Towards a new dawn
Ministry of Women and Child Development
Government of India

Essential Interventions & Skills for Working with Child Sexual Abuse

Introducing Mental Health & Legal Dimensions of Forensics

A Training Manual for Mental Health Professionals and Allied Health Service Providers

SAMVAD

Support, **A**dvocacy & **M**ental health interventions for children in **V**ulnerable circumstances **A**nd **D**istress
(A National Initiative & Integrated Resource for Child Protection, Mental Health, & Psychosocial Care)
Established byMinistry of Women & Child Development,
Government of India
Located in Dept. of Child and Adolescent Psychiatry,
National Institute of Mental Health & Neurosciences (NIMHANS),Bangalore

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Acknowledgements

At the outset, we would like to express our gratitude to the Hon'ble Minister of Women and Child Development, Ms. Smriti Zubin Irani, for her vision and steadfast support, which has culminated in this unique initiative for vulnerable children. Indeed, it is this vision and support from the Ministry of Women and Child Development, Government of India, that has enabled SAMVAD to undertake the development of this manual, as part of its work on child mental health, protection and psychosocial care.

We are grateful to the mental health professionals and child protection workers and paediatricians, who have shared their experiences and challenges in working with issues of child sexual abuse, during the course of SAMVAD's training programs and tele-mentoring sessions. Indeed, these engagements stimulated much critical discourse on child sexual abuse interventions, highlighting for us the myriad dilemmas and challenges that child health service providers encounter in their practice. Likewise, we owe a debt of gratitude to the judicial officers with whom we have worked, both in court, and in judicial education programs, and from whom we have gained invaluable learning, about children's interface with legal systems.

We acknowledge the contributions of other mental health professionals to this manual, namely, Dr Eesha Sharma, Associate Professor, and Dr Harshini Manohar, Assistant Professor, Dept. of Child & Adolescent Psychiatry, NIMHANS, for proof-reading and providing further inputs to this manual. We also express our deep gratitude to Dr Joske Bunders-Aelen, Faculty, Athena Institute, Vrije University, Amsterdam, for guiding the transdisciplinary thought that informed the conceptualization and content of this manual.

Finally, but most importantly, we are grateful to the many young children and adolescents, whom we have had the privilege of assisting, through their experiences of adversity and abuse. This manual, as it should be, is as much informed by their questions and concerns, their struggles and reflections, and processes of healing and recovery, as by adult or stakeholder and service-provider perspectives. We therefore dedicate this manual to children everywhere, to their safety and protection, and their journeys of hope and reclamation—all of which continually propel us to develop more intensive, child-centric endeavours, to assist them as they traverse the long and winding roads of justice, healing and recovery.

- Sheila Ramaswamy, Technical and Operational Lead, SAMVAD
- Kritii Tikku, Mental Health Team, SAMVAD
- Saurabh Shashi Ashok, (Former) Policy and Law Team, SAMVAD
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- Dr Shekhar Seshadri, Advisor, SAMVAD, (Former) Senior Professor & Head, Dept. of Child & Adolescent Psychiatry & (Former) Dean, Behaviour Sciences Division, (Former) Director, NIMHANS

Preface

Justice B. V. Nagarathna
Judge
Supreme Court of India

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Preface for Training Manual

The launch of the Training Manual on "Essential Interventions and Skills for Working with Child Sexual Abuse—Introducing Mental Health and Legal Dimensions of Forensics" marks a critical landmark in the quest for comprehensive protection of children from child sexual abuse. It is becoming increasingly evident, from both global as well as the Indian judicial experience, in children's interface with the law, there are strong imperatives for multiple stakeholders within the child protection system to work together which is critical in cases of child sexual assault.

The National Institute of Mental Health and Neurosciences (NIMHANS) deserves commendation for their Support, Advocacy and Mental health interventions for children in Vulnerable circumstances And Distress, i.e., the SAMVAD initiative. I also commend the Ministry of Women & Child Development, Government of India for establishing the National Initiative & Integrated Resource for Child Protection, Mental Health & Psychosocial Care at the Department of Child and Adolescent Psychiatry at NIMHANS, Bangalore. This initiative is not only critical for the capacity augmentation of mental health service providers but also for strengthening the legal and institutional architecture for the protection of child rights.

A child whose psyche is disturbed by the horrors of the past cannot be expected to enjoy the inalienable right to make choices about his life. Child sexual abuse not only afflicts the core of the personality of a child but can also have a debilitating impact on his life choices, education, career, family and intimate life. Children at tender age tend to suffer mental health conditions involving flashbacks, nightmares and fear of being alone because of their past suffering. Therefore, the judicial system and the public health system must take every step to mitigate the psychological, emotional and mental impact of crime so as to nurture emotional resilience against trauma.

Therefore, it is axiomatic that knowledge and skills to address repercussions of child sexual abuse within both mental health and legal systems ought to keep pace with awareness and reporting. Lack of mental health resources and uneven distribution can lead to unaddressed childhood mental health issues related to trauma and adverse experiences. This, combined with scarce expertise in treating such traumas, contributes to significant mental health problems in children. This training manual is thus a step in the direction of tackling this serious challenge.

With the implementation of the Protection of Children from Sexual Offences Act, 2012 (POCSO Act, 2012), child mental health professionals are increasingly called upon to assist legal authorities by providing assessments, expert opinions, and testimonies for court decisions. Building on the provisions of the Indian Evidence Act, 1872, the POCSO Act, 2012 strengthened the validity and reliability afforded to the statements and evidence provided by child witnesses and child victims of crime, thereby seeking to also provide justice to sexually abused children, by punishing alleged perpetrators of sexual offence.

Unlike in pre-POCSO times, legal and judicial personnel enter the picture soon after the abuse is reported to law enforcement authorities. In so doing, the POCSO Act, 2012 also operates in a complex context, not least because it is heavily reliant on child witness testimony i.e. the child's disclosure and subsequent narrative of the abuse experience, for prosecution of the accused. This challenge is further exacerbated by the adversarial justice system, which was not designed to accommodate the needs of child witnesses but within which the POCSO Act, 2012 is required to operate. Despite the special provisions that the law makes to ease the process of child witness testimony, adversarial adjudication, characterized by principles of orality and cross-examination, does not favour vulnerable witnesses such as children, who may have deficits in communication and other competencies required for testifying in court, and are at risk of both secondary traumatization and re-traumatization during court processes.

In light of the above challenges, eliciting evidence from children calls for certain skills and sensitivities: information that can stand the tests of

reliability is dependent on the developmental level of children, their emotional states (particularly in the aftermath of abuse), the manner in which children are interviewed or questioned and the environment in which these processes are conducted. In other words, these considerations are important for: (i) enhancing the child's competencies to 'tell the truth' or provide accurate testimony, as essential to the purposes of the court; (ii) maintaining the balance between adhering to the frameworks of the law and ensuring child rights, mental health and well-being.

The complexities of addressing the issue of child sexual abuse require us to perceive the intersectionality between healing and justice, which in turn, entails the straddling of the domains of child mental health and law. Thus, 'Interventions & Skills for Working with Child Sexual Abuse: Introducing Mental Health and Legal Dimensions of Forensics' harmonizes mental health knowledge with legal mandates.

This initiative is a crucial step towards realising the noble mandate of the framers of the Constitution. As per Article 47 of the Constitution, the State is obliged to not just treat public health as its primary duty but also to make all possible efforts to ensure equitable access to healthcare services. These efforts must be made to progressively realize the 'Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health', as acknowledged in international conventions and agreements. The right to mental healthcare is a critical component of the constellation of rights emerging from Article 21 of the Constitution and stands fortified by the Mental Healthcare Act, 2017. Even the World Health Organisation's Constitution states: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." This training manual serves not just as an educational tool, but as a beacon guiding mental health and allied medical professionals in their crucial role at the confluence of child protection, law and mental health.

It is my hope and belief that this training manual would go a long way in enhancing access to substantive justice for victims of child sexual abuse. By equipping mental health service providers and allied health service providers

with the requisite knowledge and skills to assist sexually abused children, this educational resource provides a way forward for judicial personnel in interfacing with child witnesses, addressing dilemmas of mandatory reporting, child witness competencies in the provision of court testimony, problems of suggestions and tutoring and children's struggles in contending with the adversarial justice system, to forensic interviewing, court preparation of child witnesses and provision of expert testimony. It encourages mental health professionals to undertake their increasing roles and functions in child forensics and medico-legal matters, as often requested by legal and judicial personnel— there is a paucity of time, knowledge and skills in child work that hinder the latter from engaging with children in the often difficult context of the courtroom.

It would also lead to alleviation of hurdles faced by children afflicted by the painful memory. It would enable the justice system to acquire expertise in addressing child protection, trauma, and mental health comprehensively. It would fortify the procedural and substantive aspects of the implementation of the POCSO Act, 2012 by making it easier to obtain reliable testimonies from young children and navigate the ethical complexities of witness preparation.

I hope that child mental health professionals and institutions engaged in child protection and welfare adopt and disseminate this training manual. This would go a long way in helping the justice system evolve and bridge the gap between awareness and effective support for vulnerable children.

I am sure that the Training Manual would be of immense help to all stakeholders working in the field of child sexual abuse.

[B.V. Nagarathna]

NEW DELHI;
27th JANUARY, 2024.

Introduction

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Introduction

Erstwhile notions of forensic psychiatry being primarily concerned with criminal responsibility and fitness to stand trial are now outdated. The domain of forensic psychiatry has now advanced considerably to include the interface of mental health and law in various civil and criminal contexts, ranging from marriage, divorce, adoption, guardianship and property to fitness to stand trial and criminal responsibility. The evolution of forensic psychiatry has benefitted much from the developments in medico-legal understanding, appreciation of the relationship between mental health status and evaluations for psycho-legal capacities, and the rights of vulnerable witnesses, to name a few. However, unlike in many western countries, there is limited infrastructure and systematic training, in India, in forensic psychiatry. NIMHANS being one of the few exceptions, there are hardly any forensic training programs offered at graduate level. Most psychiatric services do not comprise of dedicated forensic units, and forensic evaluations are generally conducted by mental health professionals with little or no training in forensic psychiatry.

The above-mentioned limitations only become heightened in the context of child forensic psychiatry. Despite the many developments in child laws in India, particularly over the last decade or so, in relation to child sexual abuse and juvenile justice, mental health capacities have struggled to keep up with the rapidly emerging needs of children, as they interface with the law. Some of the challenges pertain to the domain of child and adolescent mental health in itself, namely, the paucity of child mental health services, shortage of skilled personnel and the existence of very few specialized training programs in child psychiatry; many training programs do not adequately incorporate childhood trauma and abuse into their curricula. These concerns have created difficulties for child mental health professionals attempting to embrace their increased responsibilities of providing treatment interventions and supporting children through legal processes.

There are, therefore, several imperatives that propel us towards re-examining and strengthening the role of mental health professionals in children's interface with the law. SAMVAD's initiation of the country's first and exclusively child-focused forensic training program, in the context of child sexual abuse, is thus an important milestone in both child

mental health as well as child forensic psychiatry. As detailed in the training manual, on "Essential Interventions & Skills for Working with Child Sexual Abuse: Introducing Mental Health & Legal Dimensions of Forensics" the aim of the training is to equip mental health professionals with essential conceptual knowledge and skills on childhood trauma and abuse and its implications for legal procedures. The focus is on models of child sexual abuse, children's internalizations of abuse, and it's emotional and behavioural impact on children, child interviewing, assessments and therapeutic interventions. The manual first lays a foundation for child mental health work in the context of child sexual abuse. These mental health aspects are then linked to the child sexual abuse law, with implications for supporting children through legal and judicial procedures. Service providers are thus assisted to develop the skills to work in partnership with the legal systems of the country, in order the protection and mental health interests of the child are served.

Considering that child forensic psychiatry lies at the crossroads of child law and mental health, systematic and intensive training of a transdisciplinary nature is critical to diversifying and consolidating the capacities of mental health professionals and allied service providers, such as pediatricians and gynecologists, to be able to assist children in contexts that extend beyond the clinical setting. We must remind ourselves that the role of child mental health service providers is, after all, to ensure children's mental health and well-being particularly in situations of trauma and adversity. Consequently, their role encompasses varied spaces, spanning home, school, neighborhoods and child care institutions to police stations and courtrooms. In light of this, SAMVAD's pioneering effort in the area of child forensics is a welcome initiative in the field; I hope that many mental health professionals and allied health service providers, and most of all, vulnerable children, will benefit from the use of this manual.

Dr. Pratima Murthy
Director, NIMHANS

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Director
National Institute of
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Many Years Ago... The Recognition of Child Witness Concerns

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Dr. Shekhar Seshadri
Additional Professor

दिनांक
Date : 4.9.1999

To

Dear

I am in receipt of your letter of 25.8.1999 and the enclosed documents. I have the following comments to make based on my study of the documents, my experience as a child psychiatrist in a teaching hospital, my experience of working in the area of child sexual abuse and my efforts to develop parameters of good practice in this area specially where forensic evaluation is concerned :

(1) Medical examination of children for sexual abuse is subject to training and practice in sexual anatomy of children in paediatric and gynacological practice and a prevailing ethos of how good, accepted parameters are followed for forensic evaluation. Because of growth spurts in children, often medical evidence may not be obvious if the examination is conducted later. In this context, the medico-legal definition of penetration (where penile penetration is emphasized, often leading to situations of digital penetration or penetration with objects being not considered as abuse) is itself under scrutiny for law reform. The examination of children in such instances can lead to medical conclusions that sexual abuse has occurred or has not occurred or that ONE CANNOT SAY THAT ABUSE HAS NOT OCCURRED.

(2) In this case, one has to rely on interview methods to elicit history of abuse. I cannot comment on brief summary of the interview process. Either I need to work with the children myself or I need detailed transcripts of all sessions with the children (including details of the therapists' intentions, actual transactions and a verbatim description of all processes thereof) to be able to judge the abuse has occurred or that the interviewer / counsellor in Mumbai has followed a recommended sequence for good forensic practice. Overall, their summary indicates that the techniques used are accurate and these are the techniques recommended for such evaluations.

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दिनांक
Date : .....

(3) Even if the medical evaluation done is accepted, it does not rule out that abuse has not occurred, only that damage/ alteration of the sexual anatomy of the child as a consequence of abuse cannot be commented on at the time of examination.

(4) Visitation rights to the grandfather would cause negative impact if abuse is established. However, in my experience the legal processes themselves are traumatizing for children and cause secondary victimization. Whether abuse has occurred or not, the children are very much into a process and their well being in this process must be ensured by all concerned people and authorities. Thus, any decision concerning the children must be judiciously made and preferably in the presence of a behavioural scientist (counsellor, psychologist, psychiatrist) and other relevant decision makers so that the children are aware and prepared for whatever is planned "in their interest".

Do let me know if you require any clarifications. Once again, procedurally, it would be useful if the court were to call me as expert witness and if I had access to full transactions or direct work with the children.

I remain,

Yours sincerely,

(SHEKHAR SESHADRI)
Additional Professor of Psychiatry

Contents

About the Manual

SAMVAD's Work

SAMVAD (Support, Advocacy & Mental health interventions for children in Vulnerable circumstances And Distress) is a National Initiative & Integrated Resource for Child Protection, Mental Health and Psychosocial Care established by the Ministry of Women & Child Development, Government of India. This initiative is located in the Dept. of Child & Adolescent Psychiatry, NIMHANS. With the aim of enhancing child and adolescent psychosocial well-being, through promotion of transdisciplinary and integrated approaches to mental health and protection, SAMVAD was established to extend its support and activities to all the states in the country. It comprises of a multidisciplinary team of child care professionals, with expertise in training and capacity building, program and policy research pertaining to child mental health, protection, education and law.

SAMVAD has been mandated by the Mission Vatsalya Guidelines of the Ministry of Women & Child Development, Government of India *"to develop and increase counselling capacity as well as resource persons at the State/UT level, including Psychiatric counselling and mental health wellbeing of children in coordination with Support, Advocacy & Mental Health Interventions for Children in Vulnerable Circumstances And Distress (SAMVAD)- National Institute of Mental Health and Neurosciences (NIMHANS)."*

SAMVAD's Vision & Strategic Objectives

Develop standardized child-centric modules and resources for the capacity building of primary, secondary and tertiary level psychosocial and mental health care service providers.

Strengthen knowledge and skills in child and adolescent protection and psychosocial care in various cadres of child care service providers in the country, through training and capacity building initiatives at primary, secondary and tertiary care levels of child protection and mental health.

Enhance child and adolescent protection and psychosocial care programs implemented by government and non-government agencies, by providing technical support on program design and quality.

Undertake studies, audits, research and advocacy on issues pertaining to child and adolescent protection and related issues of mental health and psychosocial care.

Utilize the experiences of capacity building, technical programmatic support and research in informing child and adolescent laws and policies in the country.

Why this manual was developed

The limited availability of mental health human resources and mental health care facilities, as well as their skewed distribution contribute to unmet child mental health needs. These unmet needs, in general issues of adverse childhood experiences and childhood trauma, in low middle income countries, such as India, play a major role in the development of child mental health morbidities. However, the expertise and skills to provide treatment interventions for childhood trauma are scarce, with few tertiary mental healthcare centres demonstrating the capacity to assist children with such complex child mental health needs. Child sexual abuse (CSA) is one such childhood trauma and an experience of adversity, which is being duly acknowledged as a protection and mental health-related concern in children, due to increasing public awareness. However, the knowledge and skills to address CSA, in both mental health and legal systems, especially the need to recognise the links between child protection, trauma and mental health concerns, has not been commensurate with CSA awareness and reporting.

In the light of India's relatively newly adopted CSA law, child mental health professionals have an increasingly important role to play in child sexual abuse: like in other countries, they are increasingly being asked to assist legal authorities, by way of assessment, provision of expert opinion and testimony to make dispositional recommendations in CSA cases. This requires child mental health professionals to move beyond their routine mandates of psychiatric interventions and treatment of affected children, to understanding not only the key provisions of the Indian Protection of Children from Sexual Offences (POCSO), 2012 law but the many challenges of its implementation, such as eliciting valid and reliable testimony from children and adolescents, especially very young children, re-traumatisation of children through court inquiry, the dilemmas of preparation of child witnesses for court proceedings as against the court's concerns about tutoring.

Thus, and also since the child is typically the sole witness against the suspected abuser, successful prosecution is heavily dependent on the child's disclosure and narrative on the abuse experience. This is especially true when there is no medical evidence available and the case rests on the word of the child as against that of the alleged perpetrator. The challenges of obtaining child witness testimony are compounded by concerns of children's age and developmental (dis)abilities, as well as accuracy of memory, their credibility, and vulnerability to suggestibility. One of the key systemic interventions required to mitigate the gaps in accessing justice is the strengthening of evidence collection in CSA cases, by facilitating knowledge development amongst practitioners on the dynamics of CSA perpetration, its varied impacts across key domains of child development, and crucially, its impact on the child's ability to contend with complex legal processes.

Keeping these considerations in mind, the development of child forensic skills, techniques and knowledge among child care professionals and other stakeholders, working in varied capacities with children who have undergone sexual abuse, will thus enable them to handle cases of sexual abuse in a manner that accommodates children's needs and capacities, consequently promoting efficiency in evidence gathering processes and minimising the impact of secondary victimisation on children.

Child forensics in India, is in a nascent stage, despite the enormous imperative to develop standardised systematic protocols in this area. It is in recognition of this that the proposed training manual has been developed, in accordance with the above-described roles and functions that child mental health professionals are required to undertake in child sexual abuse cases. The training program adopts a transdisciplinary approach to training and capacity building, through a convergence between legal and child mental health domains. The integration of knowledge from both domains allows for more comprehensive assistance and support to children, whose needs for healing, well-being and justice need to be met by both mental health and legal systems. It is only though this approach that the gains obtained through (clinical) treatment of the sexually abused child's mental health issues can be maintained—by ensuring that the mental health support initiated by healthcare services are continued throughout the child's interaction with the legal and judicial system, in ways that prevent re-traumatisation and secondary victimisation that is known to occur within the latter systems.

Aim and Objectives

The manual aims to enable child mental health professionals to bring transdisciplinary approaches to addressing the complex medico-legal issues in child sexual abuse i.e. to integrate mental health and legal knowledge to ensure comprehensive support and assistance for sexually abused children. The specific objectives of the manual are to enable mental health service providers and other health professionals working with children to:

- Understand child sexual abuse dynamics and processes, in terms of their impact on:

- Children's decisions on abuse-disclosure and reporting.
- Children's mental health i.e. emotional and behavioural problems resulting from the trauma of child sexual abuse.

➢ Develop skills for responding to mental health concerns emerging from child sexual abuse, namely:
- First level responses to the trauma of abuse, including psychosocial care, medical and placement interventions.
- Methods of interventions for long term healing and recovery.
- Life skills education interventions and activities for personal safety and for enhancing children's decision-making in contexts of gender and sexuality.

➢ Gain knowledge on the role envisaged for child mental health functionaries in court processes in cases pertaining to child sexual abuse by:
- Developing a knowledge of court processes, particularly child witness concerns in an adversarial criminal justice system.
- Engaging in the debates and discussions on appreciation of medical and other forms of evidence in child sexual abuse cases.

➢ Learn about child sexual abuse law in India (POCSO Act 2012) and of due medico-legal processes so as to:
- Engage in mandatory reporting processes of child sexual abuse.
- Elicit child testimony, and support children through court processes.

For whom

With a view to enable mental health professionals to build their capacities in the area of child forensics, this manual is ideally for use, both as a guide as well as for teaching purposes, by advanced level mental health professionals. These would include psychiatrists, psychologists, social workers and paediatricians typically from departments of psychiatry and paediatrics, and allied social sciences, located within secondary and tertiary healthcare facilities.

The manual is particularly intended for tertiary healthcare facilities that serve as teaching hospitals, and implement academic programs, in order that child sexual abuse work may be systematically taught to residents and post-graduate students, during the course of their work and study.

How it organized for use

Divided into 21 modules, the manual begins by locating child sexual abuse work in the context of the POCSO 2012 Act and moves on to modules that focus on mental health perspectives on child sexual abuse. Building on this understanding, modules on court processes and psycho-legal assistance follow, enabling mental health professionals to gradually shift from mono-disciplinary approaches in child sexual abuse to transdisciplinary ones, by applying their knowledge and skills in a legal context.

The methods suggested in the manual combine inputs from conceptual frameworks on child development, child sexual abuse and legal procedures, with practical skill training to enable participants to translate theory into practice i.e., 'learning by doing'. A plethora of creative, participatory pedagogies are used, to enable participants to bring in their experiences and reflect on child and adolescent issues and methods for use in their work. Such experiential methods range from video/film viewing to case study analysis and group discussions and role plays—particularly in order to enable the translation of conceptual knowledge into skills for use in the field. Thus, each

module, of an average duration of 3 hours, reflect a combination of theory or conceptual framework and practice—with a heavy emphasis on practical skill training activities.

