child's turn to reveal a fact about herself. Example: "Blue is my favorite colour", or "my favourite food is noodles". You may gradually modify this to 'let us tell fun facts about ourselves' or 'what no one knows about me is…' and elicit more personal details such as 'what makes me happy is…' or 'my favourite person is…' or 'who I miss most is…'
    - Alphabet pool: Having alphabets cut out from cardboard, each person draws from it and gives out one information which starts with the letter drawn out. For example: B-" I like to play ball" or S- 'I love to sing'. The facts or personal details revealed may gradually be used to talk to the child and ask more questions.
    - Find out what the child is interested in and likes to do by way of hobbies—such as drawing, craft or reading stories about particular topics.

- **Establish a spirit of collaboration**

Do an activity together…anything that interests the child and shows him/her that you are an ally.
You could…

- Play a board game and chat as you play.
- Read a story together.
- Do a jigsaw puzzle.
- Draw and colour a picture.

Whatever you do, it needs to be a joint activity i.e. both counselor and child participate in it. Asking the child to draw a picture while the counselor watches is *not* a joint activity! Not participating in the activity and having the child alone do it is more akin to instruction and children may feel nervous or as if they are being tested instead of a feeling that the counselor is a friend, a person who is 'on their side'.

Skill-Building Activity for Getting to Know the Child

Method: Role Play

Materials: None

Process:

- Ask participants to get into pairs. In each pair, one is to assume the role of the counselor and the other the role of the child (of any age).
- Ask them to role play the first session with the child…how would it play out?
- Their role play/ session needs to use the rapport building concepts discussed (above) and reflect the various steps involved, namely introduction, context establishment and getting to know each other better (including all the sub-steps discussed).

Discussion:

- Invite 2 to 3 pairs to come forward and do their role plays in plenary. (Thank those who have had the courage to come forward and make a start!)
- Ask the rest of the group to observe these role plays and state which of the concepts/ techniques discussed are reflected in these role plays—they can make suggestions on how to incorporate missing steps or on how they might do things differently.
- It is not wrong to start the interview with neutral questions/ games to enable the child (especially a slow-to-warm-up child) to feel comfortable before proceeding with establishment of context etc. However, the point is not to spent inordinate amounts of time on neutral questions and games, without introduction and establishment of context—this is because the child is left wondering why he/she is there with you…and in some children, this time lapse may serve to increase children's anxiety. So, it is best to begin with the introduction and proceed with the other steps either directly, or interspersed with neutral conversations and games—in accordance with each child's temperament and responses.

**Remind the participants that this is not an exercise in pin-pointing faults nor are these role plays suggesting that these are the 'right' or 'only' ways to proceed in counseling; these role plays offer a platform for us to experiment and try out new techniques and discard some that may not be so useful…so the purpose is purely to learn.*

3.2. Skill 2— Listening and Interest

Objectives

- Being aware of different levels of listening.
- Understanding the importance of listening skills.

Time

1 hour

Concept

The adult world is often too busy with its coping processes and too distressed to listen to children's experiences. It is critical to listen to the stories of children and understand it from their perspective. Listening encourages the child to share his difficulties and enables us to better understand how to help.

Listening comprises of 2 components: i) Listening (Reflective and Attentive); ii) Appropriate body language.

Reflective Listening: Involves paying attention to a client's verbal and non-verbal messages and listening in a way that conveys respect, interest and empathy. This form of listening might involve the counselor to respond to the client verbally. For example:
-Ok…
-Hmm…
-Alright…
-Yes…
These expressions are non-judgmental and neutral expressions that can encourage and facilitate discussion.

Listening Dos and Don'ts

Do…

- Show interest.
- Be empathetic and understanding.
- Demonstrate your interest through verbal and non-verbal cues.
- Listen for causes of the problem.
- Observe silence when appropriate.

Don't…

- Argue.
- Interrupt.
- Be inattentive.
- Do other work.
- Pass judgement.
- Give advice immediately.

Attentive listening: Involves paying attention to the client's verbal and non-verbal messages, this form of listening involves responding to the client in monosyllables and through expressions.
-Maintaining eye contact
-Nodding of the head
-Body posture like leaning forwards towards the child.
-Empathetic gestures like supportive pat on the shoulder or hand.

Appropriate Body language: Body language and postures are non-verbal communications that speak/express information about the behavior, interest/disinterest, attitude of the counselor towards the child. Hence, it is important for the counselor to be conscious of his/her body postures and language as it can affect communication.

The following are suggestions for maintaining appropriate body language while interacting with children:

- Maintain an attentive yet relaxed sitting posture. Avoid casual postures like slouching/drooping in the chair. Behaviors like yawning can hint disinterest towards the child's experiences and sharing, resulting in interrupting the counseling process.

- Avoid fidgeting around while the child is speaking. For example: the counselor must avoid shaking the feet, fiddling with pens, mobile, nails, and fingers. This interrupts the counseling process as it suggests anxiety and lack of confidence. As a result, the child might withdraw from sharing with the counselor.

- Avoid writing or making notes, and completing procedures as they can hint disinterest and also distract the counseling session.

- Maintain eye contact with the child when the child is speaking; nod your head. This expresses interest and genuine concern towards the child.

- Avoid using your mobile during a session—if it is urgent and you really must attend the call, ask to be excused for a moment, go outside the room and take the call.

- Remember that a child needs to feel that you are truly interested in his/her narrative—good listening in itself can be powerful in healing; when a child is heard (which is rare for most children), he/she feels that his/her experiences are being respected and acknowledged.

Skill-Building Activity for Listening

Method: Game

Material: None

Process:

- Divide into pairs. One member of each pair leaves the room and one stays in.
- Round 1: Group that is outside (when they re-join their partners) to talk for a minute continuously about some very important event in their lives to their partners. Instruct the group inside to sit with their fingers blocking their ears i.e. not to listen to their partners talking.
- Round 2: Group outside to talk for a minute about some very happy event in their lives to their partners. Instruct the group inside to look away, not make eye contact, not respond and act as if they are not listening.
- Round 3: Group inside and outside to talk non-stop to their partners. Neither should listen.
- Round 4: Group outside to share some very difficult experience in their lives with their partners. Instruct the group inside to be attentive, make eye contact, and express emotion.

Discussion:

- How the group outside felt during each round of the game?
- Various levels of listening i.e. from not listening at all (1) to 'hearing' without listening (2) to talking so much that there is no listening (3) and finally active listening (4). In which round is good communication taking place? Why?

3.3. Skill 3— Recognizing and Acknowledging Emotions

Objectives:

- How to identify and recognize emotions.
- How to communicate to a child that you recognize & acknowledge his/her emotions.

Time

2 hours

Concept

While listening to children as they narrate various experiences, counselors often say or tell children that 'I understand how you feel'. However, merely telling children that we understand how they feel does not convey to or convince a child that you understand exactly what they felt or experienced—unless you are able to state it in a more specific manner. When a counselor is able to read the emotions in a child's narrative and reflect these emotions to the child, it means he/she has been able to recognize and acknowledge the child's emotions.