Each module lists specific objectives and an optimum teaching time, to allow for presentation of conceptual frameworks, and implementation of activities and discussions. Detailed descriptions of concepts, approaches and frameworks are laid out i.e. what the facilitator may say on the subject; alongside these, activity boxes provide instructions on the 'do and learn' aspects of the training. Each module is followed by a list of recommended readings. Where possible, materials for the activities to be implemented in each module, are provided i.e. such as cards, case studies etc. Links are provided to SAMVAD's Life Skills Manuals and other materials, as relevant. Video clips have been embedded in YouTube/Google Drive to enable easy access through the QR codes provided in the manuals. Where full length (commercial) films are used, it is recommended that facilitators and users of the manual procure them by buying DVDs or access them from common OTT platforms (such as Netflix/ Amazon Prime or others).

While it is recommended that the manual be used in its entirety, by systematically running the sessions, in the order in which they are presented, it may be used in parts with service providers, in accordance with their needs i.e. individual, stand-alone sessions, focussing on any given aspect of child sexual abuse may also be conducted. Towards this end, session-wise as well as complete training program schedules are provided in the annexes.

It may be noted that the activities and discussions outlined in the training series are essentials and guidelines; it is at the discretion of the facilitator on how creatively to use these to enable the participants, to introduce context-specific issues in accordance with the learning needs and work of the participants. Since the manual uses strongly participatory approaches, the quality and the success of the learning is heavily dependent on the participants, and the experiences and commitment that they bring with them to share.

While the recommended users of the manual may be paediatricians and mental health practitioners working in secondary and tertiary care facilities, ultimately no one who is deeply interested in children and their predicaments, can be excluded from its use! Thus, this manual is also for anyone who cares to work systematically with children's issues…one who continuously and intensively works in direct contact with children…who has a deep interest in transdisciplinary and experiential methodologies…and is consequently, grounded in the field realities and complexities of working with childhood adversities.

And so, the manual, a first of its kind in child forensics in the country, is for anyone who has a passion for children and child work… who believes in advocating for protection and justice for children, but always with a view to ensuring their mental health and well-being. We would love to hear from those using the manual, and in turn, to use their experiences to always revise and refine our knowledge and pedagogies…for the essence of transdisciplinary approaches, as warranted by child protection and mental health work in general, and child sexual abuse interventions in particular, entails continuous co-production of knowledge, through integrating practical perspectives that are scientific, sectoral and ever grounded in the field realities and praxis of child work.

You are welcome to contact us on info@nimhanschildprotect.in for assistance and support…we would also love for you to share your experiences with us!

1. Introduction to Child Sexual Abuse Legislation in India

Learning Objectives

- To develop an overview of the main provisions of the Protection of Children from Sexual Offences Act, 2012 (POCSO), Medical Termination of Pregnancy Act, 1971 (MTPA) and the Prohibition of Child Marriage Act, 2006 (PCMA).
- To grasp the meaning of child protection in the context of these legislations.
- To understand how to apply legal provisions to cases of child sexual abuse.
- To examine the legal grey areas and debates in these legislations.

Time

3.5 Hours

Concept

Gender and Sexual Offences: Implications of POCSO

In order to understand the relevance of the enactment of the POCSO Act, it is imperative to first contextualise previous statutory attempts at dealing with sexual offences (particularly with regard to children). Prior to POCSO, the key provisions in the Indian Penal Code (IPC), dealing with sexual offences were, namely, sections 354, 375, 376, 377, and 509. In the context of child prostitution and child trafficking cases, IPC sections related to kidnapping, slavery and forced labour were also applicable.

These sections were, however, severely limited in statutory scope and enforceability, given the complex realities of child sexual abuse, first highlighted in the landmark Supreme Court judgement of ***Sudhesh Jhaku v. KC Jhaku*** (1999), wherein Singh, J., quoting Legrand (1973), stated that men who are sexually assaulted should have the same protection as female victims, and that women sexual assaulters should be as liable for conviction as conventional (male) rapists. If rape were to be considered as a sexual assault, rather than a special crime against women, **rape law could be put in a healthier perspective and reduce the mythical elements that have tended to make rape laws a means of reinforcing the status of women as sexual possessions.**

The impetus for a separate statute to address the issue of child sexual abuse is examined in the light of the case of ***Sakshi v. Union of India*** (1999 & 2004), the **Law Commission of India 172nd Report** and the results from the findings of the **'Study on Child abuse: India 2007'** undertaken by the Ministry of Women and Child Development, Govt. of India.

The critical issue, therefore, was one of under-inclusion, which adversely affected the legal protections afforded to all non-female victims (including male and transgender/transsexual victims). As has been highlighted in much of the scholarship surrounding the issue, the fundamental error was inherent in the conception of the perpetrator-victim relationship through the rubric of gender i.e., male perpetrators offending against female victims for reasons limited to sexual proclivity and modesty/honour. What is interesting to note, in this regard, are the continuing statutory deficiencies in the criminal provisions for rape under the IPC (which continue to be the sole legal protections against sexual offences involving adult victims). Related to this primary issue were other critical deficiencies, namely, the restricted statutory understanding of the spectrum of non-penetrative sexual offences

(including verbal harassment, non-penetrative sexual contact, stalking, pornography etc.), and indeed, the definition of penetration itself (i.e., whether it was inclusive of non-penile penetration).

Following the aforementioned judgement, wherein it was held by the Supreme Court that legislative amendment would be required to address the lacunae in statutory provisions relating to sexual offences, the Court in Sakshi v. Union of India (1999) directed the Law Commission to examine "sexual intercourse" under the IPC and make recommendations for amendments as required. The 172nd Law Commission Report then recommended that the law on rape needed to be 'gender-neutral, wider, and more comprehensive in order to bring it in line with current thinking'. However, in 2004, the Court was again constrained to retain the limited statutory scope of 'penile penetration', keeping in mind the potential ramifications of a wider judicial interpretation in the absence of appropriate legislation. Simply put, this judicial concern is related to the constitutional guarantee that no person should be convicted of an offence unless it constitutes a violation of the law at the time of the offence.

Highlights of the POCSO Law

A child is any person below the age of 18.
POCSO criminalizes sexual activity with children.
The Act is gender neutral: which means that both boys and girls may be victims/perpetrators.
CSA is any kind of sexual contact between an adult and a child, or in cases of older adolescents if there is coercion and assault.
There are 4 main types of offences under POCSO

- Penetrative Sexual Assault
- Sexual Assault
- Sexual harassment
- Using a child for pornographic purposes/ Storing pornographic material

Subsequently, it was the Ministry of Women and Child Development's National Study on Child Abuse in 2007 that brought to fore the urgency for the law on the subject to be updated and revised. Through the study, it was revealed that 53.22% of study respondents reported one or more forms of sexual abuse (incl. severe abuse). Out of these respondents, 52.94% were reported to be boys.

So, why is this relevant today?

These developments culminated in the need for a child abuse legislation that avoided the previous problems of under-inclusion, through gender-neutral provisions on sexual offences, to cover both perpetrators and victims who did not fit the male-female binary. This is a critical advancement of the POCSO Act, 2012 in the context of child sexual abuse (despite the existing limitations for sexual offences against adult victims). However, despite the progress made under the POCSO framework, gender biases continue to play a role in the implementation of the POCSO Act, wherein multiple instances of police refusal to register an FIR have been noted, because of the prevailing notion that "other genders can't be sexually abused".

Classification of Sexual Offences under the POCSO Act, 2012

As the POCSO Act set out to provide as comprehensive a framework as possible to cover the gambit of sexual offences against children, all offence categories are exclusive of each other (i.e., no overlap in scope) and classified in a sliding scale of punitive sanctions (with enhanced punishments for 'aggravated' forms of penetrative and sexual assault). The key ingredients of each offence category are stipulated below:

i) **Penetrative Sexual Assault:** The key requirement for application of this offence category is any form of penetrative sexual abuse. This extends to penile and non-penile penetration (object penetration). In terms of the scope of this offence category, the definition of penetration extends to any orifice of the child's body i.e., oral, anal, and vaginal penetration.

ii) Sexual Assault: The requirement for this category is any form of sexual contact that is non-penetrative. While this includes genital contact, it also extends to non-genital contact with 'sexual intent'. This can include inappropriate touching that does not include contact with the child's genitalia, but is demonstrably carried out with sexual intent. Admittedly, in cases of non-genital contact, the question of whether the contact was pursued with sexual intent, would depend on the facts and circumstances of the case.

iii) Sexual Harassment: This next offence category deals with non-contact sexual offences, including 'words, sounds, or gestures'; any form of exhibition (of a body part/object); inducing a child to exhibit any body part; showing/threatening to use a depiction of the child's body/soliciting for child pornography; physical or virtual stalking. The question of sexual intent is critical here and will depend on the facts and circumstances of the case.

iv) Child Pornography: This category of offences relates to making, storing or transmitting child pornography in any manner. The following will constitute pornographic representation:

- representation of the sexual organs of a child;
- usage of a child engaged in real or simulated sexual acts (with or without penetration);
- the indecent or obscene representation of a child

Aggravated Offences

Keeping in mind that most child sexual abuse is perpetrated through known perpetrators (including those in a position of trust and responsibility), the abuse can have severe mental health consequences for the child even in cases where the nature of abuse is non-penetrative. Therefore, the Act stipulates circumstances in which the sexual abuse is considered aggravated, and consequently, subject to higher punitive sanctions. The circumstances that determine whether the penetrative sexual assault/sexual assault is of an aggravated nature depend on the following three questions:

1. Who is the offender/accused? Was he in a position of trust and responsibility to the victim? (eg: police, armed forces, CCI staff, relative of child).
2. Who was the victim? (eg: mentally/physically disabled children, children below 12 years)
3. What was the nature of the offence? What were the consequences? (eg: sexual assault committed in a group, use of deadly weapons, sexual assault causing serious bodily harm, causing temporary/long term disability, infecting child with HIV, causing pregnancy, committing offence more than once etc.)

Note: If ANY of the three questions are satisfied, the assault would constitute aggravated assault under the POCSO Act, 2012.

Activity: 'Me and Ramo Bhaiyya'

Method: Discussion

Material: *See* Image 1 showing the child in a public park with an older male (Ramo Bhaiyya) who has exposed his genitals to the child.

Process:

- What do you see in this image?
- Is there anything alarming or disturbing you notice in this child's drawing?
- Is the child aware of the sexual abuse? What are some reasons the child may not know what Ramo Bhaiyya is doing, that may constitute an offence under the law?

Discussion:

- Discuss the ways in which children may not have the language to describe sexual abuse therefore resorting to pictorial depictions and words such as "pee-pee", "snake" and "banana", to explain the mechanics of the sexual abuse.
- Discuss applicability of relevant legal provisions under the POCSO Act.

Mandatory Reporting

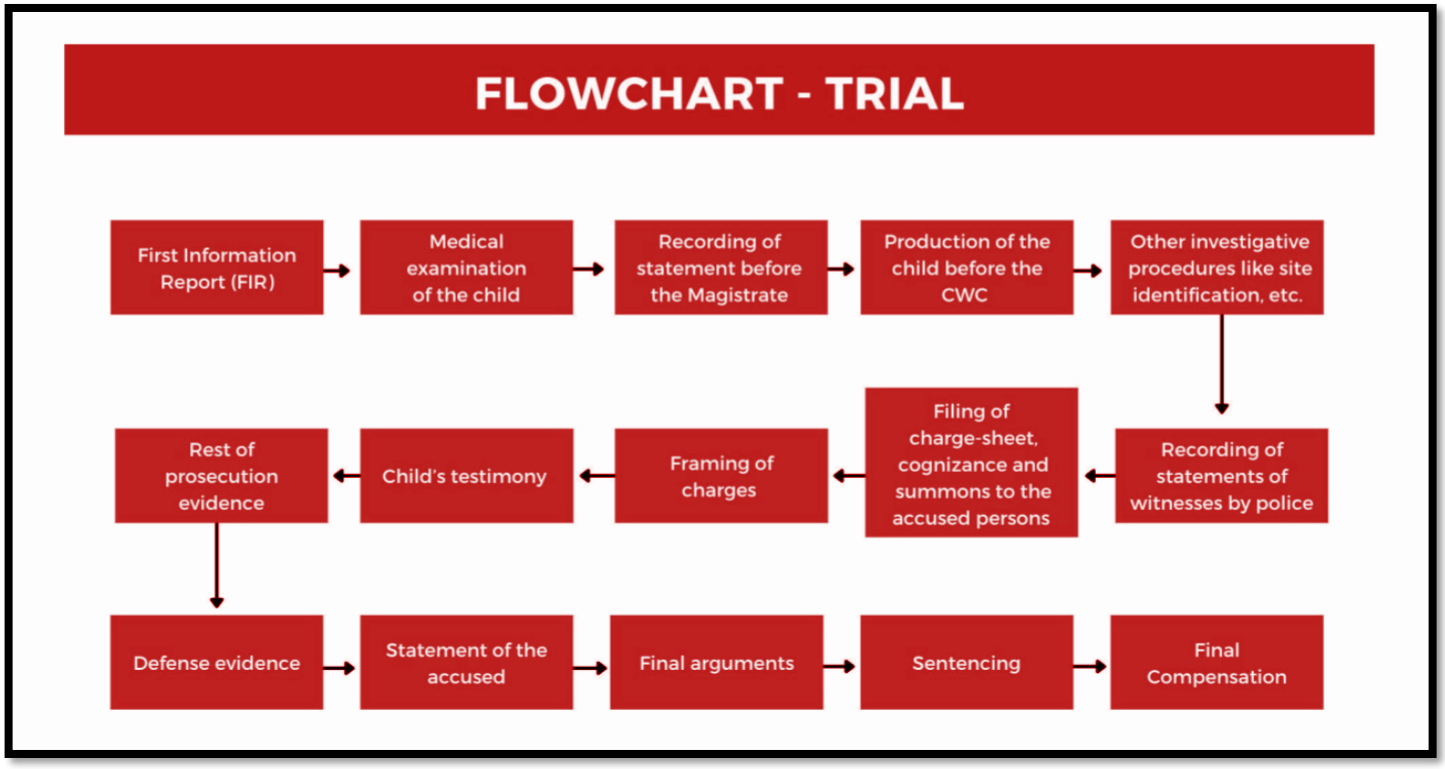
Under the POCSO framework, any person who believes that a sexual offence against a child may be committed, or knows that it has been committed, or is likely to be committed has to report the matter. Organizations may also report cases of child sexual abuse through the relevant nodal functionary. In this regard, a POCSO case must be reported to the Special Juvenile Police Unit (specifically the Child Welfare Police Officer), or alternatively, any police officer so that an FIR can be registered. This will trigger the subsequent legal processes, which includes sharing of information of the report, by the police, to the Child Welfare Committee (CWC) and the Special Court, in addition to the medico-legal examination of the child, and placement of the child in a child care institution (if necessary).

In the case of organisations, the in-charge has a special obligation to report information pertaining to the subordinate, failing which, a higher penalty is attracted i.e., imprisonment for up to a year.

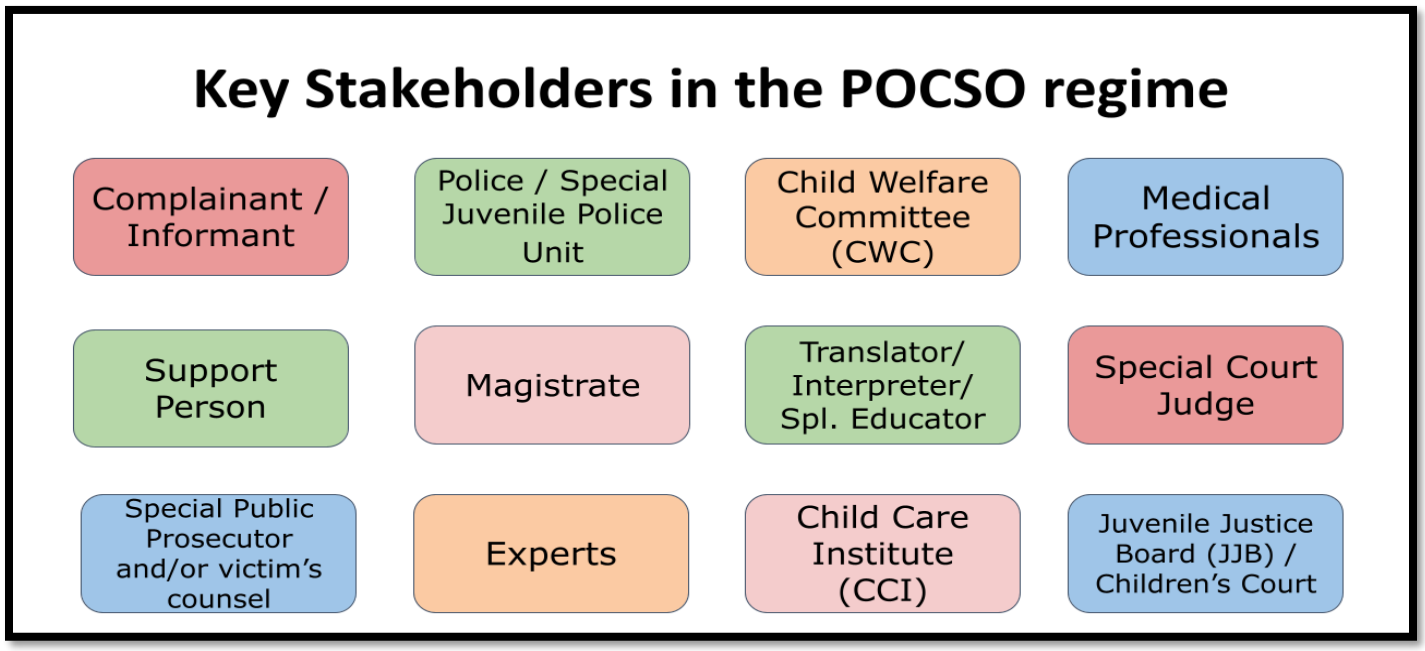
Once the Special Juvenile Police Unit (SJPU) or any police officer is informed of the incidence of child sexual abuse, the investigation and legal procedures commence.

A flowchart of the trial procedure is given herein in order to understand the rigours of the criminal justice system.

Figure 1. Flowchart showing the legal course of a PCOSO Case.



Key Stakeholders in the POCSO Regime



It is important to identify the key stakeholders within the POCSO Regime in order to understand their roles and responsibilities in ensuring a child-oriented process for victims of CSA. Coordinated concerted efforts of all stakeholders is essential to support a child victim, right from reporting until the Court has pronounced a verdict.

Figure 2. Key Stakeholders in the POCSO Regime

Complainant/Informant: Any person giving information, which leads to lodging of the report by the police officer is the informant, and the person who files the complaint is the complainant. Such persons may also be vulnerable witnesses and could be eligible for protection based on the facts of the case. Their support and testimony may also be instrumental to the legal proceedings.

Special Juvenile Police Unit (SJPU)/Police: Section 2 (55), JJ Act, 2015 states that SJPU means a unit of the police force of a district or city or, as the case may be, any other police unit like railway police, dealing with children and designated as such for handling children. With respect to the setting up of the SJPU the JJ Act, 2015 says that every police station shall have at least one officer, not below the rank of Assistant Sub-Inspector, designated as the Child Welfare Police Officer (CWPO) to exclusively deal with children either as victims or perpetrators. The State Government shall constitute SJPU in each district and city, headed by a police officer not below the rank of a Deputy Superintendent of Police or above. It shall consist of all CWPOs, two Social Workers having experience of working in the field of child welfare, of whom one will be a woman. SJPU will also be constituted for the Railway Protection Force (RPF) or Government Railway Police (GRP) at every railway station as per requirement. Where a SJPU cannot be set up, at least one RPF or GRP Officer will be designated as the CWPO. The SJPU is tasked to coordinate all functions of police related to children. In the case of CNCP, SJPU will coordinate with the Social Workers and produce before the CWC. The SJPU will also coordinate with specialised service providers like doctors, paramedics, special educators, counsellors and Childline for immediate support to children. Section 19 of the POCSO Act, 2012 states that any information regarding an incidence of child sexual abuse has to be reported to the SJPU or the Police.

Child Welfare Committee (CWC): A CWC is a body notified and constituted under Section 27 of the JJ Act, 2015 for every district for exercising the powers and to discharge the duties conferred on such Committees in relation to children in need of care and protection under this Act. The CWC usually sends the child to a Children's Home while the inquiry into the case is conducted for the protection of the child. The CWC meets and interviews the child to learn his/her background information and also understand the problem the child is facing. The probation officer (PO) in charge of the case must also submit regular reports of the case. The purpose of the CWC is to determine the best interest of the child and find the child a safe home and environment either with his/her biological parents or adoptive parents, foster care or in an institution.

Medical Professionals: The POCSO Act, 2012 read with the corresponding rules clearly define the role and responsibilities of medical practitioners in the form of mandatory reporting, medical examination, treatment of injuries, prophylaxis for sexually transmitted diseases (STDs) and HIV, emergency contraception and referral to mental healthcare. Medical professionals play a dual role in responding to victims of CSA. The first is to provide the necessary medical treatment and psychological support. The second is to assist the children in their medico-legal proceedings by collecting evidence and ensuring proper documentation for effective legal processes.

Support Person: A person assigned by the Child Welfare Committee, in accordance with sub-rule (7) of rule 4, to render assistance to the child through the process of investigation and trial, or any other person assisting the child in the pre-trial or trial process in respect of an offence under the POCSO Act. The Supreme Court has also ruled that the State has an obligation to provide Support Persons to POCSO victims and this cannot be made optional. Unless there are good reasons recorded by the CWC in its order, the appointment of Support Persons is mandatory.

Child Care Institute (CCI): The JJ Act, 2015 provides for the setting up of institutional care structures for children. The types of CCIs:

For Children in Need of Care and Protection (CNCP):

Children's Home, Open Shelter, Specialised Adoption Agency, Fit Facility/Person.

For Children in Conflict with the Law (CICL):

Observation Homes, Special homes and Places of Safety.

Magistrate: A Metropolitan Magistrate or a Judicial Magistrate may record a voluntary statement of the child / de-facto complainant under Section 164 of the Code of Criminal Procedure. 164 CrPC Statement may be taken anywhere from a few weeks after the recording of the initial complaint to a month or two months. Given that this might be one of the first formal settings in which a child is required to recount their experiences, precautions must be taken to prevent retraumatization. The Procedure for recording the statement of child victim is contemplated under section 164(5) Cr.P.C., Section 25, 26 of POCSO Act, 2012 and Rule 11 of The Criminal Rules of Practice 2019.

Translator/Interpreter/Special Educator: The POCSO Rules, 2020 state that children who have suffered sexual abuse are entitled to the appointment of a translator or interpreter. Furthermore, to have a special educator for the child or other specialized person where the child is disabled is also an entitlement in POCSO cases. This is to ensure that the child may participate fully in the process and is not put through further hardship due to difficulty in language, communication or differential abilities. As per the provisions of the POCSO Act, 2012, the assistance of a Translator / Interpreter / Special Educator can be taken from the very first legal process be it with the police or at the time of recording the 164 CrPC statement before the Magistrate up to giving witness testimony before the Special Court, as well. In each district, the District Child Protection Unit shall maintain a register with names, addresses and other contact details of interpreters, translators, experts, special educators and support persons for the purposes of the Act, and this register shall be made available to the SJPU, local police, magistrate or Special Court, as and when required.

Special Court Judge: The POCSO Act 2012 provides for establishment of Special Courts for the purpose of ensuring speedy trial. Since 2019, a Centrally Sponsored Scheme, has enabled the setting up of Fast Track Special Courts (FTSCs) including 389 exclusive POCSO Courts across the nation for expeditious trials relating to sexual offences. Given that the trial safeguards under the POCSO Act are child-oriented, Special Court judges also are tasked with ensuring these processes are followed.