On another level, this technique, especially the acknolwdgement part of it, also refers to acceptance of emotions. Acceptance of emotions means that you do not judge (you do not disagree with or correct) any feeling that the child may have. Emotions are neither good nor bad…they just are and we feel them, no matter that. Is anger bad? No, it is not…like happiness, excitement, enthusiasm or sadness, it is just another feeling…but not to be confused with hitting which may arise from feelings of anger (recall our discussion on context and behavior); so anger is legitimate, an action prompted by anger, such as hitting, may not be legitimate as it is harmful to someone. Take for example a situation in which you see a policeman beating a young boy or an institution staff stealing from the children's rations—would you not feel angry? Because you have an innate sense of what is just or unjust, you would be angry when you see someone weaker being exploited…and you should feel angry, for, if you did not, it might suggest that you are apathetic or that you don't care. Should you hit the policeman because you are angry? That is a different matter…the discussion is no longer about legitimacy of feelings but about legitimacy of an action. So, when you are acknowledging a child's emotions, you are validating his/her experiences, and legitimizing the emotions and feelings that arose from those experiences. Remember that you are not accepting or acknowledging the behaviours (which may have been positive or harmful) that stem from these feelings

Ways in which we recognize and identify emotions…
- Non-verbal cues: facial expressions, gestures
- Verbal expressions: tone of voice, actual content of speech
- Other behaviours

Of course we empathize…and we feel for the child but how do we show it?
- Non-verbal cues (holding hands, facial expressions, hugging…depending on the child's comfort)
- Verbal expressions (tone of voice, "I know it must have been difficult…it seems like you are really hurt and angry…"

Take another example—one where a child has lost his mother. If the child were to tell the counselor that he was very sad, the worst

response a counselor could give is to say 'don't be sad...after all, we are here for you'. While the intent may be to comfort and support the child, there are some issues with this response:
- How can a child not be sad after the loss of his mother? (after all, a 50 year old adult also cries when he loses his 80 year old mother and that is considered legitimate!);
- Why should a child not have the right to feel or express emotions?
- Would telling the child not to be sad make the child feel better or worse—because he feels judged for expressing his feelings?
- If the child does not feel reassured or comforted, then the purpose of counseling is lost—and so is the relationship of the counselor with the child because the child will not trust the counselor to understand his feelings.

The skill of recognizing and acknowledging emotions comprises of two parts: the first is to identify the emotions that the child may be feeling; and the second is to legitimize the feelings or emotions that we have identified. When children describe events in their life, the very first thing to do is to recognize what they are feeling and acknowledge that for example: '…when that happened, you must have been very sad and upset…you might have been angry too…' This will then assure children that you not just understand but empathize with their predicament - that in itself helps children feel supported and comforted (and is one of the main objectives of counseling). The idea is to be one with the child's emotions. Share in the happiness, grief, sorrow or feeling that is being expressed. Do NOT judge the emotions expressed (even if they are seemingly negative emotions). Remember that emotions are neither good nor bad. Never tell someone how they should feel!

*Use the examples below as part of your discussion after the participants have attempted the skill building exercise. Note that there are many ways to respond and these are just some suggestions and possibilities.

Example 1:

Saira, age 6: "When I went to school and came back, my father was gone. No one knows where he went. My mother left me here [in the institution]…but will she come back to see me?"

Possible Response: "Coming back from school and suddenly finding your father gone must have been very scary, especially as no one knew where he went. Coming to a new place and not having your mother around as you are used to is also difficult and scary for you—I am sure you miss your mother and feel sad that you are not with her. I am not sure whether she plans to come back to see you but …I will try my best to contact her and see if she can come. Meanwhile, I am here for you to talk to and play with…as are the other children".

Example 2:

Puneet, age 8: "My mother died a year ago…then I went to my aunt and uncle's house and stayed there for sometime. They said my parents were bad people and that I was useless and just taking up space in the house…they did not want me so they sent me here [to institution]."

Possible Response: "For someone to lose their mother is a very difficult experience…you must have really been sad and felt her loss. In addition to your sadness and loss, when your uncle and aunt said bad things about your parents and about you, you must have felt insulted and angry—naturally…no one likes it when insulting things are said about them and their family. I don't know how you feel about coming to this institution but considering that you were not very happy staying with your aunt and uncle, I hope this will be a more peaceful arrangement for you".

Skill-Building Activity for Recognizing and Acknowledging Emotions

Methods: Listing and generation of response

Materials: Children's narratives (see below)

Process:

- Divide participants into pairs and ask each pair to select any 1 or 2 cases (depending on time availability).
- Read each of the children's narratives (below) and do the following:
    - Identify and list the emotions expressed in each narrative.
    - Develop a verbal response to the child's narrative that indicates that you recognize and acknowledge the emotions felt by the child. In other words, when the child has spoken those sentences, what will you say immediately? Or what would you say next?

Note: Your response should not be more than a couple of sentences; No long drawn-out explanations, no suggestions or advice or provision of solutions! No expression of intent either ('I will say…')—say what you would say imagining that the child is sitting in front of you! Focus only on validation of emotions and experiences.
(Hint: Use the emotions you have identified/ listed to frame the sentences for the response).

Discussion:

- When the participants have completed their discussion in pairs, ask them to share their responses in plenary, for each narrative.
- Invite the group to critique the emerging responses (is the response validating emotions or is it providing help and advice? Would the child feel understood and comforted?)), to make additions and suggest alternative ways of responding.

Children's Narratives

Saira, age 6
"When I went to school and came back, my father was gone. No one knows where he went. My mother left me here [in the institution]…but will she come back to see me?"

Puneet, age 8
"My mother died a year ago…then I went to my aunt and uncle's house and stayed there for some time. They said my parents were bad people and that I was useless and just taking up space in the house…they did not want me so they sent me here [to institution]."

Shekhar, age 10
"Two years ago, I was sent to work as a helper in a shop to supplement the family income. The shop owner often yelled at me and hits me even for minor mistakes. But I cannot do anything because my family needs the little money that I earn."

Mamata, age 14:
" I feel scared all the time…I cannot eat, I cannot sleep…if I try to close my eyes, I see images of that man—he is coming towards me and I know he is going to hurt me."

Seema, age 15:
"My 25 year old cousin came to stay with us for a holiday. When my family was in another room, he said he loved me and he kissed me and put his hands inside my blouse and touched my breasts. I did not like it; he has gone back and is not in contact with me. I don't know what to do."

3.4.Skill 4—Acceptance and Non-Judgmental Approach

Objectives

- To understand what non-judgemental attitude means.
- To reflect non-judgemental attitude in communication with children.

Time

2 hours

Concept

To accept someone and to be non-judgemental is perhaps the hardest counseling skill of all, to practice. What does being judgmental mean? It means to take a position on an issue or action based on what you think is right or wrong; in other words, being judgmental also means to take a critical position on someone or something in a manner that may also be condemnatory, disapproving, or negative.

Children are exceedingly sensitive and easily able to sense when they are being judged. If a counselor appears judgmental or disapproving, the therapeutic alliance (relationship between child and counselor) is weakened or adversely affected because the child feels that the counselor is not on 'my side'; consequently, the child may no longer wish to continue communication with the counselor i.e. he/she may refuse to engage in further interactions. Children with conduct and behavior problems, such as children in conflict with the law, tend to be particularly difficult to establish rapport and trust with because they have been frequently judged at home, in school and virtually everywhere they go. As such, they have developed an identity of being a 'bad person'. So, when the counselor is judgemental, it only reinforces what they already believe and is unlikely to get them to be trusting of the counselor and open to reflection and behavioural transformation.

However, does this then mean that we should not take a position when an adolescent sexually abuses a young child or when an adolescent murders someone? Absolutely not. Being non-judgemental does not mean that we remain neutral by condoning violence or abuse. As counselors, we believe that children and adolescents must be held responsible for their actions. But does accountability mean that they have to be belittled, rejected, harangued and sermonized to? This would not be in the realm of counseling and would certainly require no skill to communicate in this manner (and most adults are already good at this way of dealing with children!). Holding a child accountable for his/her actions without being judgmental means presenting or framing the child's action as the problem, not the child or person as the problem i.e. making the difference between the person (who may be intrinsically good) and the person's actions which may have had problematic consequences (and which require reflection and evaluation).

Now, we all have opinions, viewpoints and positions on various matters, including other people's actions. Having a personal opinion or position is certainly not wrong. We are all entitled to have them. But imposing our personal opinions on others is not good counseling practice—doing that is

akin to instruction and advice, which are not the same as counseling. Non-judgemental counseling (and indeed counseling itself) thus entails:

- Recognizing and acknowledging a feeling/emotion—WITHOUT being judgmental about whether that feeling is 'right' or 'wrong'.
- NOT giving your personal opinion in a way that is critical or blaming in any way.
- Allowing for children to express ***their*** opinion and viewpoint.
- Providing space wherein their opinions and actions can be examined so that children have an opportunity to reflect on them—based on which they can make (more informed or thoughtful) decisions about their lives and actions.
- Acting as a sounding board, not giving your opinion expecting the child to follow it).

This is not to say that the counselor cannot present his/her views at all. The counselor can present *options and alternatives* (especially as the child may not be aware of all the possibilities that exist) but these must be done in a neutral manner and again, they need to be placed before the child for his/her consideration. Ultimately, it is the child's life and therefore the child's right to select which option he/she would want to follow or what position or action he/she wishes to take—the counselor is only facilitating the process, not making the decision.

The examples below use a framework that we call the window approach to working with adolescents on issues of sexual decision-making. The life skills series on 'Relationships and Sexuality' developed by the Community Child and Adolescent Mental Health Service Project a rights-based approach to sex and sexuality, implementing the activities on the premise that adolescents are at a developmental stage wherein they have love-romance-sex needs and that they have the right to have these needs met. However, the issue is how they make decisions about meeting their romantic and sexual desires—and these decisions cannot be made randomly or whimsically. The series has thus developed what is called a 'window approach' to provide a framework for decision-making—a window approach means not speaking directly about abuse prevention (which may be the final objective and therefore the last discussion in the series) but 'opening each window' one by one to introduce different but related concepts of personal safety and abuse: starting with (acknowledgement of) love/ attraction and physical pleasure, it moves on to examining and understanding concepts of privacy, consent and boundaries; learning about health and safety; and finally to consider relationship contexts (roles and expectations of others, and activities we do with various people by virtue of our relationship with them). Adolescents learn to use each window and concept individually and then collectively to arrive at decisions about sex and sexuality behaviours.

We will now use the approach that we have taken in the Life Skills Series to provide a brief first-level response to the child—this is part of the practice of non-judgmental attitude. [Discuss one example and then do the activity so that the participants can attempt to use the frameworks discussed in the example].

Non-Judgmental Attitude in Practice …Frameworks for Working with Sexuality & Abuse Issues

Example 1: A run away adolescent who gets pregnant

- Acknowledge adolescent's feelings of attraction/ desire for love (natural)
- Your concern for her safety—her intentions may have been clear/ may have wanted a serious relationship…but how do we know about the other person's intentions? Not a question of trusting her but of trusting others in the world out there…
- Engaging in physical intimacy is not a matter of right or wrong...people have different positions on it—some believe that it is legitimate only within a context of marriage, others believe that they can do so before marriage too. The issue is how one engages in physical intimacy…there are certain criteria to consider as you make the decision: who is this person and what are my relationship expectations of him? (emotional, long term, short term…?), are we both consenting? Will I be safe and protected from disease and pregnancy? (discuss STIs/pregnancy risks and use of condoms)
- Now that adolescent is pregnant…decisions about the baby—to keep it or give it up for adoption? What does adolescent want to do? (Remember, do not push your agenda—it is the adolescent's decision!)
- Discuss pros and cons of keeping the baby and giving baby up for adoption—and based on these, adolescent makes a final decision on what to do.
- If she decides to keep the baby, how will she plan her life around it? How will she provide for the baby financially? In case she finds someone to marry some years down the line and he doesb't want the baby…? (It is a matter of preparing the adolescent…even if she finds it difficult to envision issues that may arise in the future).

Example 2: An adolescent who sexually abuses a young child

- Acknowledge that everyone has sexual needs and desires...sexual acts can be pleasurable.
- But there is a context to them...where, when, how and with whom we do them...have to be thought through before we act on our needs/ desires.
- How would the other person have felt when you did that? Could they have been hurt, angry, scared...? (Empathy building)
- In case victim was a child—at what age are people usually ready for sexual engagement i.e. physically and in terms of feeling desire/ attraction? Do young children have the physical/ mental capacity to engage sexually? So then can we...?
- Did you know that there is a law called POCSO? It says... (No threatening! Provide information.)
- New JJ amendment/ December 2015 after Nirbhaya case...transfer system for heinous crimes. (Provide information).
- Even if the person is same age as you, can you still go ahead and act on your desires? What about the other person's permission/ consent? (Discuss issues of boundaries and consent…)

Skill-Building Activity for Acceptance and Non-Judgmental Approach

Activity 1: Distinguishing between Judgmental versus Non-Judgmental Communication

Method: Observation and Analysis

Material: Two scenarios/ conversations between counselor and child—one that is judgmental and the other that is non-judgmental (see below).

Process:

- Read the two scenarios/ conversations below, between counselor and child.
- Make a note of what the difference in the counselor response styles are in scenarios 1 and 2.
- Identify in which scenario the counselor is being judgmental and in which one non-judgmental i.e. in scenarios 1 or 2?