Special Public Prosecutor: The Special Public Prosecutors are appointed by the state government under Section 32 of the POCSO Act to prosecute offences committed under the Act. As envisioned by the POCSO Act, 2012 and the JJ Act, 2015, the duty of the public prosecutor is not confined to prosecution, but to ensure justice to the victims also. Therefore, any concerns of the child when it comes to the Trial or cooperation with providing the best evidence to the Court is done with coordination of the Special Public Prosecutors and the various stakeholders.

Juvenile Justice Board/Children's Court: In cases where the alleged perpetrator is a child in conflict with the law (CICL), then the forum of adjudication will be either the juvenile justice board (JJB) or the Children's Court, set up under the JJ Act, 2015. For children under the age of 16, the JJB may take appropriate measures. The Children's Court may take appropriate measures in cases where a juvenile aged between 16-18 is transferred by the JJB to be tried as an adult, after a preliminary assessment.

Experts: The Judge is not expected to be an expert in all fields, especially, where the subject matters involve technical or specialized knowledge or experience in the subject matter. The Indian Law of Evidence allows an opinion of any person other than the judge as to the existence of the facts in issue or facts that are relevant to a matter, which resultantly, presented before the court of law in the form of 'expert evidence'. Section 45 of the Indian Evidence Act, 1872 states that an 'expert' means a person who has special knowledge, skill or experience

either in foreign law, science, art, handwriting, or finger impression and such knowledge has been gathered by him either by practice, observation or proper studies. The POCSO Rules, 2020 state that, an "expert" means a person trained in mental health, medicine, child development or other relevant discipline, who may be required to facilitate communication with a child whose ability to communicate has been affected by trauma, disability or any other vulnerability. Therefore, medical professionals including psychiatrists, counsellors, psychiatric social workers, paediatricians, gynaecologists may assist the Court in POCSO proceedings given their specialised knowledge and professional qualification in relation to children.

Recording the Child's Statement

With respect to recording of the child's statement by the concerned police personnel (Section 161 Statement) or the Magistrate (Section 164 Statement), the following are critical safeguards that have been instituted to mitigate the possibility of secondary traumatisation and facilitate a 'child-friendly' procedure:

- A child's statement should be **recorded at their home**, or a place where he usually stays, or a place which the child chooses. The child ***cannot*** **be detained in a police station in any situation**.
- The Child should **not come in contact with accused or accused's lawyer** during statement recording by Police/Magistrate.
- **Child's identity** is to be protected by the Police.
- The police must try to record the statement in an **audio-visual manner**.
- **Assistance of special educator** may be taken where required.
- Should preferably be recorded by a **woman police officer** not below the rank of **sub-inspector**. The Police should **not be in uniform** when the statement is recorded.
- It should be recorded in the presence of a **parent, guardian, or any person whom the child trusts**.

In certain cases, concerning children with temporary or permanent mental/physical disability, wherein it is not possible to elicit the child's oral testimony, there are certain procedural relaxations that have been introduced to reduce the number of trial appearances for the child.

Section 164 (5A) (b) of the Criminal Procedure Code (CrPC) prescribes that the child's S.164 statement can be taken as the examination-in-chief during the trial._Therefore, in cases of severe trauma and risk of secondary traumatisation, a child may not be required to provide testimony in court, keeping in mind that mental illness is also statutorily recognised as a disability. There is a caveat to this, however. Child witnesses may still be required to appear in Court for their cross-examination, as this is recognised as an inalienable part of the accused's right to a fair trial. (*Rahul v. State of Maharashtra (2018))*

Medical Examination of the Child

Some of the key provisions of POCSO relating to medical examination of the child are as follows:

- Emergency medical care must be provided within 24 hours of reporting to the police. There is NO requirement for legal documentation prior to medical examination.
- The examination is required to be conducted in the presence of a parent/guardian/or any person who the child trusts.

- A registered medical practitioner must conduct a medical examination within 24 hours of receiving information of the case. This applies to all hospitals irrespective of whether they are government-run or private.
- If the victim is a girl child, the examination should be done by a female doctor, or in the presence of a woman. Subject to the medical tests, options under the MTPA Act need to be discussed with the child and their guardian in the event of a pregnancy.
- The child's health needs are to be attended by the concerned medical practitioner including treatment for physical injuries, exposure to STDs, referral for de-addiction/mental health services.

Furthermore, there are certain procedural safeguards that must be followed during the course of medical examinations, keeping in mind the possibility of re-traumatisation of the child owing to the invasive nature of the procedures. These safeguards are to be followed in all cases of sexual offences, as stipulated in the 'Guidelines & Protocols on Medico-legal care for survivors/victims of Sexual Violence' released by the Ministry of Health and Family Welfare, Government of India. In this regard, the Bombay High Court recently made scathing observations of the 'degrading' and 'unscientific' two-finger test performed at the largest Maharashtra State-Run Hospital on one of the survivors from the 2013 Shakti Mill Gang Rape Case, despite clear directions of the Supreme Court on the subject.

The Court noted that such unscientific medical procedures constitute *cruel, inhuman* and *degrading treatment*. It was also observed that the practise was continued in a reputable medical institution despite the existence of State-level Guidelines.

Legal Procedure for Medical Termination of Pregnancy

The Medical Termination of Pregnancy Act, 1971 regulates the procedure and approvals required for abortions in India and the qualifications required for Registered Medical Practitioners (RMPs). MTPA was also amended in 2021 to incorporate some critical changes to the law.

As it stands, the following is an overview of important provisions relevant to children and pregnancies resulting from the rape of children:

- Any woman under the age of 18 needs permission from her guardian for termination of pregnancy.
- Pregnancy may be terminated if RMP is of the opinion that continuance of pregnancy **poses a risk to mental/physical health** of pregnant woman. Anguish after pregnancies resulting from rape constitutes grave injury to mental health of pregnant woman.
- For termination of pregnancies under 20 weeks, opinion of 1 RMP is required. For pregnancies between 20-24 weeks, the opinion of 2 RMPs is required.
- Pregnancies after 24 weeks can be terminated only if the State's Medical Board diagnoses 'substantial foetal abnormalities'.

Constitutional Court's powers vis-à-vis Medical Termination of Pregnancies

While the MTPA is clear on the 24-week period for termination of pregnancies, even in case of child sexual abuse (notwithstanding substantial foetal abnormalities), the 2021 case of ***Kumari V v. State of Karnataka and Ors.*** is significant, wherein the Karnataka High Court permitted a 16-year-old child victim of rape to medically terminate her pregnancy which crossed the 24-week period, while exercising the Court's constitutional powers under Article

226 and upholding her right to reproductive choice as an intrinsic part of her Right to Life under Article 21 of the Constitution of India. Therefore, despite the statutory limitation, the High Courts can nonetheless intervene in exceptional circumstances.

The Supreme Court in the case of ***X v. The Principal Secretary*** **(2023)** deliberated on the conflict between the statutory obligation of mandatory reporting and the rights of privacy and reproductive autonomy of the minor under Article 21 (Fundamental Right to Life) of the Constitution.

"We cannot disregard the truth that such activity **(consensual sexual activity between adolescents)** continues to take place and sometimes leads to consequences such as pregnancy. The legislature was no doubt alive to this fact when it included adolescents within the ambit of the MTP Rules…."

Child marriage and child sexual abuse

The Prohibition of Child Marriage Act, 2006, makes child marriages voidable and makes the parties to a child marriage (other than the child) punishable for an offence under the said Act.

"Child marriage" means a marriage to which either of the contracting parties is a child.

"Child" means a person who, if a **male**, has not completed **twenty-one** years of age, and if a **female**, has not completed **eighteen** years of age. There is a difference in age by definition under the POCSO Act, 2012 and the Prohibition of Child Marriage Act, 2006. The child may file before the appropriate District Court/Family Court to declare the marriage null and void at any time; even after attaining majority but within two years of attaining majority. Children born from such a marriage are legitimate and enjoy all rights of maintenance, inheritance etc.

Tackling sexual assault within child marriage

In the case of ***Independent Thought v. Union of India and Another (2017)***, the Court articulated for the first time the government's constitutional and human rights obligation to address child marriage and respect the rights of married girls.

"There can be no doubt that if a girl child is forced by her husband into sexual intercourse against her will or without her consent, it would amount to a violation of her human right to liberty or dignity guaranteed by the Constitution."

The provisions of the POCSO Act, 2012 as well as provisions under the Indian Penal Code will apply to wives who are under 18 years of age.

Pre-trial and trial assistance for victims under POCSO

The POCSO Act and Rules provide for appointment of support persons to assist the child during investigation of the case (pre-trial) and during witness-testimony by the child (trial). The support person has to inform the child and the child's guardian about the status of the case, next date of hearing, etc. The support person must maintain confidentiality. Additionally, the support person is required to help the child understand court procedures and what is expected of the child in this context. This is a critical aspect of facilitating child-friendly proceedings and mitigating the possibility of re-traumatisation in the adversarial courtroom as children do not understand the law or why they are required to give testimony etc. The child may also have fears regarding the accused harming the child.

Victim Compensation

An important aspect of current criminal law jurisprudence is the provision made for award of compensation for victims of sexual offences. Statutory provisions, in this regard, exist for providing compensation to victims under the CrPC and the POCSO Rules. Rule 9 lays down a list of circumstantial and consequential factors that must guide the award of compensation under POCSO. These factors typically relate to the nature and severity of the offence, with minimum and maximum compensation specified for each category.

The National Legal Services Authority, in furtherance of the Supreme Court's directives in the *Nipun Saxena* case, prepared the 2018 Compensation Scheme providing for rehabilitation and compensation of victims of sexual offences. Typically, in matters of compensation, the District Legal Service Authorities play a critical role in assisting child victims and their families seek compensation. The Special Court may on its own or through an application, pass an order for interim compensation for relief or rehabilitation at any stage after registration of the First Information Report. (FIR) Therefore, while child victims do not have to wait for the conclusion of the case to receive interim compensation.

However, despite the provisions for compensation, Courts have reported difficulties in providing timely interim compensation owing to the difficulties in assessing the circumstances of the case and deciding the quantum of compensation. In this regard, an interesting example of possible ways forward is the recent Delhi High Court decision in *Umesh v. State (and other connected matters)* wherein, owing to multiple instances of delayed compensation, the High Court took key steps to streamline the process of compensation. It was directed that:

i. Delhi Police would provide a digital record of FIRs (from 2018 till the date of the judgement) to the Delhi State Legal Services Authority. Details of 87,000 FIRs were provided to SLSA to cross reference cases wherein compensation was not provided.

ii. Additionally, it was directed that when provisions pertaining to sexual offences are added to the FIR at a later stage, a copy is also to be sent to SLSA.

Activity: Let's try understanding the law in practise…

Method:
Case Study

Material: Case Studies (2 case studies are available under 'Additional Material' at the the end of this module)

Process:
Present each case study (one by one) and request participants to reflect on them.

Discussion (Case Study 1):

- Request participants to analyse the various facts and circumstances of the case and discuss some of the relevant POCSO provisions that would apply to the case in terms of offence categories, pre-trial/trial assistance, statement recording etc.
- Discuss the ways in which child offenders under the POCSO Act may also be victims of sexual offences themselves, and the imperative to fully evaluate the facts and circumstances the case.
- Discuss applicability of relevant legal provisions under the Juvenile Justice Act, particularly in the context of adolescent offenders, and implications for the case.

Discussion (Case Study 2):

- Request participants to analyse the various facts and circumstances of the case and discuss some of the relevant POCSO provisions that would apply to the case.
- Discuss the perpetrator-victim dynamic in the context of mutually consenting relationships between adolescents and implications of gender dynamics on the implementation of POCSO.
- Discuss applicability of relevant legal provisions under the Juvenile Justice Act, particularly in the context of adolescent offenders, and implications for the case.

What have the Courts said about Mutually Consenting Relationships?

As discussed earlier, the statutory age of consent is 18, leaving any and all sexual engagements under the age of 18 statutory sexual assault. As a result of the same, seeing as there are currently no legislative exemptions to the prescribed age of consent, all mutually consenting adolescent sexual engagements necessarily fall under the purview of POCSO. However, keeping in mind the object of the Act i.e., to prevent and penalise child sexual abuse, the issue of the statutory validity of POCSO's provisions penalising mutually consenting relationships between adolescents has received significant attention.

In this regard, it is significant to also note observations made in recent POCSO cases by the Hon'ble High Courts:

- ***Vijayalakshmi & Anr. v. State & Anr.*** – "Punishing an adolescent boy who enters into a relationship with a minor girl by treating him as an offender, was never the objective of the POCSO Act".

- ***Sabari v. Inspector of Police –*** The High Court observed that there is a necessity to amend the definition of "Child" under POCSO i.e., lower the age to 16 (thereby lowering the age of sexual consent), with the caveat that the adult partner cannot be significantly older than the 16 y/o, i.e., more than 5 years older.

Activity: Let's listen to some perspectives on the right age to consent!

Method:
Discussion

Process:

- What are your thoughts on some statutory age of consent and its utility in addressing child sexual abuse?
- Keeping in mind the protection imperative of POCSO, what are your thoughts on exceptions to the minimum age of consent? Could this result in lesser prosecutions of incidents of child sexual abuse?
- If you're in favour of lowering the age of consent, what do you think should be the minimum age of consent? Should there then be statutory specifications pertaining to the age difference in a mutually consenting relationship?
- In the case of runaways, what might be suitable interventions to address such behaviour?

Discussion:

- Elicit participant perspectives on the current age of sexual consent/majority under the POCSO Act and possible consequences of the same for adolescents in mutually consenting relationships.
- Discuss the previous case studies and explore possible positive/negative consequences on the enforceability of the Act, as a result of the minimum age of consent
- It is also pertinent here to discuss the perpetrator -victim dynamic here through a gender lens, keeping in mind the nature of POCSO complaints in mutually consenting relationships.

Keeping in mind the discussion undertaken on the subject of mutually consenting relationships, it is significant to consider two more cases on the subject of capacity for sexual decision-making:

- ***Virender Singh v. State of H.P***: "The boy is aged 24 years, whereas the girl is aged 16. Even though the age gap between them is enormous, this is probably because of social background. Families arrange marriages in the Indian social setup. In such arrangements, mostly, the bride is younger than the groom, sometimes with a considerable age gap…Such social settings might be a catalyst for a girl to fall in love with a more senior boy. Even otherwise, it is not unusual that a girl aged 16 years of age falls in love with a boy aged 24 years or vice versa."

- ***Shoukat Hussian and another v. State of Punjab and others:*** Punjab & Haryana High Court, last year, granted protection to a Muslim Girl (17-Year-Old) who married a Muslim Man (36-Year-Old) while noting that both are of Marriageable Age under Personal Law.

"*The Court cannot shut its eyes to the fact that the apprehension of the petitioners needs to be addressed. Merely because the petitioners have got married against the wishes of their family members, they cannot possibly be deprived of the fundamental rights as envisaged in the Constitution of India.*"

As is observable in these two cases, there is a significant age gap between the parties, thereby raising two interrelated and significant questions which will be explored in the next module: i) Does the adolescent have the capacity to consent to sexual activity; ii) Does a significant age difference raise concerns about grooming of the adolescent, thereby making it imperative for there to be a more comprehensive assessment before considering the possibility of a settlement (in light of the facts and circumstances of the case)?

These questions will be discussed at length in the '*ABCs of Child Sexual Abuse: Dynamics of Abuse'*.

Suggested Readings

- The Protection of Children From Sexual Offences Act, 2012. http://wcd.nic.in/childact/childprotection31072012.pdf.
- The Medical Termination of Pregnancy Act, 1971 (MTPA). https://main.mohfw.gov.in/?q=acts-rules-and-standards-health-sector/acts.
- The Prohibition of Child Marriage Act, 2006 (PCMA). https://www.indiacode.nic.in/bitstream/123456789/15943/1/the_prohibition_of_child_marriage_act%2C_2006.pdf.
- The Indian Penal Code, 1860. https://www.indiacode.nic.in/handle/123456789/2263?sam_handle=123456789/1362.
- The Juvenile Justice (Care and Protection of Children) Act, 2015. https://cara.wcd.gov.in/PDF/JJ%20act%202015.pdf.
- Schedule on Specified Disabilities under the Rights of Persons with Disabilities Act, 2016. https://www.indiacode.nic.in/bitstream/123456789/15939/1/the_rights_of_persons_with_disabilities_act%2C_2016.pdf.
- *Sudhesh Jhaku v. KC Jhaku,* 1998 CriLJ 2428.
- *Sakshi v. Union of India*, (2004) 5 SCC 518.
- *Lilu @ Rajesh and Anr. Vs. State of Haryana; (2013) 14 SCC 643.*
- 172nd Law Commission of India Report. *Review of Rape Laws (2005). http://www.lawcommissionofindia.nic.in/rapelaws.htm.*
- 283rd Law Commission of India Report. *Age of Consent under the Protection of Children from Sexual Offences Act, 2012.* (2023). https://lawcommissionofindia.nic.in/report_twentysecond/.
- Ministry of Women and Child Development, Government of India. Study on Child Abuse: India 2007. http://www.wcd.nic.in/ childabuse.pdf.
- Pathak, H. (2016). Beyond the binary: Rethinking gender neutrality in indian rape law. Asian Journal of Comparative Law, 11(2), 367-[ii].
- Choudhry V, Dayal R, Pillai D, Kalokhe AS, Beier K, Patel V (2018) Child sexual abuse in India: A systematic review. PLoS ONE 13(10): e0205086. https://doi.org/10.1371/journal.pone.0205086.

Additional Materials

Image 1 ('Me and Ramo Bhaiyya'): For Activity 'Me and Ramo Bhaiyya'

Case Study 1:

Kushal, a 17-year-old boy, raped a 4-year-old child who lived near the garage in which he worked as a mechanic. The child was found injured in a nearby abandoned building with bloody clothes by one of her neighbours in the night. There were empty bottles of alcohol present nearby. She was admitted at a hospital and is recovering from her injuries. Kushal's father is employed as a security guard and is usually not home. His mother left the home when he was 10 years old and he has not heard from her since then. Kushal has never been to school and has worked odd jobs here and there till he found work at the garage 4 years ago. He hangs out with his friends from the garage who also work as mechanics there. They are 2-3 years older than him. The other boys at the garage started showing Kushal pornographic videos a few months ago after work, when they usually got drunk together. His friends used to make fun of him and often said, "You can't be a real man until you've experienced sex.''

Case Study 2:

Karthik is a 17-year-old boy. After completing the 10th standard, he started working at a garage. He was in a mutually consenting, romantic relationship with a 16-year-old girl who lived in his neighbourhood. However, the families of Karthik and the girl opposed the relationship. Fearing that they would be separated, Karthik and the girl decided to run away to another town and got married in a temple and lived together for 6 months. During this time, Karthik was employed to do odd jobs as a handyman in someone's estate. The parents of the girl lodged a police complaint and when Karthik and the girl were found, an FIR was registered against Karthik under the relevant provisions of the IPC for kidnapping and Section 3 (penetrative sexual assault) of the POCSO Act. As the girl was found to be pregnant, Karthik was charged under Section 5 (aggravated penetrative sexual assault) of the Act as well.

2. The Experience and Impact of Childhood Trauma

Learning Objectives

- To learn about the nature and impact of the experience of childhood trauma.
- To identify child and adolescent mental health problems that may result from trauma experiences.

Time

3.5 Hours

Concept

In as long as we learn about trauma as a theoretical concept, we will never really know how children experience it. So, let us begin by doing an exercise to deeply understand the meaning and experience of childhood trauma. (See Box for Activity 1…do this first!).

What is trauma?

Trauma is the emotional, psychological and physiological residue left over from heightened stress that accompanies experience of threat, violence and life changing events. It is a more overwhelming event than a person would ordinarily be expected to encounter.

Complex trauma
Children's exposure to multiple traumatic events
Often of an invasive, interpersonal nature
Wide-ranging, long-term effects due to this exposure.
*Children in Adverse Circumstances (ACES)

Types of Trauma

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

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

The difference between trauma and other difficult experiences is that traumatic events are usually out of the ordinary, and extreme in nature, such as those described above. They are times when individuals feel ill-equipped to cope i.e. their normal coping mechanisms, mainly resilience, family and social supports, are either dysfunctional

or inadequate in helping them address their problems. Traumatic events also have adverse long-term impacts on individual psyche, their inter-personal relationships, and interactions with the world. Thus, what characterizes a traumatic event is one or more of the following features:

- It happened suddenly and unexpectedly;
- The person is unprepared for it;
- The person felt powerless to prevent it;
- It happened repeatedly and/or a long period of time;
- Someone was intentionally cruel:
- More than one (traumatic) event occurred close to each other or in succession.

Another way of categorizing childhood trauma is as follows:

- **Acts of omission** (things caregivers should do to children but do not do): consist of psychological neglect, sustained parental non-responsiveness and psychological or physical unavailability. [Parents who do not respond to children with love, affection and caring].

- **Acts of commission** (things caregivers should not do to children but do them instead): Involve actual trauma directed toward the child. These acts (of abuse), whether physical, sexual, or psychological, can produce longstanding interpersonal difficulties, as well as distorted thinking patterns, emotional disturbance, and posttraumatic stress.

Yet another lens to view childhood trauma is that of Adverse Childhood Experiences (ACEs). Using a social determinants lens to child (mental) health, ACEs refers to a cluster of childhood experiences thought to be particularly damaging to healthy development. ACEs are generally developmental experiences that are not typical in child development and often overwhelm the normal coping resources of a typical child. They generally include various forms of violence and threat exposure (physical, emotional and sexual abuse, bullying and other forms of discrimination, family dysfunction, domestic violence and crime) and various forms of deprivation and loss exposure (parental death, illness, incapacitation, and absence). There is much evidence for how there are strong relationships between ACEs and physical and mental health problems across the lifespan.

Activity: The Experience of Childhood Trauma…what it means

Method: Visualization, drawing, narrative

Materials: paper or notebook and pen

Process:
Ask participants to do the following, step by step:

- Close your eyes and think of a traumatic time/event in your lives.
- Imagine the event as an image (not a narrative/ not in words)…like a still photograph.
- Now, draw it.
- Share your picture with the person seated next to you—and have him/her try to make sense of your picture and tell you what might be happening in it. He/she may ask you questions based on the picture, to elicit more detail and understanding from you.
- Participants may also be asked to share, later in plenary, their pictures and stories.

Note: In case the activity is being conducted online, participants may be encouraged (on a voluntary basis) to share their art on camera and request other participants to 'guess' what the event may have been; or participants may use their art work.

Discussion:

- What sort of images and feelings came back to you?
- Was it easy to express the emotions you felt? (Why not?)

Explain:

- How it is difficult to recall and recount trauma narratives, even for adults—because of the painful and anxiety-provoking emotions that they bring back to us, even years after the event occurred.
- How images of trauma are first coded into memory as images, sights, sounds, smells and tastes…not as narratives. This is a distinguishing feature of traumatic memories—they are first stored as sensory memories, often in fragments. These sensory experiences then get converted into language, and emerge as narratives i.e. provided that the person has the developmental abilities for this. In other words, for very young children, who do not as yet have language and verbal abilities, or are still developing these abilities, it may be difficult to expect that this conversion process has taken place. This is why young children have a sensory but not a narrative memory of what they experienced—and consequently, struggle to 'tell what happened' as is expected of them.