Discussion:

- What did the counselor do differently in scenario 2 versus scenario 1?
- Which do you think would be more effective in building a relationship with the child and why?
- How do you think the child would have responded/ said next in i) scenario 1; ii) scenario 2?

Situation A	
Scenario 1	**Scenario 2**
Child: I hate being here in this shelter! I don't want to stay here! I want to go home! Counselor: Yes, it may be difficult for you to be here. But think about all those children who do not have food or shelter such as you have here. Child: I hate the food here…it tastes horrible. Counselor: I have tried it and it is not great tasting…but it is not too bad…	Child: I hate being here in this shelter! I don't want to stay here! I want to go home! Counselor: Yes, it must be difficult for you…it must make you very sad to leave home…and angry to be in a place you dislike, where you don't have the facilities and conveniences you are used to. Child: I hate the food here…it tastes horrible. Counselor: What else about being here makes it hard for you?

Situation B	
Scenario 1	**Scenario 2**
Counselor: Did you know this person before you ran away with him? Adolescent: Yes, we were friends. Counselor: But he was so much older than you… Adolescent: Yes, but he said he cared for me and that he would look after me. Counselor: Don't you know that girls should be careful? and it will be a problem if we just believe some man like that… Child is silent. Counselor: And now you see what has happened…girls should be careful about relationships… and didn't you know about the dangers of HIV? Should you not think about your health?	Counselor: Did you know this person before you ran away with him? Adolescent: Yes, we were friends. Counselor: Did you feel comfortable and confident being with him? Adolescent: Yes, he said he cared for me and that he would look after me. Counselor: Yes, I guess you trusted him. Sometimes we all can get manipulated. Child is silent. Counselor: Now that HIV has happened, we would like to help you carry out whatever decisions you want to take. I know this must be difficult and frightening for you but I assure you of our support to you.

Activity 2: Being Non-Judgmental in Practice

Method: Role play

Material: None

Process:

- Divide participants into pairs; one participant assumes role of child and the other that of counselor.
- Ask each pair to select one situation (from below) and conduct a conversation with the child in the following ways:
- Round 1: What would the counselor say/ how would the session proceed if the counselor was being judgmental?
- Round 2: What would the counselor say/ how would the session proceed if the counselor was being judgmental?

* Ask the participants to imagine that the other steps in counseling have been completed i.e. rapport building, recognition and acknowledgement of emotions etc. They need to now talk to the child about the problem at hand—how would they do that without being judgmental?

Discussion:

- Request some of the pairs to step forward and do their role play in plenary.
- Discuss what they felt was the difference between being judgmental and non-judgmental.
- Invite the rest of the group to share feedback and comments on the conversation/ interaction…was the counselor able to be non-judgmental? If so, how? If not, how?

Situations:

- A 16 year old girl ran away with an older man and has just returned home, and found to be pregnant.
- A 15 year old boy sexually abused an 8 year old girl. (Your client is the 15 year old boy).

3.5. Skill 5— Questioning and Paraphrasing

Objectives

- How to use open and close-ended questions in interviewing children.
- How to use paraphrasing in the counseling process.

Time

2 hours

Concept

While interviewing a child, it is necessary to ask questions, whether they are questions pertaining to events or the child's thoughts and feelings or actions and decisions. But what is the difference between an inquiry conducted by a counselor versus one conducted by the police? [Ask participants what they think]. Both are inquiry processes. But they differ in their purpose and in their style of questioning (and response). How so? [Ask participants what they think].

For the counselor's inquiry not to be like a police inquiry, there are certain ways of asking children questions. Also, the counselor's interview is not one long question-answer session with the counselor asking question after question and the child having to answer each question. The inquiry process needs to be embedded within the counseling process; in other words, the counselor needs to also provide responses (recognizing and acknowledging the child's emotions, for instance) during the course of conversation with the child.

Now, there are two types of questions: open-ended and close-ended questions.

Close-Ended Questions: Where, When, Whom?

Have you ever done a survey? What kind of questions does a survey contain? Usually they are close ended—which means that a question can have only one possible, specific response like 'yes' or 'no'; even where there are multiple options for answers, the respondent is allowed to select only one or select more than one from the options presented i.e. he/she cannot give a detailed descriptions of other responses he/she may have to the question. For example, a survey question may ask 'does your child get enough food to eat?' and the answer option are 'yes' or 'no'; or 'what are the causes of child malnutrition?' and the answer options may be 'dirty water', 'poor sanitation', 'inadequate quantity of food available'…but if the respondent has other views on causes of malnutrition, there is no room to express them. Here is an example of how close-ended questions could play out in a child counseling session:

Leela : He behaved badly with me.
Counselor: Did he touch you?
Leela: Yes.
Counselor: Did he touch you in your private parts?
Leela: Yes.
Counselor: Did you try to scream for help?

Leela: Yes.
Counselor: And did someone come to help you?

What do you observe from this interaction where only close-ended questions were used? A lot of information on the event and the child's experience might get left out…because the questions are coming solely from the counselor's perspective and assumptions, based on what he/she thinks may have happened, but much more or very different things may also have happened. For instance, 'he behaved badly with me' may have included not just sexual touching but physical violence too but the counselor assumes that it means only sexual touching; the counselor's asking whether he touched the child in her private parts leaves out the possibility that he may have touched her in other parts or even that he may have done other things to the child.

The limitation of close-ended questions is that they do not help explore what happened in a detailed manner or encourage the child to talk about all the aspects and dimensions of his/her situation. Children are unlikely to tell you what happened or how they feel unless you create a space for them to do so—close-ended questions do not create this space and allow for information to come freely from them. Also, children (already used to adult, hierarchical ways of communication) are afraid to tell you the whole story and/or they think you don't want to know or that is all you want to know i.e. if you don't ask they won't tell!

This is not to say that close-ended questions should never be used. They are certainly useful and necessary—when specific information needs to be elicited such as time, place and name of person, for these can have only one answer—**when, where, whom?** The point is to use close-ended questions, but to a lesser extent with children, and in ways that will not block further information/ response.

Open-Ended Questions: What, How, Why?

These types of question lead to elaborate answers that do not end in one word.
They help to explore How and Why issues, thereby eliciting detailed, descriptive information from the child. For example:
Leela : He behaved badly with me.
Counselor: What happened?"
Leela: He touched me and made me uncomfortable.
Counselor: Could you tell me a little more about that?
Leela: He put his hands under my skirt and rubbed it.
Counselor: That sounds uncomfortable and scary—and you must have got hurt too. What did you do then?
Leela: I was so scared…I tried to scream…and then I ran from there…
Counselor: Sounds really scary. What happened next?

What do you observe from this interaction where open-ended questions were used?

Open-ended questions encourage the child to give his/her perceptions, opinions and viewpoints so that the counselor is better able to understand events and issues from the child's perspective. Instead of merely getting concrete factual information, the counselor is also able to glean what the

child felt. When exploring children's experiences of trauma and abuse, it is more useful to use open-ended questions in order to gently encourage the child to talk about difficult experiences.

Again, as mentioned, we are not suggesting that close-ended questions should never be used or that only open-ended questions must be used at all times. Both types of questions are valid and should be used. It is about the purpose of use i.e. what type of information a particular question is trying to elicit—if it is very specific information about place/time/person, where only one answer is possible, then close-ended questions must be used; but if the puspose is to detail out and event and understand how a child felt or responded, then open-ended questions are more useful. The counselor's skill lies in how to use the two types of questions, in combination, in an interview with a child—and in how to intersperse the questions with responses that are reassuring to the child rather than a one-way conversation wherein the counselor asks questions and the child has to answer.

Paraphrasing:

This is a skill of summarizing the content shared by the child to ensure and confirm that the counselor has not misinterpreted or missed out any information provided by the child. This helps avoid incorrect inferences, conclusions and judgments being made by the counselor. The child is also reassured that he/she has been understood. However, summarizing in this case does not mean merely repeating what the child said—it entails re-phrasing what the child along with:

- Recognition and acknowledgement of emotions to provide reassurance.
- Reflecting back the child's feelings about the experience.
- Saying something additional—to provide the child with hope and encouragement

For example:

"It seems like he touched you on your private parts and made you really uncomfortable and scared. It was a difficult situation to be in…But you managed to scream for help and run away, despite being scared—and that shows quick thinking and presence of mind. I am glad you told me about this incident…"

As you can see from this example, the counselor is not just repeating the child's story; he/she is also acknowledging her emotions and validating her difficult experience. However, she is taking her response one level further to provide the child with a sense of confidence—by attributing certain qualities to her (quick thinking…). Also, she is encouraging the child to be open and talk further by telling her 'I am glad you told me…'

Skill-Building Activity for Questioning and Paraphrasing

Activity 1: Distinguishing between Open & Close-Ended Questions

Method: Game

Material: A list of open and close ended questions (see below)

Process:

- In plenary, read each question aloud to the group and ask them to:
- State whether the question is open or close ended (for the initial responses, you can ask the group to state why).
- If it is a close-ended question, to convert it into an open-ended one and vice-versa (if it is an open-ended question, to convert it into a close-ended one).

**Note: Some are trick questions! They cannot be converted, for, if they are, the information they are seeking cannot be elicited. So, remind the participants that the questions have to be converted in such a way that the nature of the information sought should not change. For example, 'when did these events happen' cannot be converted into an open question—as the question is seeking a very specific answer i.e. time. So the answer can only be morning/ evening or at 6:30 pm etc*.

List of Questions

- What happened yesterday?
- Oh so he hurt you, did he?
- How many times did he do that to you?
- When did these events happen?
- Who was the person who asked you to go with him?
- Can you identify the people who accompanied you to the railway station?
- Tell me more about how he hurt you…
- What was your relationship with your mother like?
- Did you have a good relationship with your father?
- What are the things that make you angry?
- If someone shouts at you, do you get angry?
- Why do you feel anxious?
- Do you feel worried everyday?

Activity 2: Using Open & Close Ended Questions in Child Interviews

Method: Role play

Material: None

Process:

- Divide participants into pairs; one participant assumes role of child and the other that of PSS counselor.
- Ask each pair to select one child (brief) narrative/sentence (from below) and elicit information on the child's issues and circumstances with the child's narrative as the beginning of the counselor's inquiry and counseling. For example, the child says 'I do not feel like playing or doing anything'. How would the counselor continue from this point on?
- Ask participants to elicit the child's story in the following ways:
    - Round 1: Use only close-ended questions.
    - Round 2: Use both open and close-ended questions.

Discussion:

- Request some of the pairs to step forward and do their role play in plenary.
- Invite the rest of the group to share feedback and comments on the use of the questions.
- Discuss what hat they felt was the difference between using open versus close-ended questions.
- Was the paraphrasing done adequately? (In the manner discussed above?)

Child's Narratives/ Sentences

- "I do not feel like playing or doing anything anymore".
- "I hate what he did to me."
- "I feel like killing him, am so angry…"
- "I am afraid to go to school. I won't go any more".

Some Final Thoughts on Counseling Children…

- **Be honest. Tell the truth.** However difficult it may be and contrary to what we believe children do have the capacity to understand. They can cope with it. Do not tell children that dead people will return someday.
- **Never give false reassurances**. While always providing a sense of hope for the future, do not reassure children that their situation will magically change or tell them definitively that people they left behind will come. False reassurances could cause children to lose their trust in you.
- **Do not decide for children.** Provide information, discuss and resolve problem along with children; help them assess options and make decisions.
- **Avoid getting upset with them.** Remember their emotional state.
- **Never refer to any child as 'the child who lost his/her mother/father…'** because then that will become his/her whole identity rather than retaining and asserting his/her own identity, thereby blocking the healing process.
- **Be careful how you use physical touch.** Hugs and caresses are comforting for children. However, be careful how you use them. Some children may have a history of sexual abuse and may not appreciate this- in fact, they may feel very threatened. Hence, use touch only after you have established a rapport with a child.
- **Avoid giving material rewards and comforts.** These are only short-term ways of providing comfort. Focus on spending time playing and providing emotional care, warmth, affection. Children appreciate this more.
- **Be culturally sensitive.** Children can be from different socio-cultural backgrounds from that of the counselors, hence be accepting and nonjudgmental of the child.
- **Do not criticize.** Criticism threatens children and causes them to shut down communication. Children often behave and react based on their understanding and experiences of a particular situation. Focus on understand the context and experiences of the child.
- **Do not force the child to communicate and provide information.** Particularly in cases of sexual and physical abuse, but also in relation to other traumatic experiences, children must be comfortable and share information at their own pace.
- **Do not order.** Avoid telling children what to do and how to do. Gentle suggestions are welcome but allow children to decide for themselves through a process of discussion.
- **Be well-informed about other available resources and services.** Know what other community services and resources are available to children and provide information to them and their parents.

4. Common Child & Adolescent Mental Health Problems

4.1. Identifying Common Child & Adolescent Mental Health Issues

Objectives

- Identify developmental disabilities and common emotional and behaviour problems.
- To develop a care plan for the child.
- To be able to refer to specialized psychiatric care facilities (for medication and therapy as necessary).