- For older children or adults, who may convert these sensory memories into narratives, that may or may not gain some coherence over time, and take the form of a personal narrative. However, the trauma experience may still continue to return (especially if unresolved/ untreated), as sensory perceptions and as affective states.
- The body keeps a physical memory of all of our experiences i.e. trauma impacts manifest not only as psychological, but also as physiological symptoms. For example, frequent headaches and stomach aches, blackouts and fainting fits or sweating and faster heartbeat when difficult events are recalled are physiological manifestations of trauma—mainly relating to the anxiety experienced by the person recalling the event. The need to avoid these uncomfortable sensations and feelings are also reasons why people, including children, wish to avoid recounting trauma narratives.
- Trauma does not just go away (time is not always a great healer!). A traumatic event cannot be forgotten and the memory of it may remain lifelong.
- But it can be processed so that a child is able to understand and make sense of the experience, to take perspective on what happened in such a way that he/she is able to lead a relatively happy and productive life thereafter.
- Unresolved trauma will affect the way children think, what they believe, how they view themselves and the world around them and consequently, their decisions and actions, both in the present and in the future (when they become adults). Given that they sense of routine, equilibrium and predictability is impacted, in the immediate time, children's academic performance, their family and social lives and relationships are likely to be adversely affected. In the future, children who are sexually abused may grow into adolescents having difficulty with decision-making in sexual, as well as high-risk behaviour contexts. As adults, they may develop fears relating to men/ women, in accordance with the gender of the perpetrator, or make decisions against intimate-partner relationships. Therefore, identifying and addressing trauma in children is a critical are of child mental health work.

Impact of Trauma on Children

The nature and extent to which children are affected by trauma experiences vary from child to child, and is dependent on various factors such as:

- The (nature of) event—the specific traumatic event or series of events experienced by the child, the duration and the intensity of the event or events. For example, in case of violence and abuse, whether the child observed the violence or was the recipient of violence, or both; whether the violence was associated with an unanticipated single event, was a long-standing event, or was due to multiple acts; or in case of other traumas such as separation or death of a loved one, the circumstances of separation or death, the child's relationship with the person he/she has lost, the number of times that separation/loss experiences have occurred
- The child's ability to adapt i.e. perceptions and coping mechanisms

Additional Considerations in Childhood Trauma

- Premorbid functioning
- Previous life experiences
- Subsequent changes in living situation

- The child's developmental stage--how the child internalizes and processes the traumatic event depends on socio-emotional and cognitive abilities that are age and development-related. For example, how a five-year old understands and experiences sexual abuse would be very different from how a 15-year-old would do so, thus having differential emotional and behavioural impacts.
- The child's support system--which refers to availability and relationship with family or a healthy attachment figure, and other social networks, including their responses. For example, the impact of sexual abuse on a child from an intact family, who are loving and supportive of the child is likely to be very different from that of a child from a family where disclosure is discouraged, the child is disbelieved or even blamed; and different also from a child who resides in a child care institution and has little or no family and social support.

That said, (unresolved) trauma can profoundly change the way in which children view themselves, the world and other people (i.e. their relationships), both in the present and in the future, when they become adults. Trauma causes changes in psychobiology as well as cognitive and affective responses. There are, as described below, a number of typical ways in which children respond to experiences of childhood trauma.

Table: Impact of Childhood Trauma: Signs & Symptoms

Affective Trauma Symptoms	Behavioural Trauma Symptoms
• **Fear** o intrusive memories of trauma… o generalized fear and anxiety, development of new fears unrelated to trauma… o unpredictable nature of trauma, o child tries to be 'perfect' to ward of future threats o Severe **affective dysregulation** (frequent mood changes/ difficulty tolerating negative emotional states…especially when child has experienced complex trauma) • **Sadness/depressive symptoms** o Loss of trust in the world and people o Concrete loss of spaces, homes, personal belongings, routine, play o Guilt and self-blame • **Anger** o Due to injustice experienced. o 'Traumatic bonding' in domestic violence…child identifies with perpetrator (abused-abuser dynamic)	• **Avoidance of trauma reminders** • **'Traumatic bonding'** o Modelling of inappropriate behaviours and maladaptive attachment dynamics o Acceptance of inaccurate explanations for inappropriate behaviours o Identification with perpetrator (Stockholm syndrome) o Example: domestic violence…to manage the guilt/ inability to protect victimized parent + cognitive dissonance (love and fear the abusive parent)…child adopts violent parent's views, attitudes, behaviours o Also occurs in commercial sexual exploitation • **Aggressive and destructive behaviours** • **Self-injurious/ self-harm behaviours** o "When I cut myself, I know I am real" (response to numbness) o Guilt and self-blame, frustration and anger… • **Other reckless, high risk-behaviours…unsafe sex, substance use…to cope with anxiety, due to low self-worth, sexualization** • **'Parentification'** • Contexts of parental mental illness, substance use… • Over-functionality, care-taking…

Table: Impact of Childhood Trauma: Signs & Symptoms

Cognitive Trauma Symptoms	Interpersonal Trauma Symptoms
• Changes in children's cognitions/ thoughts about perpetrators/people/world/themselves. • Develop irrational or inaccurate cognitions about causation…to gain more predictability and sense of control. • Self-blaming ("I was abused because I was wearing a short dress") • Belief that they are bad, shameful, undeserving, lacking in things…hence bad things happen to them/they are deserving of bad things. • Perception that no one is trustworthy (leads to difficulty in peer relationships/ attachment to other caregivers) • Or children respond to betrayal of trust by seeking out inappropriately close relationships with peers/adults, which may/may not be safe…additional painful experiences of maltreatment/ rejection/abuse….leading to cognitions such as 'someone will love me only if I am sexual with them' or 'the more someone loves you, the more he hurts you'. • Self-fulfilling prophecies… 'my brother died when he was 21 years old, why should I live a productive life…no point" • Unhelpful cognitions contribute to negative affect, behaviours.	• Peer/social interactions impacted. • Risk of greater affiliation with deviant peers due to fear of not 'being understood' by others. • Children who feel shame/stigma may not share close friendships. • Inter-personal traumas such as domestic violence/child abuse/neglect disrupt attachment relationships with parents and caregivers. • Lack of trust…disrupt establishment of new relationships.

Table: Impact of Childhood Trauma: Signs & Symptoms

Complex Trauma Symptoms	**Biological trauma Symptoms**
• In addition to PTSD features of intrusion, avoidance, sense of threat, those with complex PTSD experience **high levels of affective dysregulation, dissociation, negative self-concept and interpersonal disturbance, due to multiple traumatic experiences.**	• Trauma has the potential to alter brain function and brain structure. • Changes in brain functioning maintained for a long time after trauma ends, so trauma symptoms may be maintained. • Stress can change neurotransmitter and hormonal activity in the brain and other parts of the body…to produce physiological responses such as increased heart rate, perspiration…leading to hypervigilance/high alertness. • Early childhood history of abuse and maltreatment impacts brain development and cognitive capacities. *Like new neurobiological connections emerge after trauma experiences, new responses can be learned to compete with fear responses. *Therapeutic responses can help re-regulate children's emotional/behavioural/cognitive functioning and minimize adverse impacts of trauma on brain and body.

Age-Specific Impact of Trauma in Children

Pre-Schoolers…

- Become passive, quiet, and easily alarmed.
- Become fearful, especially regarding separations and new situations.
- Experience confusion about assessing threat and finding protection, especially in cases where a parent or caretaker is the aggressor.
- Regress to recent behaviours (e.g., baby talk, bed-wetting, crying).
- Experience strong startle reactions, night terrors, or aggressive outbursts.

School Age Children…

- Have anxiety, fear, and worry about safety of self and others
- Worry about recurrence or consequences of violence
- Show changes in behaviour such as:
- Decreased attention or concentration
- Increase in activity level
- Change in academic performance
- Irritability with friends, teachers, events
- Angry outbursts or aggression
- Withdrawal from others or activities
- Absenteeism
- Increased somatic complaints (e.g., headaches, stomachaches, chest pains)
- Re-experiencing the trauma (e.g., nightmares or disturbing memories during the day) Hyperarousal (e.g., sleep disturbance, tendency to be easily startled)
- Avoidance behaviours (e.g., resisting going to places that remind them of the event)
- Emotional numbing (e.g., seeming to have no feeling about the event)

Adolescents…

- Have anxiety, fearfulness and depression
- Engage in Self-harm behaviours
- May show Aggressive or disruptive behaviour
- Suffer Sleep disturbances masked by late night studying, television watching, or partying
- Use high risk behaviours (pertaining to substance and sexuality or truancy and runaway behaviours), as coping mechanisms to deal with stress
- Have expectations of maltreatment or abandonment
- Have increased risk of re-victimization, especially if the adolescent has lived with chronic or complex trauma

➢ Impact of Trauma (1): Medical Indicators

The response to stress can often manifest in physical/somatic symptoms, such as aches and pains. As stress is often associated with heightened levels of anxiety, this may also manifest in symptoms of physiological arousal, such as sweating, palpitations, breathing difficulties. Thus, when children have medically unexplained somatic symptoms/ complaints, one must keep in mind that these may be stress related. One source of stress, particularly traumatic stress, is child sexual abuse. Furthermore, if the abuse involves contact and/or penetration, then there may be other medical indicators such as injuries, and urinary tract infection.

➢ Impact of Trauma (2): Difficulty in Emotional Regulation

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

Thus, in the aftermath of traumatic events, children may experience:

- Reduced affect or emotional 'numbness'.
- Risk for being more easily overwhelmed by emotional distress relating to anger, anxiety, sadness, and shame.
- Difficulty in responding in a 'balanced' way, within a moderate range of emotions: the slightest provocation, even if unrelated to the event may produce extreme reactions of intense fear or anger.
- The need to cope and regain emotional control through:
  - ✓ Substance-induced
  - ✓ Compulsive behaviours such as gambling
  - ✓ Engagement in high-risk or self-injurious behaviours
  - ✓ Disordered eating
  - ✓ Repression or denial of emotions

What is emotional regulation?

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

➢ Impact of Trauma (3): Cognitive Issues

Trauma-induced changes to the brain, especially if traumatic events occur in early childhood, can result in varying degrees of cognitive impairment that can lead to difficulties with attention and focus and learning disabilities.

Poor cognitive-emotional interactions lead to poor mental health outcomes. There are critical interfaces between maltreatment, stress/ anxiety symptoms, cognitive functioning or information processing and behavioural decision-making. Some specific areas in which children's cognition is impacted is described below.

Negative Assumptions about Self

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

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

Triggers and Trauma Flashbacks

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

A trigger is a stimulus that sets off a memory of a trauma or a specific portion of a traumatic experience. (Thoughts can be triggered or 'switched on' by exposure to some environmental stimuli or experience that is similar to the trauma). A flashback refers to re-experiencing a previous traumatic experience as if it were actually happening in that moment.

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

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

Perceptions of the world based on the trauma

- "The world is not a safe place."
- "People are dangerous—and not to be trusted."

- "Life holds no promise" ("what's the point of life?")

The fundamental assertion of worldview-based models of post-traumatic stress disorder is that trauma symptoms result when traumatic experiences cannot be readily assimilated into previously held worldviews. Traumatic experiences can affect the individual's basic beliefs about the world as a predictable and safe place. This is why cornerstones in recovery from trauma include re-establishment of safety, connectedness, and the shattered schema of a worldview.

➢ Impact of Trauma (4): Dissociation

Dissociative disorders usually develop as a way to cope with trauma. The disorders most often form in children subjected to long-term physical, sexual or emotional abuse or, less often, a home environment that's frightening or highly unpredictable. When children dissociate, they mentally block off thoughts, feelings, or memories about the traumatic experience. Below are some indicators of dissociation in children (drawn from Putnam's Child Dissociative Checklist (CDC[1]):

- Child does not remember or denies traumatic or painful experiences that are known to have occurred.
- Child goes into a daze or trance like state at times or often appears "spaced-out." Teachers may report that he or she "daydreams" frequently in school.
- Child shows rapid changes in personality. He or she may go from being shy to being outgoing, from feminine to masculine, and from timid to aggressive.
- Child is unusually forgetful or confused about things that he or she should know, e.g. may forget the names of friends, teachers or other important people, loses possessions or gets easily lost.
- Child has a very poor sense of time. He or she loses track of time, may think that it is morning when it is actually afternoon, gets confused about what day it is, or becomes confused about when something has happened.
- Child shows marked day-to-day or even hour-to-hour variations in his or her skills, knowledge, food preferences, and athletic abilities, e.g. changes in handwriting, memory for previously learned information such as multiplication tables, spelling, use of tools or artistic ability.
- Child shows rapid regressions in age-level behaviour, e.g. a twelve-year-old starts to use baby talk, sucks thumb or draws like a four-year-old.
- Child has rapidly changing physical complaints such as headache or upset stomach. For example, he or she may complain of a headache one minute and seem to forget about it the next.
- Child suffers from unexplained injuries or may even deliberately injure self at times.
- Child reports hearing voices that talk to him or her. The voices may be friendly or angry and may come from "imaginary companions" or sound like the voices of parents, friends or teachers.
- Child has a vivid imaginary companion or companions. Child may insist that the imaginary companion(s) is responsible for things that he or she has done.
- Child sleepwalks frequently.
- Child has unusual night-time experiences, e.g. may report seeing "ghosts" or that things happen at night that he or she can't account for (e.g. broken toys, unexplained injuries).
- Child frequently talks to himself or herself, may use a different voice or argue with self at times.
- Child has two or more distinct and separate personalities that take control over the child's behaviour.
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[1] Available at: https://connect.springerpub.com/content/book/978-0-8261-9964-5/back-matter/bmatter2

➢ Impact of Trauma (5): Re-enactments

When they encounter a threatening situation, trauma survivors may reexperience their old, unresolved feelings of terror and helplessness. These feelings will then overwhelm their psyches and prevent them from taking appropriate action, thus leading to a re-enactment and revictimization. For example, a young child is frequently physically abused and criticized by a father, and she continually feels rage and anger; whenever she is criticized by others at her work place or in her personal relationships, she re-experiences the rage she felt with her father, and enacts it in vicious and hostile ways. This in turn would get her into fights that at times got physical and resulted in her being abused. Other examples of re-enactments include behaviours self-injurious behaviours, walking alone in unsafe areas or other high-risk behaviours, involvement in repetitive destructive relationships (e.g., repeatedly getting into romantic relationships with people who are abusive or violent).

Young children also re-enact or mimic what occurred during the trauma in order to try to make sense of what was happening with them or done to them. For instance, young children who have no understanding of death but have observed an event of this nature, may lie down and pretend to be like the dead person; or a child who is being sexually abused and is engaging in sexualized play with other children. In both these instances, children may be repetitively enacting their experiences to try and make sense of them.

➢ Impact of Trauma (6): Self-harm and self-destructive behaviours

Histories of childhood sexual and physical abuse, and of neglect and separation, are highly significant predictors of self-harm behaviours such as self-cutting and suicide attempts, and other self-destructive behaviours. Self-harm behaviours are learnt behaviours that people internalize in their formative years i.e. during childhood and adolescence. Like all behaviours, they stem from our beliefs and emotions: we act a certain way because we have certain beliefs and feel certain emotions, all of which determine what actions we take. Self-harm is rooted in self-loathing and self-erasure. A self-loathing person believes deep down that they are defective and worthless. They often feel that they are morally bad and therefore deserve the bad things that are happening to them. They may even believe that they deserve to be punished and suffer. In the context of CSA for instance, children and adolescents may feel emotions such as anger, guilt or shame, each of which may form a pathway to self-harm behaviours, as might feelings of helplessness and powerlessness. The anxiety and frustration that children experience in being unable to disclose about the abuse may also lead to self-harm behaviours.

➢ Impact of Trauma (7): Adverse Impact on Developmental Trajectories

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

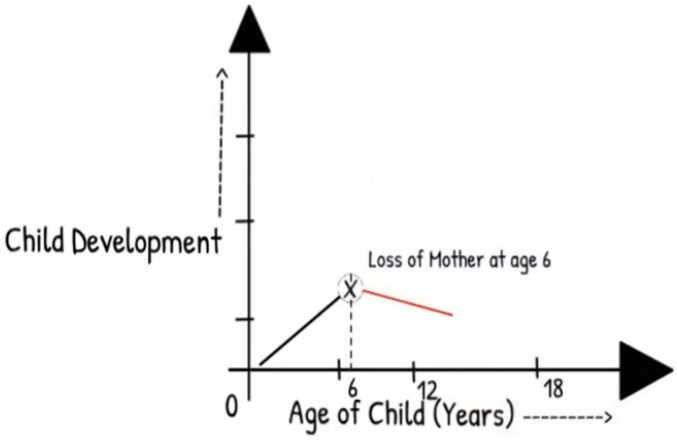
Broadly speaking, there are five key domains in child development --physical, speech and language, social, emotional and cognitive development. Early and severe trauma interferes with the usual acquisition of self-capacities and developmentally appropriate skills in children, within these developmental domains. This is thus inclusive of the development of affect regulation skills (explained above) but also impairment of other developmental functions relating to self-identity, social and cognitive skills. The achievement of developmental milestones is impaired because trauma experiences and emotions make it difficult for the child to acquire and process new information, develop family, social and peer relationships. Also, if the trauma itself is on-going and protracted and if it involves breakdown of social and civic amenities (due to breakdown in family and social

support systems), this by itself may lead to a loss of developmental opportunities because access to school is hindered and peer interactions are reduced.

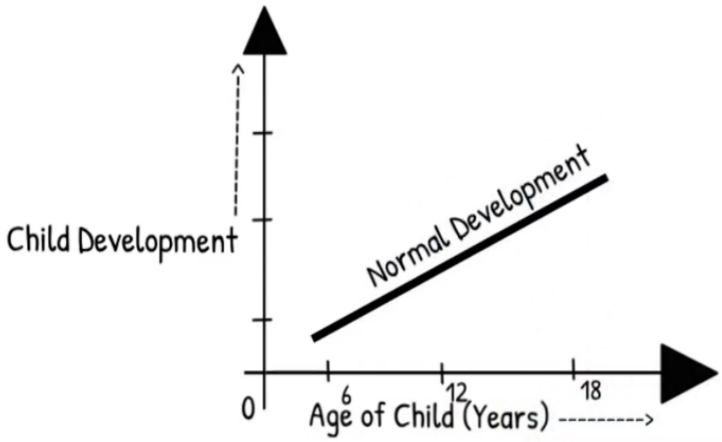
Trauma affects development both indirectly and over long term. At an inter-mediate level, if a child has lost someone or is being abused, the anxiety or the pre-occupations it causes affects learning capacities—children cannot learn in an atmosphere in an environment of unresolved doubts, questions and worries. Irrespective of whether the geographies or spaces are distal or immediate, trauma and its impact lead to a loss of sense of mastery. Where there is unpredictability about events that happen or children are unable to control how events play out, this loss of efficacy also affects self-image in a way in which the child begins to think of herself as weak and unable to predict negative events or control them when they occur. This then leads not only to negative self-identity but difficulties with new learning and skill acquisition.

Consider a child who has suffered the loss/ death of a primary caregiver such as his mother—his physical growth may suffer due to poor nutritional and other basic care; the surviving parent might become extremely over-protective of the child and not allow him to go out and play with his peers as a result of which his speech and language and social skills will be negatively impacted; his own sadness and grief and anxiety about how he will be taken care of and whether the surviving parent may also die, is likely to cause emotional distress that also impairs his attention and concentration abilities, consequently affecting his cognitive and learning capacities. In the aftermath of CSA, a young child may be overly protected by the parents, with restrictions on mobility and interactions with other people. Such a child may have difficulty with developing social skills as well as speech and language or communication abilities. A child who has suffered CSA may also experience powerlessness and helplessness that results in her being constantly worried and fearful (of being hurt), thereby also impacting her identity and self-confidence. Thus, trauma assessments and interventions in addition to using the lens of psychiatric disorders, to also use that of child development.

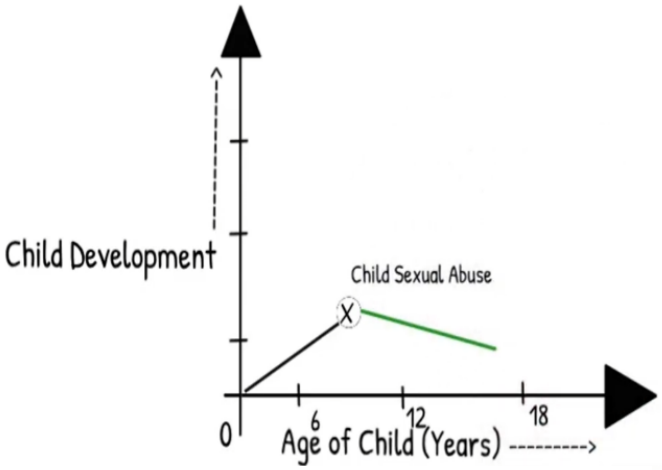
Impact of Traumatic Events on Child Development



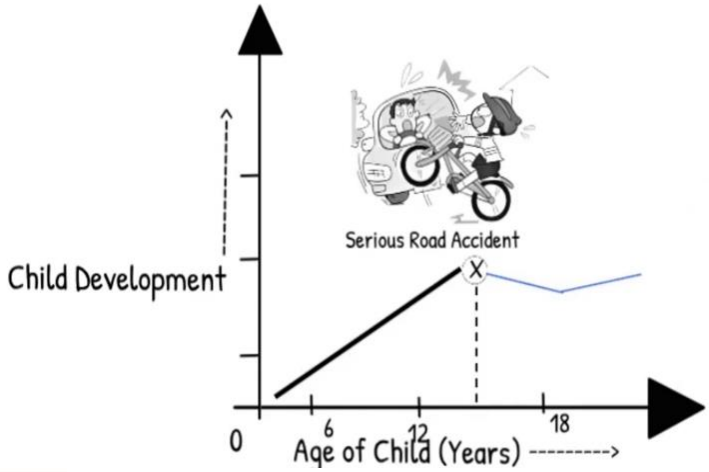
How trauma impacts development…following a loss and bereavement experience



No traumatic experience…normative developmental trajectories



How trauma impacts development…following sexual abuse



How trauma impacts development…following an accident

***QR code for a video explaining the concept available in the Additional Resources section.**

Attachment Trauma

Attachment refers to the major social and relational connection a child makes, with a primary caregiver, such as with a mother or father (or with a grandparent or guardian)—someone who spends the most time with the child and provides most of the caregiving. The process of attachment begins in infancy, and includes various elements of bonding between the child and caregiver, such as meeting basic needs for survival, physical comfort, affection and responsiveness to the child's other emotional and relational needs. John Bowlby, in his attachment theory, said that the emotional and social development of children is profoundly shaped by their relationship with their primary caregivers i.e. by the nature of their attachment relationships. In other words, if the attachment process is healthy, it leads to a person developing healthy relationships through life. Such persons, who have had loving, nurturing caregivers, who responded sensitively to them in early childhood, are said to have secure attachment—they therefore feel comfortable expressing emotions, are able to cope with negative feelings and situations in healthy ways, conducting their relationships with self-confidence and a recognition of (relational) boundaries.

Inadequate or trauma-ridden attachment relationships can lead to negative impacts on how a person relates to others, starting in childhood but carrying on into adulthood. Attachment trauma refers to a disruption in the critical process of bonding between a child and his/her primary caregiver. That trauma may be overt, entailing abuse or neglect, or it may be less obvious, such as lack of affection or response from the caregiver. Attachment trauma may also occur if there are traumatic experiences in the home, such as the absence of the primary caregiver, parental marital conflict, serious illness, or death. In such situations, the primary caregiver either cannot or does not provide care, affection and comfort to the child, also ignoring the child's distress and/or other emotional needs. Attachment trauma may render children (and adults) more vulnerable to stress, difficulty regulating emotions, dependency, impulsive behaviours, social isolation, trouble sleeping, difficulty with attention, and mental illnesses. Attachment trauma may also, in cases of neglect or abuse by the primary caregiver, place children at higher risk of various types of abuse and exploitation by others. In the context of attachment trauma, a child may be diagnosed with one of two distinct attachment disorders:

- **Reactive attachment disorder (RAD)** wherein a child rarely seeks comfort when distressed and often feels unsafe and alone. He/she may be extremely withdrawn, emotionally detached, and resistant to comforting; he/she may push you away, ignore you, or even act out aggressively when you try to get close.
- **Disinhibited social engagement disorder (DSED)** wherein a child does not indicate a preference for his/her parents over other people, even strangers. He/she seeks comfort and attention from virtually anyone, and does not exhibit any distress when a parent isn't present. While they are overly familiar with strangers, children with DSED often have trouble forming meaningful connections with others.

Attachment traumas may result in children developing problematic attachment patterns of the following types:

- Avoidant, or dismissive avoidant, attachment occurs when the caregiver is not sensitive or reactive to distress in a child. That child is then more likely to avoid showing emotions or to turn to the caregiver for comfort. Later in life this person may be emotionally distant or unexpressive, in relationships.
- Resistant, anxious or preoccupied attachment, is the result of a caregiver who is inconsistent or unpredictable with comfort and responsiveness to distress. The child may use strategies like neediness or extreme emotional responses to get the attention of the caregiver. As an adult, someone who formed this type of attachment may feel very insecure in relationships and may act needy and clingy, always looking for reassurance.
- Disorganized type of attachment occurs when a caregiver's behaviours are in some way atypical or frightening i.e. such as being overtly abusive. The child then has no clear strategy for seeking comfort or attention, and later in life this can lead to very tumultuous relationships.

John Briere's Self-Trauma Model

According to the self-trauma model, early and severe child maltreatment, in addition to its negative impacts, interrupts child development. It prompts negative emotions in response to abuse-related stimuli (triggers) and interferes with children's abilities for acquisition of self-capacities, particularly those pertaining to emotional regulation. Poor emotional regulation abilities places individuals at heightened risk of being easily overwhelmed by emotional distress associated with the memories of abuse and trauma. This in turn results in the use of dissociation and other methods of avoidance in adolescence and adulthood. Thus, impaired self-capacities lead to the adoption of avoidance strategies, which further hinder the development of self-capacities.

This negative cycle is exacerbated by the concurrent need to the traumatized person to process conditioned emotional responses and distorted cognitive schema by repetitively re-experiencing cognitive and emotional memories of the traumatic event. Such a process also overwhelms self-capacities and produces distress. If the person is not sufficiently avoidant (or dissociated), the direct exposure to upsetting material, through intrusion, will not occur; thus, he/she will not be desensitized, nor will the underlying conditioned emotional distress be reduced. Consequently, the person will continue to have flashbacks and other intrusive symptoms indefinitely, and will continue to rely on avoidance responses such as dissociation, tension reduction, or substance abuse to deal with the negative emotions arising from such re-experiencing. The trauma survivor may therefore present in therapy as chronically dissociated but beset by overwhelming and unending intrusive symptomology; and he/she may continue to have difficulties associated with identity, relationships and emotional regulation.

Activity 2: Identifying the Impact of Trauma in Children

Method: Case study analysis

Materials: Case studies provided under 'Additional Materials' at the end of this module (Facilitators may use any other case studies, from their practice).

Process:

- Ask participants to read each case, with particular attention to the contextual details and the emotional and behavioural issues described.
- With reference to the conceptual issues discussed above, identify the nature and impact of trauma as experienced by the child in each case.

Discussion:

- Ask individual participants (or sub-groups) to present their analysis of the case in terms of the nature and type of trauma impact observed in each case.
- This exercise is also an opportunity to discuss case formulation.
  (Case formulation involves the gathering of information regarding factors that may be relevant to treatment planning, and formulating a hypothesis as to how these factors fit together to form the current presentation of the client's symptoms).

Suggested Readings

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Additional Materials

Impact of trauma, deprivation and loss on child development

https://youtu.be/2x7EeGcJKFE

Case Studies on Childhood Trauma

For Activity 'Identifying the Impact of Trauma in Children'

Case 1:
A 4-year-old, adopted child with early history of neglect presented with symptoms of aggressive and disinhibited behaviour, anxiety, hyperactivity and inattention, obsessions with food, and attachment issues.

Case 2:
6-year-old Vian's mother died of cancer. He went to live with his aunt and uncle. He saw his uncle murder his toddler daughter. His uncle sexually abused him. Vian then went to school and tried to undress another child and lie down on top of her. He also cries easily and gets angry quickly--throwing things at other children.

Case 3:
10-year-old Sara is being sexually abused by her maths teacher. Her parents are not aware of this and they report (to mental health team) that Sara has 'black outs and fainting fits' daily at school—maths class is everyday. When the mental health team is inquiring about school, Sara becomes suddenly very still and silent (gazing blankly ahead) for 2 to 3 minutes and then says that she cannot remember what they were talking about.

Case 4:
12-year-old Syed is beaten regularly by his father, sometimes for no particular reason or minor errors (like when Syed spills something or forgets to do something). He who also tells the child almost daily that "you are useless…why were you born to this family? You get really low marks in school…you are good for nothing". One day when the teacher saw what was happening, and tried to talk to Syed about how wrong the father was to hit him, Syed insisted that he was a bad boy and deserved what his father said. He also said that his father meant well and was right in 'scolding and beating' him. Syed also often refuses to participate in activities in school, saying 'I can't do it…am not good at it…'

Case 5:
13-year-old Nisha is was sexually abused by her uncle. When she told her mother about this, her mother's response was that her brother (the uncle) was unlikely to have ever done things like this and Nisha must have done something to 'make him behave like that'. Nisha now engages in a lot of self-cutting behaviour.

Case 6:
15-year-old Mini has been rescued from sex trafficking. She resists all attempts of rehabilitation by the child care institution staff saying that she is not worth it. She is angry and demanding, often insistent that she be allowed to procure substance. She says that the first chance she gets, she wants to go back to either of the two 'boyfriends' she had before.

Case 7:
17-year-old Ankit hates to go to the hospital. One time, his friend had a surgery and he went to visit him. The moment he entered the hospital, Ankit started feeling extreme anxiety and panic; he started sweating and crying. Some years ago, Ankit's father had died of cancer in a hospital.

3. The ABCs of Child Sexual Abuse

Learning Objectives

- To understand the ABCs of child sexual abuse from a psychosocial perspective.
- To recognize the dynamics of abuse, including the various methods of abuse that perpetrators use both in-person and online—and how children are impacted by them.
- To be cognizant of how the methods of (perpetration of) abuse influence a child's readiness to disclose/ provide testimony.
- To apply an understanding of perpetration and abuse processes to evidence gathering and statement recording.
- To understand the emotional & behavioural impacts of CSA—and how these also serve as evidence.

Time

4 hours

Concept

Definition & Nature of Child Sexual Abuse

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

For the purposes of inquiry and investigation, it is important to have a nuanced understanding of child sexual abuse, over and beyond definitions of abuse.

Contrary to what is commonly understood, child sexual abuse (CSA) is not always a one-off act nor is it merely a series of sexual actions against a child; particularly in cases where abuse is perpetrated by known people, abuse also comprises of the series of actions leading up to the act of sexual abuse. Understanding the different methods and processes by which child sexual abuse is perpetrated helps to identify CSA more clearly and thus strengthen the evidence to convict the perpetrator.

Child Sexual Abuse is…

…an interaction between a child and an adult where the child is used for sexual stimulation.
…exploration of sexuality between minors, traditionally understood as below 18 years of age, that could be exploitative if the age difference and power dynamics between them is significant.
…not restricted to rape/penetrative genital contact.
…digital handling of the child's genitalia.
…non-genital forms of sexual touching.
…non-contact forms of abuse for the pleasure of the perpetrator such as exposing the child to pornography or taking nude pictures of the child.

**Digital handling refers to sexual abuse wherein no penile-vaginal contact occurred, but a child's genitals are assaulted by the perpetrator by use of hand or other objects.*

Activity: What is Child Sexual Abuse?

Material: Video Clip (QR code for the video available at the end of this module.

Process:

- After the introduction to child sexual abuse, to summarize the concept
- Play the video on child sexual abuse for the participants.
- Use the QR code to access the video (dubbed by SAMVAD in Hindi)
- Use the link to access the video in English (on YouTube)

Activity: Understanding CSA Basics

Method: Discussion

Materials: Statements regarding CSA provided at the end of this module.

Process & Discussion:

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

Nature or Type of Child Sexual Abuse

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

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

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

Type of Abuse	**Non-Contact versus Contact**	Non-contact abuse entails offensive sexual remarks/exposure of child to nudity or perpetrator's private parts or observation of the victim in a state of undress or in activities that provide the offender with sexual gratification or exposing child to pornography. Contact abuse entails touching of the intimate body parts including perpetrator fondling or masturbating the victim, and/or getting the child to fondle and/or masturbate him/her.

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

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

Thus, the severity of the impact of the abuse depends on not only on the type of abuse but also on the duration of the abuse and very importantly, whether the abuser is a known/ trusted person or a stranger. Thus, CSA is a complex issue, wherein impact and recovery depends on all of the above variables and how they combine together to influence the child's experience of abuse. Finally, even when there are two children, who have been impacted by identical forms and processes of abuse (similar variables), they may still be different in terms of their responses. This difference is accounted for personality and temperament of each child, and social context and circumstances of each child, due to which each child perceives and internalizes the abuse differently, thus resulting in different emotional and behavioural states or responses to the abuse.

The Dynamics of Child Sexual Abuse: Methods and Processes of Perpetration

Not all child sexual abuse is traumatic or at least not traumatic at the time at which it occurs or the ways in which it is perpetrated. Let us consider these three examples:

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

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

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

If we examine these three examples, we may agree that all of them entail sexual abuse and could be filed as POCSO cases. However, you also notice that in all three instances, there is no use of violence or force, no injuries resulting from the abuse and consequently, at least at the time of abuse, no trauma felt by the children concerned. The 6-year-old has no idea of sexuality or boundaries and since she was not hurt or threatened, but treated with affection/ given rewards, would not even be able to recognize what was being done to her as abuse, so she is unlikely to internalize her experience as being traumatic. The 10-year-old, being older, may have some sense of boundaries around his body and may feel some discomfort but the feelings of confusion, given his relationship with the abuser, may be greater than any trauma caused. The 16-year-old, on the face of it, may even be accused (by some people) of having 'given consent' and therefore it not even being a case of child sexual abuse; and in fact, the girl herself may defend the perpetrator with whom she believes she shares a romantic and sexual relationship.

Thus, the common image of child sexual abuse as being an act of violence and coercion (by a stranger) can be a misconception i.e. while that form of CSA also occurs, that is not the only method by which child sexual abuse occurs. So, what are the (other) methods by which CSA is perpetrated? How do different methods of abuse have varying psychological impacts on children? And why would it be important for mental health professionals/ medical professionals/ child care service providers to understand the method of abuse and its impact?

Processes of Abuse in Younger Children

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

Activity: Child Sexual Abuse Process in Younger Children

Material: Video Clip (Komal Video – Childline India Foundation)

Process:

- Play the video on processes of abuse in younger children (QR code for the video available at the end of this module).

Discussion

Ask the participants to think about the following and discuss in the group:

- Who was Bakshi uncle?
- Did the abuse happen on the first day or immediately after Bakshi uncle met Komal?
- What were some of the processes used by Bakshi uncle with Komal, to establish a relationship? (list down the processes as the participants share in the group)
- How did he spend time with her? What were some of the things that he told Komal?
- How did these processes help Bakshi uncle and finally impact Komal? Why was Komal unable to identify abuse? What could have been Komal's possible inner voices?
- Why did Komal's parents not suspect abuse?

- In addition to the processes, highlight how many a times the blame and responsibility of child sexual abuse is placed on the parents i.e. they caused abuse by being careless, not being available enough or by not drawing boundaries with the perpetrator. While neglect and lack of supervision or absence of parents may make a child an ideal target, more vulnerable to abuse. However, that's not the case always. Sometimes despite being in an intact family or having the most alert parents a child may get sexually abused. it is important to understand that sometimes the perpetrator not only builds trust with the victim but also uses his or her position of trust and authority to gain control over the immediate environment and the family of the child.

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

Table: Sexual Abuse Processes in Younger Children

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

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

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

Processes of Abuse in Older Children and Adolescents

In older children and adolescents, the processes of abuse are similar but the use of lure and inducement are slightly different. Given that adolescents are at a life stage wherein they are interested in issues of love, attraction and sexuality and are also keen to experiment with these experiences, perpetrators tend to use lure and

inducements that are more emotional in nature (rather than the more material ones used with younger children). This means that they 'smooth talk' adolescents about their physical appeal and qualities, making promises of long term emotional and romantic relationships with them**.**

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

Activity: Processes of abuse in older children and adolescents

Material: Video Clip

Process:

- Play the video on processes of abuse in older children (QR code for the video available at the end of this module).

Discussion

Ask the participants to think about the following and discuss in the group:

- What were some of the processes used by Vicky bhaiya? (list down the processes as the participants share in the group)
- How are these processes different from the processes used for younger children?
- How was Vicky bhaiya's relationship with the Sonia's family?
- What were some of the confusions, fears and thoughts about Vicky bhaiya and the abuse?

Lure & Inducement in Child Sex Tourism

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

Adolescents from difficult circumstances, those with poor family support, who have been neglected and/or abused, are particularly vulnerable to such attentions from offenders. Following such manipulation and abuse, adolescents experience feelings of tremendous confusion, especially as they have shared 'deep' sexual and romantic relationships with the offender. They find it exceedingly difficult to discern this as an abuse process and defend the offender, often refusing to accept that this is abuse.

Table: Sexual Abuse Processes in Older Children & Adolescents[2]

Method or Process of Abuse	Impact on Child/Adolescent
• **Use of Lure and Inducement** - *"I will ensure that even if other children are punished, you are not punished…you will always have special privilieges…"* [Expressed verbally or through actions]. - *"You are so beautiful…you know I love you…no one in the work cares about you the way I do…"* [Manipulation of adolescent girls].	Confusions regarding sex and love and care getting/caregiving

[2] Finkelhor, D, Browne, A (1985). The Traumatic Impact of Child Sexual Abuse: A Conceptualization. American Journal of Orthopsychiatry. 55: 530–541

• **Transmission of Misconceptions about Sexual Behaviours and Norms** - *"The more people you sleep with the greater your sexual experience will be…no man wants a girl who is ignorant about sex."* - *"Sexual experience is important…a real man should have tried everything at least once…"* - *"Not had any sexual experience…that is not cool…what will other boys/girls your age think of you?*	Confusion about sexual norms and decision-making
• **Blaming the Victim** - Offender blames the victim - Child infers attitude of shame about activities - Victim is stereotyped as "damaged goods" (this is often used to continue the abuse)	- Guilt, shame - Lowered self-esteem - High-risk sexual behaviours
• **Threat and Coercion** - Conditioning of sexual activity with negative emotions and memories…through violence and coercive sexual acts - Pressure on child for secrecy through use of threats	- Negative associations to sexual activities and sexual sensations - Aversion to sexual intimacy - Fear and Compliance

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

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

The Issue of Consent from a Psychosocial Perspective

We are aware that the POCSO Act does not recognize consent below 18 years of age; however, adolescents, due to their developmental stage, do engage in sexual relationships. It is often assumed that adolescents who get involved in sexual relationships, given their age and life stage, have done so by giving their consent i.e. they consented to the sexual relationship and therefore they are to be blamed. Thus, in addition to the perpetrator, other well-intentioned persons, such as caregivers, welfare, legal and medical system personnel, who are meant to be playing a helping role, also end up vilifying the child instead of supporting him/her. It is therefore critical to make the difference between so-called consent and 'informed consent'. Consent on the face of it simply entails saying 'yes' and entering into the sexual relationship. But informed consent assumes that the adolescent has given consent by knowing and understanding the consequences of sexual engagement i.e. with full information on the following:

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

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

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

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

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

**Adapted from: Georgia M. Winters & Elizabeth L. Jeglic (2017) Stages of Sexual Grooming: Recognizing Potentially Predatory Behaviours of Child Molesters, Deviant Behaviour, 38:6, 724-733*

A Note on Online Grooming

Given the rise in internet usage and proliferation of social media in everyday lives of children and adolescents, online grooming has increasingly become a cause for concern given the insidious nature of the abuse by (unknown) perpetrators. Employing similar methods of offline grooming, perpetrators exploit the various benefits the internet provides them – anonymity, access to children's personal information and whereabouts including their likes/dislikes, interests, hobbies to abuse children.

Activity: Identifying similarities and differences in the processes of grooming online vs. grooming in-person.

Method: Video viewing and discussion

Material: Video (QR code for the video available at the end of the chapter).

Process: View the video.

Discussion:

What are some of the processes used by the abuser in this video?

- Identify the similarities and differences in the processes of grooming online and grooming in-person (as seen in the videos of young children and older children).
- Reflect on the higher levels of secrecy possible through individual phones/computers.
- Convenience of the online space for the perpetrators.

Activity: Do you 'Agree' or 'Disagree'?

Method: Discussion

Materials: Statements (as below)

Process & Discussion:

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

Statements:

- Children / Adolescents confide in their parents about new friendships online.
- All cases of interactions with strangers online are not a serious threat to the child.
- Only if there is any immediate, physical threat or stalking, can online grooming be reported.
- All cases of online grooming are reported to authorities.
- Adolescents want to make connections online to explore romance and sexuality.
- Confusion around sex, sexual orientation and sexual intercourse makes adolescents more susceptible to abuse online.

NOTE: These statements may be used with participants to elicit a discussion.

Table: Possible Risk Factors for Online Grooming

	OFFLINE AND ONLINE	ONLINE ONLY
INDIVIDUAL	• Female • Confusion around sexual orientation • Low self-esteem • Low social support • Mental health problems social isolation/loneliness • Risk-taking behaviours • Disability • Previous victimization	• Adolescents (13-18 yrs) • Frequent internet access
FAMILY	• Conflict with parents • Single parent or reconstituted family • Low satisfaction with family • Parental substance abuse • Lack of family cohesion • Poor family relationships	• Parental failure to monitor online activity. • Lack of parental positive engagement.
COMMUNITY	• Social isolation • Possibly problems with school • Possibly dissatisfaction with school • Weak or limited peer support	• Lack of safe spaces
CULTURAL	• Culture of silence and shaming • Absolute respect for elders • Taboo topics of sex and sexuality	• Sudden proliferation of internet usage • Easy accessibility to apps and websites intended for adults

Pathways to Online Grooming

There are certain behaviours specific to online grooming that makes children and particularly adolescents more vulnerable to online grooming. These include:

- **Engaging in risk-taking behaviour online:**

  - Communicating with unknown people;
  - Searching online for someone to talk about sex;
  - Searching online for someone to have sex;
  - Sending intimate photos or videos to someone online;
  - Disclosing personal information like telephone numbers and addresses to someone online.

- **High levels of internet access, particularly with adolescents:**

  Adolescents (aged 13+) are particularly vulnerable given their normative development and needs at that age. As discussed earlier, adolescents establish a level of independence and self-sufficiency making peer relationships in the process. In the digital age, where "being online" is the measure of one's self-worth and individuality in real life, adolescents tend to use the internet to assert themselves. This stage of life is also when adolescents develop interest and curiosity around sexual behaviours. However, given the taboo around discussing these topics in safe spaces such as classrooms and homes, the internet provides answers and more. Therefore, adolescents tend to be more vulnerable to the lure of sexual relationships online given their desire for experimentation.

- **Lack of parental involvement in the young person's internet use.**

  The pandemic saw a rise in the number of young users (8 yrs - 18yrs) who had to use mobile phones, personal computers, laptops and other devices often without any supervision from a parent/caregiver for educational purposes. It is also the case that several parents/caregivers may not be aware of how different applications even function on devices, sometimes their own, and are therefore unable to monitor children's activity online.

NOTE: Children who demonstrate vulnerabilities offline are likely to be vulnerable online.

Understanding the Impact of Online Grooming

Impact (1): Direct Risks

- When VIRTUAL REALITY BECOMES REALITY… A direct risk of online grooming is the possibility of the online predator contacting and trying to **meet the child in-person**. The outcome of such an in-person meeting can even be fatal in some cases.
- Coercing children/adolescents into performing pornographic acts and publishing their pictures/videos amounting to the offence of **child pornography**.
- Threatening to **publish chats/messages/images/videos** in return for more favours or **extortion for money.**
- Issues of **trafficking** through false promises.

Impact (2): Escalating Risks

- Studies indicate **internet addiction** amongst young people is tied to high-risk sexual behaviour online.
- **Online gaming** may result in the normalisation of **socially inappropriate behaviours** such as fetishization of "taboo" relationships, high-risk sexual behaviour and aggression in social settings.
- Such access to inappropriate content through the hallows of the internet increases vulnerability of young people to sexual abuse and also to the **possibility of coming into conflict with the law.**

Legal Implications of Online Grooming

The lack of a specific legal definition for online grooming impacts the legal implications for perpetrators. These are some legal concerns surrounding the issue of online grooming:

- **Reporting Considerations**

  Since there is no specific offence defined under the POCSO Act, 2012 or the IPC, 1860, victims/informants have no clarity on what exactly can be reported and when reporting must be done. For instance - an adult misrepresenting their age to a child online, is a criminal offence in other jurisdictions around the world. However, in India, online grooming must lead to the commission of an offence defined under the IPC, 1860, POCSO Act, 2012 or the Information Technology Act, 2000 in order to be reported.

- **Evidentiary Considerations**

  Given the lack of medical evidence and no strict law regarding the accountability of Internet Service Providers, Search Engines and Platforms including social media applications to cooperate with the investigation or Court procedures, reliance would have to be placed on the child witness' sole testimony.

- **Punishment and Sentencing Considerations**

  As discussed, there is a minimum threshold requirement for statutory offences to be established in order to punish the perpetrator. The absence of recognition of the offence also means that no one can be punished for it (as per the principles of criminal law). Furthermore, the provisions in the IPC, 1860 or the IT Act, 2000 are not gender neutral therefore the protection afforded to male children under the POCSO Act, 2012 will not strictly apply.