Time

1.5 hours

Concept

Anyone who works with children needs to be familiar with the 4 pillars of child psychosocial care work: childhood, child development, communication techniques and common child mental health disorders. Both for children in conflict with the law and children in need of care and protection, mental health vulnerabilities/ disorders are an important part of their pathways to problems/impact and needs. Therefore, any decision, order or judgement needs to take mental health issues into consideration. Here are two examples:

i) The mental health impact of a child who has been trafficked, manipulated, sexualized and abused is likely to have severe forms of trauma. Sensitivity of such impact is imperative in any decision-making process as decisions that further undermine the agency of the child only serve to vitiate the trauma. Such a child would require intensive mental health assistance to address post-traumatic disorder issues.

ii) A child who comes from a vulnerable family background with family pathology such as alcoholism, domestic violence, neglect and lack of supervision and who also has attention deficit hyperactivity disorder (ADHD) is vulnerable to gravitate towards substance abuse and risk behaviours. Such a child would need mental health assistance to address the combination of ADHD, a neuro-developmental problem, and family pathology.

Indicators for Referral to Psychosocial & Mental Health Facilities

- Self-harm and suicide risk
- Severely traumatic contexts such as sexual abuse/ trafficking (wherein child has been sexually exploited or experienced severe physical violence…)
- Substance use (high frequency/ intensity use especially of alcohol/cannabis…)
- Excessive violence/ aggressive behaviour (destruction of property/ causing severe injury to others through physical or sexual abuse)
- Repeated run away behaviour
- 'Odd behaviours' such as talking to self/ no time or place orientation/ disinhibited behaviours/become very suspicious or paranoid/hear or see things that are not there/act very differently than they did before.

While mild to moderate issues can or should be addressed by primary level caregivers (such as institution staff/ counselors/ teachers…), severe manifestations of mental health problems require to be referred to specialized or tertiary level mental health services. It is important for child care professionals therefore to recognize signs and symptoms of mental health problems that require referral.

Activity for Identifying Common Child & Adolescent Mental Health Issues

Activity 1: A quick Overview of Signs and Symptoms

Method: Memory Game and Quiz

Materials: Cards with signs and symptoms of common child & adolescent mental health disorders (see below for cards).

Process:

- Divide into 5 groups (6 members in each group).
- Each team will be given 2 mins time to see and memorize all the symptoms of the mental health problem which is displayed.
- Later, each team will be given opportunity to recall all the symptoms which was displayed.
- The team which is able to recall all the symptoms correctly are awarded 10 points.

Activity 2: Applying What We Know…

Method: Game

Materials: A large space; cards with the names of disorders on them; case studies (see below).
*Lay out the cards (each with a separate disorder written on it) in different corners of the space.

Process:

- Listen to each case study that is read out.
- Decide what child mental health issue the said child may have (from amongst the problems & disorders that you know of now).
- Stand by the card that that corresponds to the disorder that you have decided on for a given case.
- Justify your decision!

Case Studies for Child Mental Health Issues

Case 1: Suma is a 15 year old girl rescued from sex trafficking. She is at the girls' home and reports that she is unable to eat, sleep or focus on activity as she feels fearful and restless all the time, that she keeps seeing scary images all the time. She also cries a lot and frequently gets into fights with the other girls.

Case 2: Vishnu is a 14 year old boy is at the boys' home. He was found at a railway station. Each time he is asked where he is from/ his family's whereabouts and other details, he gives different information. He is also observed to be doing dances for other children, using somewhat sexual moves. He offers to work for you, saying he can make you tea and wash dishes.

Case 3: Ravi is a 10 year old boy who has run away and come to the boys' home for the 4th time. He says that he quit school a year ago because it was boring and that he was always getting into trouble with the teacher for going in and out of class. He also says that his parents beat him a lot and so, he does not want to live at home any longer, and that he prefers to be out of the house anyway.

Case 4: Meera is a 16 year old girl who was sent to the city with the promise (by someone in her village) that she would be sent to school. Instead, she found herself put to work for 2 years by family in the city. She was given no time off, not sent to school and often denied food. She is now in the girls' home, crying all the time, having difficulty with eating and sleeping, disinterested in all activities that the home does; the staff report that she does not talk to anyone or play with anyone and that she has attempted to cut herself too.

Case 5: Rani is a 12 year old girl who is in the girls home. The staff report that she nearly every other day, she suddenly 'loses consciousness' and often complains of a stomach ache. However, the medical check-up shows that there are no serious medical issues. Rani was rescued by childline after she was sexually abused by her step-father.

Case 6: Nitin is a 16 year old boy who has run away from home. He lived on the street for a year before he was rescued and placed in the boys' home. He often beats and bullies younger children in the home; he has contacts who help him access alcohol and cannabis even in the boys' home. He is the leader of a gang in the boys' home and he encourages the group to break windows etc to meet their demands as well as to consume alcohol/ smoke cannabis.

Activity Material (Identifying Common Child & Adolescent Mental Health Issues)

(1) Attention Deficit Hyperactivity Disorder (ADHD)	Often has trouble keeping attention on tasks or play activities. (Poor concentration)	Often does not seem to listen when spoken to directly.
Excessive running/ climbing (more than other kids).	Often does not follow instructions and fails to finish schoolwork/ activity; moves on to something else.	Often loses things needed for tasks and activities (e.g. toys, school assignments, pencils, books, or tools).
Often has trouble playing rule-based games or enjoying leisure activities quietly.	Is often easily distracted.	Is often forgetful in daily activities.
Is often "on the go" or often acts as if "driven by a motor."	Often restless/fidgets with hands or feet or squirms in seat.	Often gets up from seat when remaining in seat is expected.
Often has trouble waiting one's turn.	Often interrupts or intrudes on others. (pushing/poking/hitting…).	Impaired social judgement/ hasty decisions without due thought (older children).

(2) Conduct Disorder	Aggressive behavior, such as cruelty to animals, fighting and bullying.	Truancy from school
Defiant, disobedient, provocative behaviour	Destruction to property/ vandalism	Fire setting
Running away from home	Stealing	Repeated lying

(3) Depression	Frequent sadness, tearfulness, crying.	Hopelessness
Poor concentration	Decreased interest in activities; or inability to enjoy previously favorite activities	Frequent complaints of physical illnesses such as headaches and stomach aches
A major change in eating and/or sleeping patterns	Social isolation, poor communication , refusal to play	Low self-esteem and guilt Extreme sensitivity to rejection or failure
Talk of or efforts to run away from home	Increased irritability, anger, or hostility	Difficulty with inter-personal relationships
Thoughts or expressions of suicide or self-destructive behavior		Persistent boredom; low energy

(4) Anxiety	Clinging to caregivers	Afraid to be away from caregiver
Bed-wetting (in older children)	School refusal	Excessive shyness
	Difficulty interacting with new/unknown people	Thumb-sucking/ nail biting
Sleep disturbances/ nightmares	Poor concentration	Medically unexplained complaints of physical illnesses such as headaches and stomach aches
Fear of harm befalling self/others	Frequent hand-washing/cleansing behaviours	Frequent behaviours of checking (on people/doors being locked…)

(5) Post Traumatic Stress Disorder (PTSD)	Experiencing recurring images and nightmares of the event	Constant fear and anxiety
Loss of interest/ no motivation to carry on daily activities, even those that they like i.e. play	Intense physical and psychological distress when exposed to sights/ sounds symbolizing events	Avoiding people, places, events that remind them of the traumatic event
Lack of energy, tiredness, (also a result of stress)	Sad, crying, clinging to parent	Withdrawal from family and friends
Sleep disturbances/ nightmares	Irritable and easily angry	Bed-wetting
Body aches--children particularly may complain headaches, chest pain and abdominal/ stomach pain.	Difficulty concentrating/ focussing on activities	Feeding problems/ loss of appetite
Attempts of suicide/ self-harm	Frequent illness and skin and respiratory ailments	Use of drugs/ alcohol to cope with the situation

(6) (a) Mild Intellectual Disability	Able to learn practical life skills & function in daily life.	Attains reading and math skills up to grade levels 3 -6.
IQ of 50 to 69	Able to blend in socially but can have deficits in socio-emotional skills	Has the potential to be trained in socio-emotional skills, personal safety & vocational skills.
6 (b)Moderate Intellectual Disability	Noticeable developmental delays (i.e. speech, motor skills)	May have physical signs of impairment (i.e. thick tongue)
IQ of 35 to49	Can communicate in basic, simple ways	Able to learn basic health and safety skills
Can complete self-care activities—requires much training.	Difficulty socially blending in (often play with very much younger children/ cannot integrate socially with their age-group)	
6(c) Severe Intellectual Disability	Considerable delays in development	Little ability to communicate
IQ of 20 to 34	Needs direct supervision in social situations.	Need considerable supervision and assistance for self-care

Profound Intellectual Disability	Significant developmental delays in all areas (physical/ social/ emotional/ language/ speech)	Obvious physical and congenital abnormalities
IQ below 20	Requires close supervision/ Not capable of independent living	Requires complete assistance in self-care activities

4.2. Assessment & Individual Care Plans

Objectives

- To understand clearly the context of the child.
- Identify psychosocial care, mental health and protection issues for which the child requires assistance.
- To be able to develop an individual care plan and refer to specialized facilities when necessary.

Time

1 hour

Concept

Assessments:

We now use the understanding and knowledge now obtained on children, childhood, child development and communication skills, to do assessments and develop individual care plans. Assessment proformas are not just general factual profiles that we obtain mechanically through a form-filling exercise with the child! You now know that obtaining information from a child i.e. conducting inquiry entails the use of multiple child communication skills (which you can now use effectively).

What to do with assessments?

- Develop Interventions...
- Provide first level responses (validation of emotions/ immediate attention to medical aid & basic needs/relaxation techniques…)
- List problem areas you/ the child need to work on, including psychological and social support/intervention required.

Completed assessment forms are also not just for your files or a statistical record of demographic data! They are meant to generate individual care plans for children, to enable rehabilitation, repatriation and other forms of assistance as required for age-appropriate, optimum development and healing and recovery. In developing individual care plans and making decisions plans regarding placement, rehabilitation, reintegration of child into family and/or referral to psychiatric facilities, it is essential to always consider the following:

- Child's psychosocial context and issues
- Child's right (to decide)
- The best interests of the child (safety)
- Other systems' responses to the child/ how child is affected/ how you will respond to systems

See Annexes I & II for suggested assessment proforma, developed by the Community Child & Adolescent Mental Health Service Project, Dept. of Child & Adolescent Psychiatry, NIMHANS. These have been in use over the last few years both in NIMHANS's special clinical services for children in difficult circumstances as well as in its community outreach programs in schools and child care

institutions. Forms that are relevant i.e. depending on the profession and cadre of the trainees, may be discussed by going through them i.e. item by item.

Note: Assessment proforma for young children 0 to 6 years are available in the training manual 'Working with Preschoolers'; Assessment proformas for children in conflict with the law are available in the training manual 'Working with Children in Conflict with the Law'.

Distinguishing between Rehabilitation and Mental Health Assistance:

Rehabilitation entails a wide range of activities such as physical and nutritional care, (non-formal) education, vocational training, generic life skills sessions for children on self and personality development, creative art and craft activities, leisure and entertainment activities, rest and relaxation activities. In essence, rehabilitation is about maintaining children's developmental trajectories, by ensuring that they are engaged in age-appropriate tasks and activities that promote (normal) development.

In cases of children within the Juvenile Justice System (wither in a care and protection home or in an observation home), rehabilitation is also linked to issues of repatriation and reintegration, in case of children in care and protection systems. Contrary to general perception, repatriation is not merely a linear two-part procedure of tracing a child's family and sending the child home or back to his/her family. Furthermore, blanket statements that 'all children should not be in institutions, they should be at home with families' are incorrect; traditional, societal perceptions such as the best place for children being home/ with parents does not always hold true, particularly in the case of children in difficult circumstances. Home and families are the best places for children only if they are safe and nurturing. In situations of deprivation, neglect and abuse, children are certainly safer and better off in well-run child care institutions that are able to provide for their basic needs and education. Thus, the following are the considerations for repatriation:

- The decision to send a child back to his/her family needs to be based on:
  i) The child's wish at the time when repatriation processes are initiated;
  ii) The ability of the family to ensure safety and developmental opportunities for the child (a home study may be undertaken for this purpose).
- The issue of repatriation will therefore require some discussion and preparation with the child, so that he/she is agreeable to going home and is equipped to manage any challenges that come up. (These issues require to be discussed with the child by counsellors). In situations where the child, whether due to abuse or family dysfunction, does not wish to return to his/her family, there can be no coercion of the child, by the system/ agency, to return home. Remember that this is where child rights plays out in practice! We would need to respect the child's wish and make alternative placement arrangements.
- The child's parents/ family may also require to be prepared—and assisted to be able to take the child back; this may include some changes in the home and in the parents' behaviour towards the child, to enable a more supportive, nurturing environment for the child. [Parents may also be referred for family counselling to address issues of violence, alcoholism and other factors contributing to family dysfunction].

(Child) mental health assistance entails clinical assessments of children's emotional and behavioural issues, the contexts in which they occur and an analysis (case formulation), based on

which different interventions by way of psychiatric medication and other therapeutic inputs are devised (in keeping with the needs of each individual child). This is particularly important in cases that meet criteria for a psychiatric diagnosis. **Such assessments and interventions are carried out by qualified mental health professionals, namely psychiatrists/psychologists/social workers.** Thus, it is inadvisable for mental health assistance to be carried out by child care workers who are not qualified in the field of mental health.

That said, in-house counsellors in child care institutions and child care service providers, particularly frontline workers can be trained to provide basic mental health assistance to children in difficult circumstances. In fact, mild to moderate issues can be responded to at primary level by various cadres of community-based child care workers; in case of severe problems, it is recommended that assistance is sought, through referral, from tertiary care systems (in accordance with referral criteria previously discussed).