Implications of CSA Methods & Dynamics for Statement Recording & Evidence Eliciting

In addition to eliciting a narrative on the immediate abuse, it is also important to understand the methods and processes used by the perpetrator to sexually abuse the child. Statements regarding lure-seduction-manipulative-grooming behaviours as well as on threat and coercion behaviours by the perpetrator help to strengthen the evidence of abuse. In fact, if the statement focuses only cross-sectionally (at a moment in time) on an incident of abuse, failing to recognize that CSA is often a process that consists of a series of actions entailing lure, seduction, manipulation and/or coercion and threat, then some cases may fall i.e. defense lawyers may argue that touching the child in certain ways, especially when touch is not used in genital areas/ private parts, is not child sexual abuse.

Furthermore, there are several instances, especially in peer relationships, of adolescent girls coercing adolescent boys into 'running away and getting married' and/or into physical intimacy—threats of self-harm and suicide to coerce boys into doing their bidding are becoming increasingly common. Similarly, there have also been instances (even if fewer in number) of older girls and women using processes of grooming and/or coercion with adolescent boys...take for example the case of a 17-year-old boy who was sexually abused by a 19-year-old girl who was his college mate. Therefore, a conventional approach to understanding abuse i.e. that it is always perpetrated by males over females, may result in unfair gender biases and improper decision-making about abuse. Providing justice entails the breaking out of stereotypes regarding age and gender, else, how could a 17-year-old boy (who is a victim of abuse) hope to be understood and believed (in court and elsewhere) whilst reporting? The fear of disbelief and of the humiliation of questions that court asks regarding his masculinity are likely to deter male adolescents from reporting abuse.

Thus, in order to **focus on the experiences, events and narratives of abuse perpetration**, whomsoever it is by and whatever the age, the mental health professional or the child care service provider must ask children and adolescents questions to elicit a more longitudinal narrative of the abuse, for example:

- How do you know this person (alleged perpetrator)?
- Where did you meet him/her and how long do you know him for?
- Tell me about how your friendship/relationship developed...
- What kind of activities did you do in your time together? Tell me all the different things he/you did.
- Can you remember some of the things (s)he used to tell you? Anything that ever made you feel worried or uncomfortable?

Such questions (asked in a gentle and reassuring manner) will help the mental health professional or the child care service providers understand the dynamics of the abuse and therefore also to establish that abuse occurred. It will help establish whether manipulation and grooming processes have taken place—in which case, even if an adolescent were to say (s)he consented, the court may be able to establish that that consent was 'manufactured' and thus decide that there was sexual abuse.[3] It is thus important for professionals to apply their (psychosocial)knowledge of abuse dynamics and processes in evidence gathering and decision-making.

3. Distinguishing so-called 'consenting' sexual relationships from sexual relationships in which grooming and manipulation has taken place i.e. to 'manufacture' consent is a challenging task. As of now, some ways of inquiry to make these distinctions are largely available in mental health practice. It would be useful therefore, for the court, to ask for mental health professionals to conduct some aspects of child sexual abuse inquiry.

The Problem with the Morality Lens…

It is important to understand adolescents' high risk sexual behaviours from a mental health perspective, to know that some of these problem behaviours are attributable to their experiences of trauma and abuse. If the causes and contexts of these adolescent risk behaviours are not understood, and 'moralistic' positions are taken, resulting in vilifying and labelling the child/ adolescent, then justice will not be done.

In fact, it would be incorrect to assume that caregivers and others accompanying children through CSA systemic processes are always empathetic to the child or that they are interested in children receiving justice. There have been instances where families/ caregivers/ institution staff have been reluctant to go through with CSA systemic and legal processes either due to social stigma associated with sexual abuse reports or the need to protect the perpetrator for family honour and other reasons or due to the vested organizational and political interests (such as happens in institutions wherein they are concerned about 'protecting the institution's name' than about children's safety).

Mental health professionals and the Child care professionals need to be alert to the unsupportive environments sexually abused children come from, understanding that the pressure that many children are under, to 'not report'. One of the ways in which this pressure and lack of support is reflected is through criticizing children's behaviour i.e. labelling a child as a long-standing pathological liar or accusing a child of high-risk sexual behaviours and substance abuse—the logic being 'if a child behaves like this and is of such poor moral character, how can his/her account of abuse be true? Such a child should not be believed…his/her views should not be considered'. However, the presence of so-called 'immoral' sexual behaviours and substance abuse behaviours does not preclude a child or adolescent from being abused, so it is recommended that professionals do not enter into value-based or moral judgments about a child or adolescent's behaviours because this will only make a child or adolescent defensive and fearful, causing him/her to provide inaccurate statements or retract statements of abuse.

Finally, a nuanced understanding of CSA will help those assisting children to anticipate situations in which retraction of statements may take place. When abuse has taken place through grooming processes (i.e. lure, inducement and manipulation) and violence, threat and coercion methods have played little or no role in the abuse process, children/ adolescents are likely to be reluctant to provide statements; or they tend to retract any statements previously made about inappropriate touch and interactions with the perpetrator because:

- The abuse is carried out in a seeming context of consent and mutual pleasure.
- Such abuse is carried out by persons in whom children have tremendous trust so children are in a state of confusion when these persons are suddenly 'vilified'.
- Due to the emotional and material benefits that children gain from the offender; they may be reluctant to recognize or concede that the relationship is an exploitative one.
- Due to children/ adolescents being blamed for 'giving consent' and the ensuing feelings of shame and guilt, the social stigma causes children and adolescents to not want to report the sexual abuse.

- Sometimes there might be a threat from the perpetrator and the threat can also take a very conflicting form wherein the perpetrator puts the onus of protecting him/her on the child i.e. *'I will be destroyed…my life will be ruined…'* as a result of which the child feels guilty and responsible for having got the perpetrator 'into trouble'.

In such situations, where less overt abuse methods have been used, it requires the magistrates and judges to be skilled in their inquiry, not only asking about abuse incidents and actions at any given point in time, but also eliciting information on the nature of the child or adolescent's relationship and the types of interactions they have had over a period of time. (The requisite inquiry is described in detail in the final chapter of this training manual).

Note: The above content refers to sexual (abuse) relationships between children or adolescents and adults. If working with POCSO charges that involve two mutually consenting adolescents i.e. romantic and sexual relationships between peers, then the perspective required to be taken is a slightly different one. From an adolescent sexual rights perspective, such relationships actually do not fall in the realm of child sexual abuse. Thus, such cases, ideally should be referred to the mental health system rather than the legal system. *Please refer to Annex 2 on 'POCSO 2012 in Action: When and Why it Does Not Work' for more detailed explanations.*

Clinical Contexts of Consultation

There are broadly three contexts in which children present for psychosocial consultation on sexual abuse issues. The first is when child sexual abuse is already established by agencies and individuals and they refer the child to the mental health system. Such referrals may be received from:
i) District Child Protection Units;
ii) Childline and child care agencies/ service providers;
iii) Police;
vi) Courts and judicial personnel.

Children are brought by such agencies and bodies either for interventions in the wake of trauma and emotional problems and/or for inquiry and evidence gathering for use in court cases. Thus, in this context, the mental health system is not required to establish whether or not CSA has occurred, as it is already known—usually, children would have reported abuse or in case of children in sex trafficking, they have been rescued through a raid on sex work institutions, and so the abuse has come to light.

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

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

- The child discloses or reports abuse.
- An adolescent girl is found to be pregnant.
- (Frequent) urinary tract infections in the child are reported by the child/ caregivers and/or genital injuries in the child are reported/ observed.
- Emotional and behavioural issues that are associated with anxiety, anger and depression.

When to Suspect CSA: Signs & Symptoms

Below is a list of signs and symptoms of child sexual abuse i.e. emotions and behaviours that if children show, we must suspect abuse.

Table: Emotional & Behavioural Signs & Symptoms of CSA

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

It is useful for professionals to know and understand signs and symptoms of CSA. The mental health and health professionals have to develop the medical and psychosocial reports that may be needed for the legal processes. When psychosocial reports contain some of the signs and symptoms listed below, the it gives a sense that CSA has taken place and the inquiry and statement recording can proceed accordingly.

Activity: Impact of Child Sexual Abuse

Material: Video clip

Method: Film viewing and discussion (QR code for the film available at the end of the module).

Process

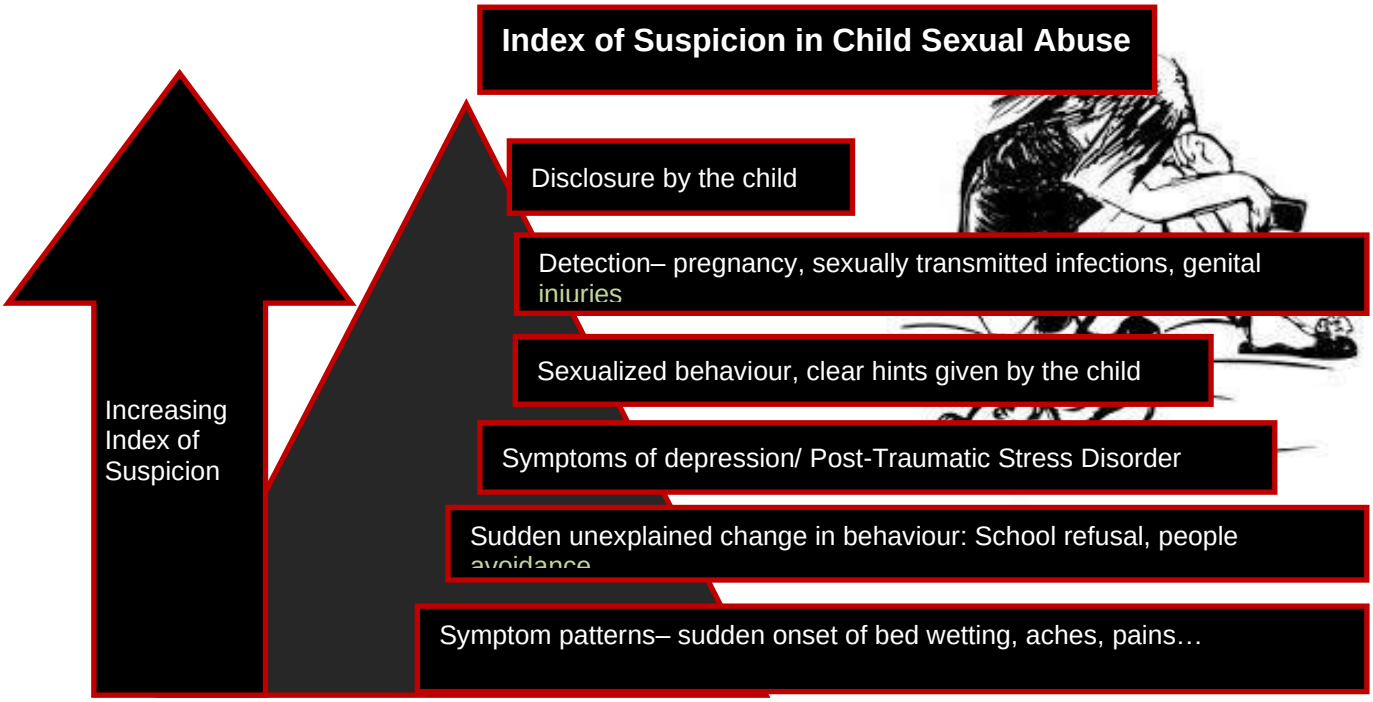
- Ask the participants about their thoughts or different kinds of impacts of child sexual abuse as seen in the video.

Discussion

- Different children internalize abuse in different ways and therefore they may also be impacted by the abuse differently.

To understand further, there is what is called an index of suspicion in child sexual abuse i.e. when to suspect child sexual abuse and how true one's suspicions likely to be. Refer to figure below--it diagrammatically represents the index of suspicion in child sexual abuse.

At the peak of triangle, the index of suspicion is highest i.e. there is no doubt when a child reports or discloses that abuse has taken place, especially when a child spontaneously reports without particular inquiry by an adult.



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

Emotional and behavioural issues relating to anxiety and depression may occur due to sexual abuse but may also be due to other difficult and traumatic experiences such as parental marital conflict, bullying, learning difficulties and academic pressures, loss and grief (death-related) experiences…so, while emotional and behavioural changes may lead to CSA suspicion, further examination and inquiry needs to be made (by a psychosocial or mental health professional) to understand exactly what difficult event(s) or experiences they are attributable to in a given child. During inquiry, if sexual abuse is ruled out, then the signs and symptoms may be attributable to other difficult experiences.

Traumatic Impact of Child Sexual Abuse: Finklehor's Traumagenics Model

Finklehor's traumagenics model postulates that the experience of sexual abuse can be analysed in terms of four trauma-causing factors, or what we will call traumagenic dynamics – traumatic sexualization, betrayal, powerlessness, and stigmatization. This model provides a helpful way to understand CSA, and may also be used to assess the impact of CSA trauma on an individual. (Refer to table below for summary of the model). These

dynamics alter children's cognitive and emotional orientation to the world, and create trauma by distorting children's self-concept, world view, and affective capacities. For example, the dynamic of stigmatization distorts children's sense of their own value and worth. The dynamic of powerlessness distorts children's sense of their ability to control their lives. Children's attempts to cope with the world through these distortions may result in some of the behavioural problems that are commonly noted in victims of child sexual abuse.

Four Traumagenic Dynamics:

- ***Traumatic sexualization***

- Refers to a process in which a child's sexuality (including both sexual feelings and sexual attitudes) is shaped in a developmentally inappropriate and interpersonally dysfunctional fashion as a result of sexual abuse.

- It occurs:

    - through the exchange of affection, attention, privileges, and gifts for sexual behaviour, so that a child learns to use sexual behaviour as a strategy for manipulating others to satisfy a variety of developmentally appropriate needs.

    - through the misconceptions and confusions about sexual behaviour and sexual morality that are transmitted to the child from the offender.

    - when very frightening memories and events become associated in the child's mind with sexual activity.

- The impact on the child varies, according to the child's age, understanding of sexuality, and the quantity and types of sexual activity that the perpetrator engages the child in.

- Experiences in which the offender makes an effort to evoke the child's sexual response, for example, are probably more sexualizing than those in which an offender simply uses a passive child to masturbate with.

- Experiences in which the child is enticed to participate are also likely to be more sexualizing than those in which brute force is used.

- However, even with the use of force, a form of traumatic sexualization may occur as a result of the fear that becomes associated with sex in the wake of such an experience.

- Experiences in which the child, because of early age or developmental level, understands few of the sexual implications of the activities may be less sexualizing than those involving a child with greater awareness.

- Children who have been traumatically sexualized emerge from their experiences with inappropriate repertoires of sexual behaviour, with confusions and misconceptions about their sexual self-concepts, and with unusual emotional associations to sexual activities.

- Traumatic sexualization in young child victims, manifests in behaviours such as sexual preoccupations and repetitive sexual behaviour, including masturbation or compulsive sex play. Some children display knowledge and interests that are inappropriate to their age, such as wanting to engage school-age playmates in sexual intercourse or oral-genital contact.

- In older adolescents (and adults), it manifests as aversion to sex, flashbacks to the molestation experience, difficulty with arousal and orgasm, as well as negative attitudes toward their sexuality and their bodies. The frequently demonstrated higher risk of sexual abuse victims to later sexually assault may also be related to traumatic sexualization.
- Sexual contact associated in a child's memory with revulsion, fear, anger, a sense of powerlessness, or other negative emotions can contaminate later sexual experiences.

➢ ***Betrayal***

- Refers to the dynamic by which children discover that someone on whom they were dependent has caused them harm.
- Children may realize that a trusted person has manipulated them through lies or misrepresentations about moral standards, and treated them with callousness.
- Children can experience betrayal not only at the hands of offenders, but also on the part of family members who were not abusive but unable or unwilling to protect or believe them.
- The degree of betrayal is also related to a family's response to disclosure. Children who are disbelieved, blamed, or ostracized undoubtedly experience a greater sense of betrayal than those who are supported.
- Child victims often feel isolated, get involved in drug or alcohol abuse, in criminal activity, or in prostitution. The effects of stigmatization may also reach extremes in forms of self-destructive behaviour and suicide attempts.
- The impact of betrayal on young child victims is that there may be an intense need to regain trust and security, manifested in the extreme dependency and clinging; older adolescents (and adults) have impaired judgment about the trustworthiness of other people, or in a desperate search for a redeeming relationship. Women and girls may become vulnerable to relationships in which they are physically, psychologically, and sexually abused.
- Distrust may manifest itself in hostility, anger and isolation, with an aversion to intimate relationships. In case of women/ girls, sometimes this distrust is directed especially at men and is a barrier to successful heterosexual relationships or marriages.
- The anger stemming from betrayal is part of what may lie behind the aggressive and hostile posture of some sexual abuse victims, particularly adolescents—who may try to protect themselves from future betrayals of this nature. Antisocial behaviour and delinquency sometimes associated with a history of victimization are also an expression of this anger and may represent a desire for retaliation.

➢ ***Powerlessness***

- What might also be called disempowerment, the dynamic of rendering the victim powerless – refers to the process in which the child's will, desires, and sense of efficacy are continually contravened.
- A basic kind of powerlessness occurs in sexual abuse when a child's territory and body space are repeatedly invaded against the child's will. This is heightened by coercion, manipulation and threat.
- Children feel powerless also when their attempt to stop the abuse fail, including when they disclose and are not believed.

- One reaction to powerlessness is fear and anxiety, which reflect the inability to control noxious events. Many of the initial responses to sexual abuse among children are connected to fear and anxiety. Nightmares, phobias, hypervigilance, clinging behaviour, and somatic complaints related to anxiety have been repeatedly documented among sexually abused children.
- Another effect of powerlessness is impairment of a person's sense of efficacy and coping skills. Having been a victim on repeated occasions may make it difficult to act without the expectation of being re-victimized. This sense of impotence may be associated with the despair, depression, and even suicidal behaviour often noted among adolescent and adult victims. It may also be reflected in learning problems and running away behaviours.
- A third impact may be Attempts to compensate for the experience of powerlessness. In reaction to powerlessness, some sexual abuse victims may have unusual and dysfunctional needs to control or dominate. Some aggressive and delinquent behaviour would seem to stem from this desire to be tough, powerful, and fearsome, if even in desperate ways, to compensate for the pain of powerlessness. When victims become bullies and offenders, re-enacting their own abuse, it may be in large measure to regain the sense of power and domination that these victims attribute to their own abuser.

➢ ***Stigmatization***

- This final dynamic, refers to the negative connotations (e.g., badness, shame, and guilt) that are communicated to the child through the CSA experience. These become incorporated into the child's self-image.
- Such feelings and internalizations may occur due to the perpetrator blaming the victim for the sexual activity, demeaning the victim, or furtively conveying a sense of shame about the behaviour.
- But stigmatization is also reinforced by attitudes that the victim infers or hears from other persons in the family or community. It may thus grow out of the child's prior knowledge or sense that the activity is considered deviant and taboo, and it is certainly reinforced if, after disclosure, people react with shock or hysteria, or blame the child for what has transpired.
- Children may be additionally stigmatized by people in their environment who now impute other negative characteristics to the victim (e.g., loose morals or "spoiled goods") as a result of the molestation.
- Older children, who are more cognizant of sexuality issues and social taboos/ attitudes towards it are more likely to suffer stigmatization, as are those who have to deal with religious and cultural taboos.

Table: Traumatic Impact of Child Sexual Abuse: Summary of Finklehor's Traumagenics Model

EFFECT	PROCESSES	'PSYCHOLOGICAL IMPACT	BEHAVIOURAL MANIFESTATIONS
TRAUMATIC SEXUALISATION The conditions in sexual abuse under which a child's sexuality is shaped in developmentally inappropriate and interpersonally dysfunctional ways.	Child rewarded for sexual behaviour inappropriate to developmental level Offender exchanges attention and affection for sex Sexual parts of child fetishized Offender transmits misconceptions about sexual behaviour and sexual morality Conditioning of sexual activity with negative emotions & memories	Increased salienceof sexual issues Confusion about sexual identity Confusion about sexual norms Confusion of sex with love and care getting/care giving Negative associations to sexual activities and arousal sensations Aversion to sexual intimacy	Sexual preoccupations and compulsive sexual behaviours Precocious sexual activity Aggressive sexual behaviours Promiscuity and prostitution Sexual dysfunctions; flashbacks, difficulty in arousal and orgasm Avoidance of or phobic reactions to sexual intimacy Inappropriate sexualization of parenting
Isolation Drug/alcohol abuse Criminal involvement Self-mutilation	Offender blames, degenerates victim Pressure on child for secrecy from the offender Child infers attitude of shame	Guilt, shame Lowered self esteem Sense of differentness from others	

Suicide	about activities Child blamed for events Victim is stereotyped as "damaged goods"		
BETRAYAL The child's immediate or delayed discovery that someone on whom they are virtually dependent has caused or wishes to cause them harm	Trust and vulnerability manipulated Violation of expectation that others wil will provide care and protection Child's wellbeing is disregarded Lack of support and protection from parents	Grief, depression Extreme dependency Impaired ability to judge trustworthiness of others Mistrust; particularly of men Anger, hostility	Clinging Vulnerability Allowing own children to be victimized Isolation Discomfort in intimate relationships Marital problems Aggressive behaviour Delinquency
POWERLESSNESS The child's will, wishes and sense of efficacy are repeatedly over-ruled and	Body territory, invaded against child's wishes Vulnerability to invasion continues over time	Anxiety, fear Lowered sense of efficacy Perception of self as victim	Nightmares, Phobias Somatic complaints; eating and sleeping disorders Depression, Dissociation Running away

frustrated and the child experiences the threat of injury or annihilation	**Offender uses force or trickery to involve child** **Child feels unable to protect self and halt abuse** **Repeated experiences of fear** **Child is unable to make others believe**	**Need to control** **Identification with the aggressor**	**School problems, truancy** **Employment problems** **Vulnerability to subsequent victimization** **Aggressive behaviour, Delinquency** **Becoming an abuser**

Linking Normative Childhood Sexual Development to Child Sexual Abuse Risks

Sexual behaviours in children are not unusual, and usually appear in a continuum. Most children and adolescents exhibit sexual behaviours that are typical for their age primary propelled by their curiosity to gather information about how their bodies function, know about natural life processes such as reproduction, pregnancy etc. At a very young age, children begin to explore their bodies. They may touch, poke, pull or rub their body parts, including their genitals. However, these behaviours are not sexually motivated. They typically are driven by curiosity and attempts at self-soothing. Curiosity about bodies, and their differences, can also prompt children to try to look at others in states of undress, rub up against them and ask questions about genitals and toileting.

These behaviours become concerning when the sexual behaviours are developmentally inappropriate for e.g. when knowledge of the sexual acts or activity is not typical for their age, sexual behaviours are too frequent, unusual and persisting.

When these kinds of behaviours occur in children, it either is a sign of them being exposed to the adult sexual activities as a witness or they themselves are responding to these sexual behaviours and are being sexually abused.

It is important to understand that sometimes the typical/ normative development itself becomes a risk for sexual abuse. Given that children have curiosity and their inhibitions are lower, the perpetrator may use these as opportunities to engage them in sexual play activities, asking them to undress, touching them etc. With older children given their curiosity to find out about relationships, sex and sexuality, the perpetrator may use the grooming techniques and engage with them and provide them with wrong information about relationships, sex and sexuality and manipulate them by promoting wrong notions about these issues. So, in a way the developmental stages themselves may become a risk and vulnerability factor for children and adolescents in context of CSA. Look at the table below to see some typical sexual behaviours shown by children at different developmental stages and how these become a risk factor for child sexual abuse.