5. Field Practice

5.1. 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 Supervised 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 list of children that you can work with individually—it could be children whom they have observed to have emotional and behaviour problems.
- Ask participants to get into pairs.
    - Each participant-pair must work with one child, over a period of about an hour to do the following:
    - Administer the individual assessment proforma
    - provide some basic inputs through use of the basic counseling skills taught in the workshop
    - Feed back to the institution staff/superintendent on the institution on what the child's issues and requirements are (the individual care plan).
- The work with individual children is done by the participants under supervision of the facilitator—so ensure that you provide on-going assistance i.e. as the participants work with children and have questions or doubts.
- 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 interaction and interview with the child was challenging? Provide suggestions accordingly—encourage participants to also assist each other with solutions.

5.2. 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. So practice and more practice!

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

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

Process:

- Ask participants to do the following:
    - Select 1 child in your institution.
    - 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.
    - Bring the assessment form as well as the (completed) problem analysis/ matrix, with you to the next workshop.
    - You will need to present your case at the workshop.

In the next workshop, the facilitator may begin with the case presentations—this is an effective way to do a review of the previous workshop, and decisions may be made about where the learning gaps are, and where participants needs repetition or additional learning support.

Annex I

Assessment Proforma for Children in Care & Protection (ages 7 to 17)

Community Child & Adolescent Mental Health Service Project
Dept. of Child & Adolescent Psychiatry, NIMHANS and Dept. of Women & Child Development, Govt. of Karnataka
Assessment for Children in Care & Protection Systems (Institutions/Childcare Agencies)

1. Basic Information

Name: **Name of Institution/Agency:**

Age: **Sex:** **Class:** **Date:**

2. Presenting Problems/Complaints

3. Institutional History(where all the child has been /lived, for what periods of time, experiences and difficulties, circumstances of coming to this agency)

4. Family Issues Identified (Child's living arrangements/parental relationships/child's emotional relationship & attachment to parents/illness/alcoholism/violence/single-parent other difficult issues within the family).

5. Child's Temperament and Personality (Caregiver's description of child's temperament and personality –aggressiveness, sociability, attentiveness, motivation, emotionality…)

6. Schooling History (School performance/specific learning disabilities/school attendance)

7. Work Experiences

(Child labour experiences: why child had to work/ how child found place of work (trafficking?)/where the child was working, hours of work, amount of remuneration received/whether this was regular, any form of abuse encountered at the place of work/ how the owner and others treated child.)

8. Physical, Sexual & Emotional Abuse Experiences *(Ask Child)

Sometimes people behave in ways that are hurtful to children. Tell me about anyone/ people who have behaved in ways that have:

8.1. Physically hurt you and caused you injury?

8.2. Said things to make you feel hurt/sad/ angry/humiliated?

8.3. Touched you in ways that made you feel uncomfortable?(Sexual history- Note child's abuse and other sexual/relationship history)

9: Substance Abuse *(Ask Child)

9.1. Have you ever used any substances such as cigarette/ beedi / gutka/ hans (panparag) /ganja/ solution/ alcohol? (any other—specify)

9.2. Which of the above drugs did you use most?

9.3. How frequently were you using the drug and since when? (No. of times/ day/week)

9.4. Tell me about how this drug use started…including what situations/places you use it.

9.5. Did you notice the need to take more and more of the drug as time went on (compared to when you started?)

9.6. Whenever you cut down or stopped using the drug, did your body feel bad or uncomfortable—such as sick/ achy/shaking/weak/sweaty…?

9.8. Did you spend less time on other things because of your use of the drug (such as school/friends/other daily activities)?

9.9. Have the use of drugs ever put you in a difficult situation such as: (Causing health problems (specify) or making you do risky or dangerous things (describe) or Causing legal problems (provide details)

X: Feelings and Emotions

1. Anxiety

i) Look at the feelings thermometer and tell me, for most of the time, how worried do you feel? (Mark it).

0	1	2	3	4	5	6	7	8	9	10

ii) At which times do you feel really very worried? Describe when/in what situations**.**

2. Depression and Self-Harm Risks

i) Look at the feelings thermometer and tell me, for most of the time, how sad/bad do you feel? (Mark it).

ii) At

0	1	2	3	4	5	6	7	8	9	10

which times do you feel really very sad? Describe when/in what situations.

iii) Have you ever felt like life is not worth living/ you don't want this life…? When? Tell me what you do at such times.

3. Anger.

i) Look at the 'feelings' thermometer and tell me, for most of the time, how angry (or irritable) do you feel? (Mark it).

0	1	2	3	4	5	6	7	8	9	10

ii) At which times do you feel really very angry? Describe when/ in what situations/ what do people do to make you angry.

iii) What do you do when you feel very angry?

XI: Any Other Observations of the Child

Time-place orientation/ cognitive/ thought processes/ cooperativeness, rapport, social responsiveness/ Attentiveness & Activity level/ Speech and language skills:

XII Summary of Child's Problems

A. **Summary** (Based on the above assessment, summarize the main problems and concerns of the child, including protection and psychosocial issues. Mention key survival challenges and coping strategies).

Disability (Physical/ Intellectual):

Psychiatric Diagnosis:

Medical Problem:

Context:

B. **Care Plan ((**List actions taken or planned by the assessment agency/ case worker to assist the child, such as emergency actions/ measures to address immediate concerns, referrals made to other agencies/depth work).

Annex II

Suggested Training Workshop Schedule

DAY 1		
9:00—10:00 am		Introduction & Ice-Breaker
10:00—11:30 am	**Children & Childhood**	Reconnecting with children and Childhood
11:30—11:45 am		*Tea Break*
11:45am –1:15 pm		Power & Rights
1:15—2:15 pm		*Lunch*
2:15—4:30 pm		Applying the Child Development Lens
4:30—4:45		*Tea Break*
4:45—6:30		Representations of Childhood
DAY 2		
9:00—11:30 am	**Children & Childhood**	Identifying Emotional & Behaviour Problems & Contexts: Child's Experience & Inner Voice
11:30—11:45 am		*Tea Break*
11:45am —1:15 pm	**Communication & Counselling Techniques with Children**	Skill 1: Getting to Know the Child
1:15—2:15 pm		*Lunch*
2:15—3:00 pm		Skill 2: Listening and Interest
3:00—4:30 pm		Skill 3: Recognizing and Acknowledging Emotions
DAY 3		
9:00 pm —11:30 am	**Communication & Counselling Techniques with Children**	Skill 4: Non Judgmental Attitude & Acceptance
11:30—11:45 am		*Tea Break*
11:45 am—1:30 pm		Skill 5: Questioning & Paraphrasing
1:30—2:30 pm		*Lunch*
2:30—4:30 pm	**Common Child & Adolescent Mental Health Problems**	Identifying Common Child & Adolescent Mental Health Issues
4:30—4:45 pm		*Tea Break*
4:45—5:45 pm		Assessment & Individual Care Plans
DAY 4		
Field Practice & Demonstration		