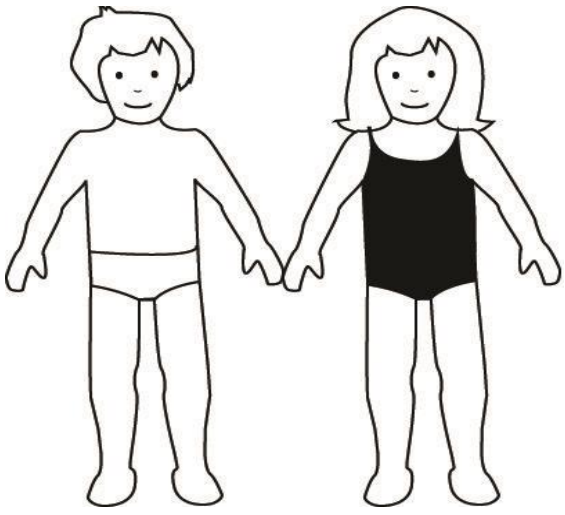


Table: Normative Child Development and Risk of Child Sexual Abuse

Pre-Schoolers		
Typical Cognitive, Language and Social Development in Preschool Children	**Typical Sexual Development and Behaviour**	**Risks for CSA**
• Young children seek pleasure • Do not see themselves from other people's viewpoints • Are not self-conscious • Limited ability to plan and control their behaviour • Poor understanding of the long-term consequences of their behaviour	• May often lack modesty and want to be comfortable • Will undress and run around nude in front of others • Don't fully understand the impact of their behaviour on others	• More likely to respond to perpetrators' requests to undress and 'show' and 'touch' body parts. • The lack of social development (and related cognitive understandings of what is inappropriate) is not present – and adds to lack of inhibition.
Curious about the world… • How things work, and about how things are similar and different from each other • About physical differences between boys and girls, and between children and adults	Wanting to see how boys' and girls' body parts are different Sexual play (showing one's own sexual body parts and looking at or briefly touching other children's body parts) is not unusual for preschool-age children	
They learn through their senses, especially by using sight and touch	• Readily explore people/objects using sight and touch • Children as young as 7 months may touch and play with their own private parts • Self-touch behaviour appears largely related to	• More easily induced into engaging in touching of genitals
• Children want to avoid being punished by their parents. Try to avoid	Whether or how often a child repeats sexual behaviour is often related to how caregivers	• Child can be engaged in sexual activity through use of material rewards (lure).

discomfort, including getting in trouble. • Want approval, praise, and rewards from their parents/adults	respond to the child's initial sexual behaviour	• Offender exchanges attention and affection for sex : 'If you don't do this [sexual act], then I will not speak with you or play with you...if you do this, I will love you'
Children often play make-believe. They often pretend to be something or someone else	• They may play or dress up as people of the opposite sex. • Playfully exposes or touches others' private parts; may ask others to do the same (you show me yours, I'll show you mine)	Can be engaged in sexual activity through play and games. 'Or secret fun game...'
They learn about behaviours by watching the people around them and imitating them. Lower speech and language abilities	Readily imitate behaviours of other children and adults, and play "doctor," "house," or "mommy and daddy" with other children	Can be engaged/'taught' sexual activity by adults. Cannot easily provide verbal reports of sexual engagement/abuse
7 to 12 years		
• Knowledge of pregnancy, birth, and adult sexual activity increases during their elementary-school years. • Accuracy of their sexual knowledge, however, depends in large part on the children's exposure to correct information and educational material. • Since parents often find communicating with their children about bodily changes and sexual matters	• Sexual curiosity and experimentation might include: touching their genitals or masturbating in private. • Being curious about the genitals of other same-age children, including looking at and touching them. • Being curious about gender, sexuality, babies and where they come from.	• Understanding social rules (and taboos), also creates inhibitions in talking about sexual issues/private parts. • Implications for disclosure-in case CSA occurs...children may hesitate to tell caregivers, for fear that they will be blamed for 'doing bad things'

uncomfortable, children frequently turn to other sources of information i.e. from other youth and from movies/ magazines/ Internet etc		
• By age 7 and 8, children begin to understand the rules of society and apply those to a variety of situations.	• Children this age start to understand that most sexual behaviours are not allowed. • Girls, especially, become shy about undressing in front of others; more private about their personal grooming activities (such as bathing)	
• Curiosity about sexual body parts and sexual behaviour. • Children's sexual behaviours continue to occur throughout this school-age period, but often hidden from others/ Caregivers. • Sex play occurs between children of similar ages and abilities, who know and play with each other regularly, rather than between strangers. • Since most of the time, boys typically play with boys and girls play with girls, sexual play often occurs between children of the same gender, and it may include siblings. • Self-touch behaviours occur with increasing frequency in boys during this developmental period		• Some degree of normalization of sexual behaviour may occur, placing children at risk of CSA. • Abuse of younger children by older children. • Less likely to disclose to caregivers...risk of CSA continuing

Adolescents (13 to 18 years)		
• Adolescents establish a level of independence and self-sufficiency • Individuating from their family...the process of transferring dependencies from parental to peer relationships. • Physical growth, puberty, hormones • ...Leading to sexual interest. • Curiosity and experimentation	• Increased curiosity • Begin to experiment sexually, more with themselves and others. • Experiences of love and attraction • Desire to engage in romantic and sexual relationships.	• More likely to be lured into sexual relations, in order to experiment. • May respond to more complex lures....including emotional manipulation. • Confusions regarding sex and love and care getting: - *You are so beautiful...you know I love you...no one in the world cares about you the way I do...*" • Confusions about sexual norms and decision-making. - "The more people you sleep with the greater your sexual experience will be...no man wants a girl who is ignorant about sex." - "Sexual experience is important.....a real man should have tried everything at least once..." - "Not had any sexual experience...that is not cool...what will other boys/ girls your age think of you?'

Suggested Readings

- *Cyber Safety Booklet for Children (For Adolescents)*. Central Board of Secondary Education (CBSE). https://www.cbse.gov.in/cbsenew/documents/Cyber%20Safety.pdf.
- Wekerle, C., Goldstein, A. L., Tanaka, M., & Tonmyr, L. (2017). Childhood sexual abuse, sexual motives, and adolescent sexual risk-taking among males and females receiving child welfare services. *Child Abuse & Neglect*, *66*, 101-111.
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- Boney-McCoy, S., & Finkelhor, D. (1995). Prior victimization: A risk factor for child sexual abuse and for PTSD-related symptomatology among sexually abused youth. *Child abuse & neglect*, *19*(12), 1401-1421.
- Davies, E. A., & Jones, A. C. (2013). Risk factors in child sexual abuse. *Journal of forensic and legal medicine*, *20*(3), 146-150.
- Plunkett, A., O'Toole, B., Swanston, H., Oates, R. K., Shrimpton, S., & Parkinson, P. (2001). Suicide risk following child sexual abuse. *Ambulatory Pediatrics*, *1*(5), 262-266.
- Stewart, J. G., Kim, J. C., Esposito, E. C., Gold, J., Nock, M. K., & Auerbach, R. P. (2015). Predicting suicide attempts in depressed adolescents: Clarifying the role of disinhibition and childhood sexual abuse. *Journal of affective disorders*, *187*, 27-34.
- Finkelhor, D. (1987). The trauma of child sexual abuse: Two models. *Journal of Interpersonal Violence*, *2*(4), 348-366.

Additional Materials

Sexual abuse is confusing – video 1

https://www.youtube.com/watch?v=Q4xwdFWjIOw

Komal Video – Young Children (Hindi)

https://www.youtube.com/watch?v=CwzoUnj0Cxc

Komal video – Young children (English)

https://www.youtube.com/watch?v=5cBQtZRbRJU&t=136s

Vicky Bhaiya and Sonia – Older Children Processes (English)

https://www.youtube.com/watch?v=ISlWnwgF6l0

Vicky Bhaiya and Sonia – Older Children Processes (Hindi)

https://www.youtube.com/watch?v=3EYdg3yvnIc

We Thought We Were Broken (Impact of CSA)

https://www.youtube.com/watch?v=WOyg6IrfuzA

Online Grooming

https://www.youtube.com/watch?v=IUjwHPah72o&t=4s

Statements for 'Agree-Disagree' Activity

• A victim of sexual abuse will avoid the abuser.
• Children who are abused display strong emotional reactions.
• An abused child will typically cry for help and try to escape.
• All victims of sexual assault respond in the same way to sexual abuse.
• A child who returns to, or spends time with the alleged offender, is unlikely to have been abused.
• A child who shows no signs of distress has not been abused.
• The perpetrator of child sexual abuse is normally a stranger to that child.
• Affectionate young children initiate sexual contact.
• A physical examination by a doctor will almost always show whether or not a child has been sexually abused.
• Relatively few child sex abuse cases are based on physical evidence.
• Repeatedly asking children questions such as: 'Did he touch your private parts?' leads them to make false claims of sexual abuse.
• Children sometimes make up stories about being sexually abused when they actually have not.
• Children sometimes make false claims of abuse to get back at an adult.
• Children are easily coached to make false accusations of sexual abuse.
• Children are sometimes led by an adult to report they have been sexually abused when they have not.
• Inconsistencies in a child's report of sexual abuse indicate that the report is false.
• Children who retract their reports of sexual abuse were probably lying in the first place.
• When a child delays in reporting sexual abuse, this is evidence of lying.

4. The Dynamics of Child Sexual Abuse Disclosure

Learning Objectives

- To debunk myths about CSA disclosure.
- To define the process of disclosure and understanding the different types of disclosure in CSA cases.
- To understand the factors that impact the likelihood of disclosure in CSA cases.
- To build awareness about barriers and facilitators to CSA disclosure.

Time

2.5 Hours

Concept

Studying, surveying, and treating child sexual abuse depends one phenomenon, which is also the most critical part of child sexual abuse work i.e. disclosure. Disclosure simply means sharing of the abuse experience with others. Disclosure of abuse may occur in two ways primarily- it could either happen intentionally or accidentally. In the first scenario, a child may disclose because the abuse, the secrecy and distress has become too overwhelming for them and they want the abuse to stop or they may even want to protect the abuse from happening to other children. While in the second scenario, the disclosure may be accidental which means that after the abuse there could be physical injuries, pregnancy, infections or there could be emotional and behavioural signs that are noticed by the child's caregiver and therefore in that context they reach out to the medical professional or mental health professional, who in turn identify and confirm abuse. Or, in another given situation there could be a third person who has witnessed abuse being perpetrated against the child and decides to come forward and report it and therefore the disclosure is made. No matter how the disclosure comes along, it is always complex and it is only after the disclosure that the efforts to protect and support the child from potential or ongoing abuse and hold perpetrators accountable for the abuse can be made.

Activity : Survivor Narratives- Disclosing Abuse

Method: Audio clip & discussion

Materials: Audio clip (QR code for the clip provided at the end of this module).

Process & Discussion:

- Play the audio clip for the participants and enter the discussion on disclosure.
- Ask the participants to share their thoughts about Zijah's narrative.
- Why do you think Zijah delayed the disclosure or took a long time to disclose?

Activity: Debunking Myths About Disclosure

Method: Discussion

Materials: Statements regarding CSA provided at the end of this module.

Process:

- Read each set of statements and ask participants in plenary whether they agree or disagree…

Discussion:

- Discuss why they agree or disagree with each of these statements.

Understanding Disclosure and Types of Disclosure

In the context of CSA, disclosure refers to the first time a child tells someone about having experienced sexual abuse (Esposito, 2015). A child could disclose abuse to a friend, a parent, a trusted family member, a teacher, a mental health, medical professional, child care service provider or anyone else the child trusts. The disclosure process is varied and unique to each child.

It is important to note that disclosure is rarely impulsive and it is more likely to occur slowly over time as part of a process. Children may make a full and detailed account of their abusive experience or they may reveal little bits of information over time, not necessarily in sequential order and to a range of different people.

Disclosure may happen in different ways. Refer to the table below to understand different ways in which disclosure may happen.

Table: Types of Disclosure

Purposeful	An intentional and deliberate revelation of the abuse with clear intent of revealing its existence.
Accidental	A statement made without planning or intent to reveal the abusive relationship. (may occur when a physical symptom is detected or when a child displays some behavioural or emotional symptom)
Prompted or elicited	A disclosure that is assisted by other people. (in response to a direct inquiry about abuse)
Precipitant	A disclosure prompted by an event that triggers a memory of the abuse. (the disclosure may be significantly delayed in this case)

While we learnt about different ways in which disclosure may happen, sometimes, children may also decide to intentionally withhold a disclosure. The reasons for not telling may be many and may include the fear of not being believed, shame, self-blame guilt, fear of upsetting adults/ caregivers, fear of the perpetrator or losing their family or being moved away from their homes/ institutions etc. In these kinds of situations, the child may sometimes despite having the opportunities to tell, may completely deny being sexually abused. In this case, the disclosure may happen accidentally (when the caregiver observes physical/ emotional/behavioural signs) or only through a third-party intervention (because they have witnessed abuse).

The Sleeper Effect

When the trauma of abuse is too severe, the mind may remove the traumatic memories by repression or dissociation. This generally happens due to the helplessness and lack of control experienced by the person over the abuse incident. So, as defence mechanism the mind may adapt to the situation by forgetting about the experience while the abuse is happening. The person in this case therefore may not be able to access the thoughts and memories related to their abuse at all for a very long time, however these memories of the abuse experience are not permanently deleted from the mind but only repressed.

The person may slowly recover these memories as they grow older or sometimes even become adults. They may suddenly find themselves flooded by memories of sexual abuse or flashbacks after a specific incident or a trigger. Once the memories of abuse start resurfacing it may be a very scary and confusing experience for the person. The person then may need trauma informed therapeutic support to make sense of their sudden fragmented recollections.

Once the memory of abuse is sufficiently recovered by the person, the disclosure may be made by the person in the same manner as other victim of sexual abuse. They may experience the same worries and anxieties about disclosure and the responses that they may get from those around them.

Dynamics of CSA Disclosure & Models

One of the earliest conceptualizations of disclosure was proposed by Roland C. Summit (1983). He proposed a syndrome 'Child Sexual Abuse Accommodation Syndrome (CSAAS)' that described how child who had experienced sexual abuse respond to ongoing sexual abuse. In CSAAS, children move through five sequential stages, one of which is delayed disclosure. The first stage is 'secrecy', wherein the child feels the need to maintain the secret of abuse out of fear of negative consequences for self, family members or even the perpetrator. In the second stage 'helplessness', the child begins to develop feelings of powerlessness and helplessness due to being unable to do anything to stop the abuse, followed by the third stage of 'entrapment and accommodation'. In this stage, the child begins to perceive the abuse situation as inescapable, and thus, learns to accept the abuse as their new reality to survive. When the abuse becomes more severe, it propels the child into disclosing the abuse, but the disclosure is usually delayed, conflicted and unconvincing, which eventually leads to the last stage of 'retraction'. If the child's anticipated fear of negative consequences of disclosing the abuse become a reality, they're most likely to retract their disclosure and deny that it ever happened. This syndrome posits that a child accommodates the abuse and withholds the disclosure as a means of coping with the effects of the abuse.

Another model highlights the role of socio-cognitive elements in non-disclosure (Bussey & Grimbeek, 1995). For children to disclose, they need to have an adequate memory of the events that occurred and the needed skills to communicate details of those events. Therefore, the abuse may not be disclosed because of these four elements, i) attention – when the child hasn't paid sufficient attention to the events, ii) retention – when the child cannot remember sufficient detail due to deficits in memory related processes concerning encoding, storage or retrieval, iii) production – when the child cannot communicate the event due to lack of verbal or motor skills for reporting it, and iv) motivation – when the child is unwilling to report it either actively or by omission. This model concluded that children need to be aware of sexual abuse so that they feel the need to report the abuse and need to be interviewed in a relaxed and non-intimidating setting and be provided with a support person throughout the disclosure process. Their fears of negative consequences of disclosing need to be adequately addressed.

Goodman-Brown (2003) identified factors that determined the latency to disclosure, i.e., the duration between the abuse event and the disclosure. Age, gender, the type of abuse (intrafamilial and extrafamilial), fear of negative consequences, and perceptions of responsibility were seen to be delaying disclosure in children. Younger children may not fully understand that abuse is wrong due to their limited knowledge about sexual matters and societal taboos, and consequently may not disclose. However, their lack of awareness may also inadvertently cause them to disclose as they may not anticipate the negative consequences of telling, and thus might be more forthcoming about information that is perceived to be shameful by older children. Older children are less likely to disclose as they are more aware of the sexual taboos and might fear adverse consequences of disclosing. Concerning gender, boys are likely to be more reluctant about disclosing the abuse due to the fear of being labelled as homosexual, seen as weak, or being stigmatized as a victim. On the other hand, girls are apprehensive about disclosing due to perceived shame and responsibility for the abuse. Further, if the abuse has occurred within the family, children will take longer to disclose due to the perceived negative consequences to self and others in the family.

Activity: Identifying processes that interfere with disclosure in children

Method: Viewing and discussion of video clips in the plenary

Materials: Video clip developed by 'Fight Child Abuse' (QR code for the video provided at the end of the module).

Process:

- Explain to the participants that they will view a few minutes long video about a girl who is sexually abused by someone she knows, which will be followed by a discussion about the same.

Discussion:

- What did you think of the video?
- What were some of the observations you made about the relationship between the child and her tutor?
- How did the tutor gain the child's trust?
- Why do you think the child felt scared and that it was her fault?
- What did you think the child was going through? What were her thoughts and feelings?
- Reiterate the factors that impact disclosure in children.

The contemporary conceptualization of disclosure processes emphasizes the individual-in-environment perspective and proposes that factors at multiple levels interact with each other, creating barriers to disclosure that range from individual to systemic in nature (Alaggia, 2004). The dynamic interaction between the individual characteristics and vulnerabilities of the child (i.e., age, gender, temperament, presence of physical or mental health issues), family environment (i.e., dysfunctional parent-child communication, presence of marital discord between parents, history of mental illness or substance use in the family, absence of either or both parents, patriarchal structures, rigid gender roles, social isolation, socioeconomic status), community influences (relationships and interactions with teachers and other childcare professionals, type of neighbourhood), and cultural and societal attitudes towards sex and sexuality impact the likelihood of disclosure. Environmental and

Activity: Exploring children's fears and the consequences of disclosure

Method: Viewing and discussion of video clips in the plenary

Materials: Video clip developed by 'Fight Child Abuse' (QR code for the video provided at the end of this module).

- Explain to the participants that they will view a few minutes long video about a girl who is scared of negative consequences of disclosure, which will be followed by a discussion about the same.

Discussion:

- What did you think of the video?
- What were some of the fears you observed in the child?
- What did the mother do to help the child talk about the abuse?
- Can you think of some other ways to help children disclose sexual abuse?

cultural contexts that discourage discussions about sexuality and promote passive acceptance of unwanted sexual experiences because they are 'inevitable' significantly decrease the chances of disclosure by any victim. Further, perceptions that propagate sexual abuse of children as a 'family matter,' which needs to stay within the family without anyone's interference also obstruct disclosure.

Why do children not disclose—the barriers to disclosure

A sexually abused child may delay disclosure or withhold disclosure due to several reasons which may include - feeling responsible for the abuse; shame and stigma associated with the abuse experience; fear of being blamed or judged negatively; fear of how they would be perceived sexually (particularly for male victims); fear of not being believed; fear of being punished; fear of family disruption including divorce, separation or being taken away from home or institution; fear of hurting the parents or caregiver by telling them about the abuse; fear of the perpetrator and negative consequences for the family and self and finally concern for the perpetrator due to the grooming process or in case the perpetrator is a family member.

In addition to some of these factors, the nature of adult-child relationship is such that there is hardly any space for dialogue or discussion, especially about matters related to sex, sexuality and abuse. Therefore, there is also very little scope for children to disclose experiences of abuse, and assuage their fears. In case of sexual abuse children already anticipate adult reactions, which are mostly negative and include - shock and disbelief, blaming child or accusing them of lying, ignoring or minimising the disclosure, anger, rejection, punishment and avoiding further discussion instead of belief /validation, not being blamed, emotional support (listening, holding the victim, asking helpful questions) and reassurance of safety, which further leads to delayed disclosure or non-disclosure. In cases where the child has been sexually abused by an adult they trust; it becomes extremely challenging and arduous for the child to disclose due to the dynamics of the relationship. Additionally, adults may have their own discomfort with issues related to sex and sexuality, and may lack confidence to respond to children (children may have had negative experiences previously on these issues and may have a sense of the adult's position on some of these issues) thus, making it hard for children to trust them with the abuse disclosure. The table below illustrates the range of barriers to CSA disclosure.

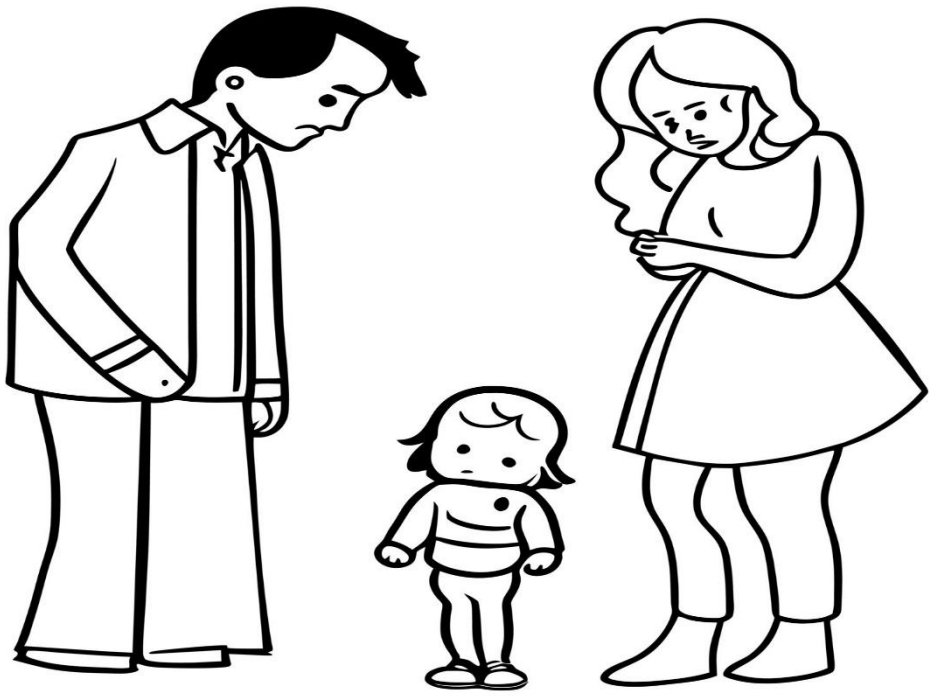


Table: Barriers to CSA disclosure in children

Type	Barriers
Individual	• Onset of the abuse at a young age • Self-Blame which causes isolation, alteration of identity, feelings of disgust • Mechanisms to protect oneself (minimization of the abuse, repression of memories, denial) • Lack of awareness or understanding of sexuality which creates confusion about the abuse and the potential outcomes of telling • Fears (of family break up, upsetting parents, not being believed, being judged, negative consequences for self or the family, future, overwhelming parents, getting into trouble, perpetrator, being harmed, being injured, being unsafe, escalation, being removed from home) • Feelings of guilt • Lack of knowledge or awareness about available support systems.
In relation to others	• Disturbed family dynamics (presence of rigid gender roles, chaos & aggression, presence of other forms of abuse, domestic violence, dysfunctional communication, social isolation, presence of substance abuse) • Family pressure to keep quiet, lack of comfort in relationships with the elders in the family, lack of understanding in parents or guardians • Presence of grooming, 'manufactured consent' (positive feelings towards the relationship with the perpetrator, perceived bond of trust/friendship with the perpetrator) • Awareness of the impact of telling (police/authority involvement, complicated legalistic processes, lack of trust in the authorities or the judiciary, perceived lack of sensitivity in authorities) • Threats or emotional manipulation by the perpetrator.
In relation to the society	• Taboo of sexuality (lack of discussion of sexuality in society and within homes and schools, difficulties in talking about the body and sexual matters) • Patriarchal mindset, cultural environment that propagates misogynistic attitudes, perpetuation of gender stereotypes • Stigma, labelling (stigma attached to being a 'victim', seeking mental health support, appearing 'crazy'), and presence of victim blaming • Absence of services available in mainstream education as well as information on available help (lack of awareness programs on sexual abuse) • Culture of silence and denial around the phenomenon of CSA

Familial/Inter Personal Barriers

Individual Barriers

Socio-Cultural Barriers

Gender-Specific Barriers

Pictures: Awareness, Myths and Perceived Barriers to Disclosures Of Child Sexual Abuse In Adolescent, Department of Clinical Psychology, NIMHANS. Meetali Et. all, June 2022.

Activity – Understanding the barriers to disclosure

Method: Case study analysis and discussion

Materials: Case studies (provided as 'Additional Materials' at the end of this module).

Process:

- Read the case studies and write a narrative from the child's perspective highlighting the barriers to disclosure (child's inner voices, fears and worries about disclosure) i.e. 'be the child' and write the narrative in first person
- Keep in mind the age and developmental stage of the child.
- Based on the different kinds of barriers to disclosure that we have learnt in the session, categorize whether these barriers are –
    - Familial/ Interpersonal barriers
    - Individual barriers
    - Socio cultural barriers
    - Gender specific barriers
- Reflect on what kind of support is needed in each of these cases to overcome the barriers to disclosure.

Facilitating and responding to CSA Disclosure

Disclosure may be facilitated by two important factors- the child's need to tell someone about the abuse i.e. some internal factors and providing an opportunity to tell i.e. external factors facilitating disclosure. Internal factors that facilitate disclosures include symptoms becoming unbearable, getting older with higher developmental efficacy, and realising that an offence was committed. External factors include settings that provide opportunities such as therapy, counselling, interviews, and information sessions, and prevention programs for children and youth to disclose.

As we understand the factors that facilitate disclosure, it also becomes important for professionals to then develop ways to enable disclosure. The most important steps include helping children understand that their experiences have been abusive, addressing some of their inner voices (fears and worries about disclosure including worries about confidentiality), reassuring them of safety and protection. It is only when children believe the benefits of disclosure will outweigh the cost of disclosure, they speak up

Responding to Children's Disclosures of Sexual Abuse

✓ **Remaining calm** – While it is natural for adults to feel shocked, angry, or sad when a child discloses experiencing sexual abuse, it is essential to stay calm as the child discloses abuse. An emotional reaction is likely to confirm the child's fear of the negative consequences of telling someone about it. Children often do not disclose because they fear they might upset their family members. Therefore, it is crucial to process your emotions in a separate space, preferably in the child's absence.

✓ **Believing and validating the child** – You may have questions about the disclosure, but it is important to demonstrate to the child that you believe them and that they're doing the right thing by telling you about it. Let the child narrate at their own pace. Children should not be aggressively questioned when they disclose because that is likely to reflect that you do not believe them. Remember, the child might have tried to tell someone before you and might have been dismissed or disbelieved.

✓ **Let the child tell the story in their own words** – Let the child narrate at their own pace and in their own words. If there are questions concerning their safety, they may be put to the child in simple terms and words that are easy for them to understand. Do not force the child to answer your questions. Do not ask questions that are leading. For example, if the child says, "My uncle hurt me.", ask the child, "Where did he hurt you?" instead of asking, "Did your uncle hurt you in your private parts?". This line of questioning can prove counterproductive once the sexual abuse is officially reported and investigated.

✓ **Reassure the child that "It is not their fault!"** – Children often blame themselves in such contexts. It is important to tell the child that whatever happened is not their fault and that they are not responsible for it in any manner. Let the child know that their disclosure does not change how you feel about them and that you still love them and care about them in the same way. Never ask the child, "Well, why did you not tell me before?". Instead, reassure them by saying, "I understand how hard it must be to talk about it. I am thankful that you trust me with your story, and I will do my best to ensure that I can help you."

✓ **Do not make promises you cannot keep** – Do not promise the child that you will keep this the information about abuse a secret. Remember, as an adult/ professional/ caregiver you are mandated by the POCSO law to report abuse. Non reporting of abuse can have safety consequences for the child and strict legal consequences for you as well. Therefore, let the child know that you might have to tell other people to help them be safe and secure. Reassure the child that they will be informed about each step and nothing will be done behind his/ her back. Keep the child in the loop, make them a part of the process so that they are assured that they are not being lied to.

✓ **Let the child know that line of communication is always open** – Reassure the child that you are available and they speak more about it later if they want to. Children might not share everything in one go and often want to see what happens to them once they disclose. They might share more details when they see that disclosing has not caused negative consequences for them.

✓ **Let the child know that line of communication is always open** – Reassure the child that you are available and they speak more about it later if they want to. Children might not share everything in one go and often want to see what happens to them once they disclose. They might share more details when they see that disclosing has not caused negative consequences for them

It is also important to remember that the ways in which the adult or the professional responds to the child sexual abuse disclosure is as important as disclosure itself. CSA disclosures are likely to cause discomfort and unease in the adults, which might be counterproductive for the child. Adults in children's lives can interrupt this cycle of shame and silence by creating safe spaces where they can tolerate their discomfort and refrain from the urge to 'fix' everything for the child. Therefore, there is significant need to build abuse awareness in children and adults, and create spaces and opportunities for children, wherein they feel safe to talk about such experiences.

Some other interventions to facilitate disclosure include designing and implementing CSA sensitization and awareness programs for adults that are aimed at reducing stigma, debunking myths and stereotypes about CSA. This would also contribute to minimising the blame that is associated with victims, and consequently, encourage the children to disclose. With respect to familial factors, improving parent-child communication can increase the chances of disclosure. Additionally, focussing on programs on skills of relationship building and counselling skills that include for professionals that would allow them to respond to children's disclosure in a balanced and reassuring manner. If a child has a trusting, comfortable and non-judgmental relationship with an adult, and they feel that they will be believed and accepted, it will be easier for them to report abuse.

Concerns about Truthfulness in Children's Disclosure Stories

Children given their developmental stage and age do not have the abilities or knowledge to fabricate an allegation of sexual abuse. Therefore, children almost never make up stories about being sexually abused. In fact, children are often revictimized in multiple ways for truthfully disclosing they have been sexually abused. Perpetrators on the other hand usually deny the abusive behaviour and the child therefore is left to contend with the power dynamics.

As discussed in the sections above, when it comes to disclosure children have a lot of fears and worries about the consequences of disclosure. However, many times, when a disclosure is made by a child the adults face the dilemma of whether the child's allegation of sexual abuse can be taken at face value or believed. Given that if the allegation of sexual abuse was true the implications for the child and their family would be far-reaching, therefore when child disclosures abuse the professionals and adults often hesitate. They respond either by asking too many questions to ensure that it happened or with avoidance. Sometimes, they may also worry about the consequences for the perpetrator, who may be a known person, friend, or a family member. They make also take positions like "his/ her life will be over" "the law is so strict …what if he/ she is innocent, even if he or she get acquitted their reputation in society will be spoilt" and therefore may begin investigation of abuse at their own level after the disclosure.

As was explained in the previous sections, children already are not very trusting of adults when it comes to making disclosures of this nature, they fear being disbelieved and when their disclosure is responded to with questions and investigation, instead of reassurance and support their fears are confirmed. This can be devastating for them and can lead to severe distress. It may also have implications for reporting and further legal processes.

Let us consider these four situations in order to understand and assess children's allegation of sexual abuse -

- The child discloses abuse (the abuse did not happen) and the adult/ professional believes the child
- The child discloses abuse (the abuse did not happen) and the adult/ professional does not believe the child
- The child discloses abuse (the abuse had actually happened) and the adult/ professional believes the child
- The child discloses abuse (the abuse had happened) and the adult/ professional does not believe the child

Which of the situations would be the best possible scenario and which of these is the worst possible scenarios?

Let us now look at the matrix below to understand:

	Believe	Disbelieve
CSA did not happen	✓	
CSA happened	✓	

Upon disclosure, the best thing to do as a professional is to extend support to the child and family and believe the child. Imagine a situation where the abuse has happened and the professional is doubtful and wants to examine the truthfulness of the child's story before proceeding further, and consequently the child is left in the abusive situation because the mental health professional/ medical professional/child care service provider is not sure. Think of all the mental health impacts it can have for the child. If at all in a certain situation it turns out that the child had indeed lied and no abuse had happened, but the mental health professional/ medical professional/ child care service provider believed the child even then there will certainly be reasons behind why the child said what he/ she said and those should be explored with the child, explaining the consequences of such behaviours for the child and the other person. But remember, these are not the rule but exceptions.

Remember the law is logical and not unreasonable. Even after the process of disclosure, the law will implement its own process and ways to examine the truthfulness of the child' allegations. We will learn about these processes in the chapters ahead, however, if the initial response to the child is of disbelief that does not instill confidence in the child to face the legal processes or the court.

It is therefore, always best to take position of always believing the victim because if you did not believe them when the disclosed and it turned out that the abuse did not happen, you only hit a jackpot and got lucky and the child got saved.

In summary, it is important to understand that the role of the mental health professional, medical professional, child care service provider, a forensic interviewer is not to examine the truth. It is to provide mental health and medical support to the child victim, enable reporting and other legal processes. Think about if you were to make an error of judgement, would you make it in favour of belief or disbelief?

Suggested Readings

- Lemaigre, C., Taylor, E. P., & Gittoes, C. (2017). Barriers and facilitators to disclosing sexual abuse in childhood and adolescence: A systematic review. Child Abuse & Neglect, 70, 39–52. https://doi.org/10.1016/j.chiabu.2017.05.009
- Alaggia, R., Collin-Vézina, D., & Lateef, R. (2019). Facilitators and barriers to child sexual abuse (CSA) disclosures: A research update (2000–2016). *Trauma, Violence, & Abuse*, *20*(2), 260-283.
- Choudhry, V., Dayal, R., Pillai, D., Kalokhe, A. S., Beier, K., & Patel, V. (2018). Child sexual abuse in India: A systematic review. *PloS one*, *13*(10), e0205086.
- Reitsema, A. M., & Grietens, H. (2016). Is anybody listening? The literature on the dialogical process of child sexual abuse disclosure reviewed. *Trauma, Violence, & Abuse*, *17*(3), 330-340.
- McElvaney, R. (2015). Disclosure of child sexual abuse: Delays, non-disclosure and partial disclosure. What the research tells us and implications for practice. *Child Abuse Review*, *24*(3), 159-169.
- Alaggia, R. (2010). An ecological analysis of child sexual abuse disclosure: Considerations for child and adolescent mental health. *Journal of the Canadian Academy of Child and Adolescent Psychiatry*, *19*(1), 32.
- Fontes, L. A., & Plummer, C. (2010). Cultural issues in disclosures of child sexual abuse. *Journal of child sexual abuse*, *19*(5), 491-518.
- Azzopardi, C., Eirich, R., Rash, C. L., MacDonald, S., & Madigan, S. (2019). A meta-analysis of the prevalence of child sexual abuse disclosure in forensic settings. *Child Abuse & Neglect*, *93*, 291-304.

Additional Materials

Won't Hide my Identity (Quint video)

Https://www.youtube.com/watch?v=tqYqAqH2Jgs

Stop The Secrets That Hurt ...My Tutor Abused Me – CSA video

https://www.youtube.com/watch?v=vE_KSbV9O00

Stop The Secrets That Hurt ... what Happens When We Tell

https://www.youtube.com/watch?v=rDoykuSJMr0

Statements for Activity on 'Debunking Myths About Disclosure'

- Children are likely to tell someone that they are being sexually abused.
- Children who do not report sexual abuse must want the sexual contact to continue.
- Parents can easily identify children who are sexually abused.
- Children cannot report sexual abuse properly because they have no understanding about the matter.
- When children disclose being sexually abused, they are usually making up stories or lying to get attention.
- If a child discloses being sexually abused a few months or years back, then it may not be true at all.
- Children are likely to forget the experience of sexual abuse after some time; therefore, they cannot be relied upon when they disclose.
- People who work with children (teachers, mental health professionals, doctors etc.) can easily identify signs and symptoms of CSA in a child.
- Adolescents who have a better understanding of sexual matters are more likely to disclose being sexually abused.
- When adolescents who are in romantic relationships disclose being sexually abused, they are usually lying or making up stories.
- Children from economically-deprived backgrounds are likely to make false allegations about being sexually abused, in order to get monetarily compensated.
- Children's accounts of sexual abuse are usually exaggerated or prone to fabrication.
- Children are likely to misinterpret and wrongly accuse someone of sexual abuse.
- If a child discloses sexual abuse and then retracts the statement, then it must be lie.
- When a child discloses sexual abuse, it is better to not involve child-welfare or legal professionals as they only complicate matters and contribute to the further victimization of the child.

Case studies for Activity on 'Understanding the barriers to disclosure'

Case 1:
Neha is a 10-year-old girl who lives with her paternal aunt and her family as both her parents work abroad. She is introverted, likes to keep to herself and describes her relationship with everyone in her aunt's family as cordial. She feels particularly close to her cousin brother who is much older than her. They spend a lot of time together and sometimes even share the same bedroom when they have guests staying over at the house. One night, she wakes up to find that her cousin is fondling her chest and rubbing against her. She feels scared and pretends to be asleep. Over the next few months, the cousin begins to touch Neha more frequently, and asks her to engage in different types of sexual activities. When Neha tells him that she does not like it, he tells her that it is very normal, and he is just expressing his love for her and slowly she will begin to like it too. She says okay and believes him.

Case 2:
Simran is a 16-year-old girl who is extroverted and likes to socialize with her peers. She is very active on social media and likes to post her pictures. Sometimes, she exchanges her private pictures with her boyfriend on social media. Unknown to her, her boyfriend saves these pictures on his phone. In a recent party at his place, she ends up experimenting with alcohol and becomes inebriated. She finds it enjoyable and starts singing, laughing, and dancing closely with her boyfriend. During the dance, she accidentally spills alcohol on her clothes and goes to the washroom. On her way there, her boyfriend's brother blocks her way and asks her to come into his room. Once there, he tries to kiss her and undress her. When she resists, he tells her that he has already seen her revealing photos and says that no one will believe her over him because of the way she behaved at the party.

Case 3:
Austin is a 7-year-old boy who lives with his mother who works to support them both. His father passed away when he was an infant. His maternal grandparents stay on a different floor in the same house. They share the same house help (Mohan) who is an 18-year-old male and has lived with the grandparents for the last 3-4 years. Austin is a shy child and takes his time to warm up to people. Many times, he is left in the care of his grandparents or Mohan as his mother works a lot. One day, Mohan asks Austin to play a 'secret game'. During the 'secret game', Mohan makes Austin perform oral sex on him. Mohan tells him not to tell anyone because it is a secret and that he might get into trouble for it and be thrown out of the house. Austin does not understand what exactly happened but feels very bad about it.

Case 4:
Rani is 8-year-old girls whose parents have recently separated. She lives with her mother and often feels angry about her parents. She has also been having difficulty concentrating in school and consequently, her grades have been affected. The teachers frequently find her distracted in class and report that she disturbs other students as well. One day in school, she goes to the washroom during her class. When she comes out, she finds the school gardener in the washroom who forces Rani to take her clothes off and then sexually abuses her. He then shows her a knife and threatens to kill her if she told anyone about it. Rani feels extremely scared and does not say anything to anyone. However, the next day, she goes to her teacher and tells her what happened. The teacher then takes her to the principal where Rani recounts the ordeal again. The principal responds by scolding Rani and telling her not to 'make things up.' She tells Rani that she will be punished if she continues to lie about it.

Case 5:
Arjun is a 17-year-old extroverted boy who is very active on social media. He is currently in a relationship with an older woman who is 27 years old. He met her on a social media app that connects people with common interests. Initially, they would exchange messages throughout the day and gradually began to have long phone

conversations late at night. Whenever he wanted to meet her, she would pick him up and take him to her house as she lived by herself. Once there, they often consumed substances such as alcohol, marijuana etc, and engaged in sexual activities. Arjun has had similar relationships with other older women (21-30 years) previously. He believes that he is "adult" and "mature" enough to engage in romantic relationships with older women. He is often told that he is "wise beyond his years" by his partner. Therefore, he believes that she really loves him and enjoys the relationship.

Case 6:

Siddharth is a 14-year-old orphaned boy who has been residing in childcare institutions since he was a young child. He is referred to a mental health institute for evaluation as he has behavioural issues, i.e., anger outbursts, breaking things, doing the opposite of what he is told etc. He is known to be a "troublemaker" at the institution. Unbeknownst to anyone, he was sexually abused by one of the staff members of the institution who told him not to tell anyone because no one would believe him as he is always creating problems. He also threatened him with severe consequences if he told anyone. Siddharth feels very angry and hopeless about his situation.

Film Screening & Discussion (A)

Learning Objectives

- To get a depictive understanding of the nuanced and complex CSA processes in children, especially the process of grooming.
- To understand how experiences of abuse are internalised and stored in memory (not always accurately).
- To get a glimpse of the difficult dynamics of reporting from a CSA victim's perspective.

Time

3 hours

Material: The movie titled **'The Tale'**. The movie may be accessed on various OTT platforms.

Synopsis of Film

Jennifer Fox is an acclaimed documentary filmmaker and professor in her 40s when her mother, Nettie, calls her in alarm after discovering an essay she wrote when she was 13. The essay is about a "relationship" Jennifer had when she was 13 and which she dismisses as something she hid from her mother at the time to not upset her, because her boyfriend was "older".

After re-reading the essay Jennifer begins to do research on that period in her life. She imagines herself as being older and sophisticated but is surprised at how small and childlike she appears in photos from that time. Jennifer's relationship began one summer when she went to an intensive horse training camp with three other girls. She lived with the beautiful and enigmatic Mrs. G, who also had Jenny and the girls run with professional coach Bill Allens, who was in his 40s. After the summer ends Mrs. G and Bill reveal to Jenny they are lovers.

After the camp, Jenny kept her horse with Mrs. G and continued to see her and Bill on the weekends. Eventually Jenny began spending time with Bill alone. He began sexually grooming her, until finally raping her, telling her that they were "making love".

When Jennifer's partner finds letters written to her by Bill, he says that she was raped, but she refuses to see it that way, proclaiming that she is not a victim. However she slowly begins to question whether her recollections are accurate and eventually realizes despite her protests she had been exhibiting symptoms of being sexually abused for years. She goes to visit Mrs. G, who refuses to acknowledge her role in Jenny's abuse and asks her to leave.

As Jennifer continues to investigate that summer, she realizes that Bill and Mrs. G were probably grooming other girls. She remembers a college student named Iris Rose who worked for Mrs. G. Jennifer tracks Iris Rose down who tells her that she, Mrs. G and Bill had threesomes and that Mrs. G was actively involved in finding girls for Bill. This prompts Jennifer to remember that she was supposed to participate in group sex with Mrs. G, Bill and Iris one weekend. However, Jenny, who threw up each time she was raped by Bill, had an anxiety attack and threw up the day before she was due to go away for the weekend, causing her mother to keep her at home. Realizing she no longer wanted to be in a relationship with Bill, Jenny called him and broke up with him, even as he pleaded with her to stay. Unlike Bill, Mrs. G coldly accepted Jenny's decision to remove her horse that weekend. Jenny wrote about her time with Bill in an essay for school (calling it a work of fiction) in which she proclaimed herself a hero, not a victim; this is the essay her mother finds at the beginning of the film.

Jennifer goes to an awards ceremony where Bill is being honoured to confront him, calling him out as a child molester in front of his wife and the other attendees. Bill denies everything and leaves. Jennifer has a panic attack and goes to the bathroom, and imagines sitting with her 13-year-old self.

Discussion

- What was the most unforgettable moment in the film for you?
- What are all the different processes/methods by which Jennifer is groomed and abused?
- What were the factors that made Jennifer susceptible to grooming?
- How are abuse experiences internalized and get stored in memory (not always completely accurately)?
- What are the immediate and long-term impacts (personal and professional) of CSA, especially of grooming? Does Jennifer suffer from any “sleeper effect”, i.e. serious symptoms that surface many years after the abuse?
- How did Jennifer perceive the abuse…and what impact did this have on her decisions for disclosure (or reporting)?

5. Identifying the Context & Experience of Child Sexual Abuse: Hearing the Child's Inner Voice

Learning Objectives

- To understand the various contexts in which CSA occurs—and how these lead to differential mental health impacts on children.
- To understand how children perceive and internalise their abuse and trauma experiences.
- Consequently, to identify the basis on emotional and behavioural problems in CSA.

Time

3 Hours

Activity: Understanding the inner voices

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.'

Concept

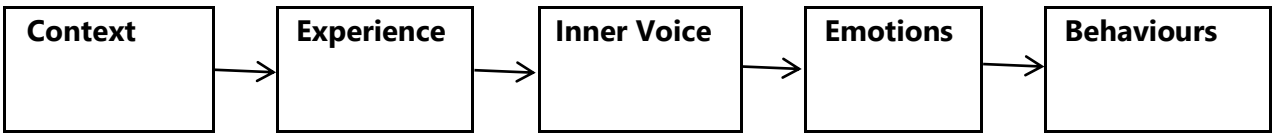
Explain to the participants that the internal voices or the thoughts that they listed during the exercise are called *inner voices*. These inner voices are the voices that play out in our minds, since the time we wake up and as we experience different events and go about doing our work through the day. These inner voices also influence our behaviours. For example, if we look at the previous exercise the inner voices such as 'I don't want to get into trouble', 'What if I try to help this girl but the man tries to hurt me' 'How can I stop this all the six other people are silent, why should I be the hero?' lead to feelings of fear or indifference and the person therefore

may decide to not step forward and help the girl who was being sexually abused in the train. However, if the inner voices were to be changed and if they were to become 'how can this person do this? I need to stop him,' 'I think I need to do something because she cannot even defend herself…let me go ahead, I don't care if others come or not.' may lead to the person going forward and stopping the abuse or taking some action to protect the girl.

Just like we have these inner voices that influence our behaviours in different situations, a child's behaviour may also be influenced by their inner voices or their own processing of the events around them.

To understand and analyse why children behave the way they do or where their behaviours or emotional issues come from, a simple yet effective framework called the inner voice framework has been developed. 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 analyse the child's context and behaviour.

The Inner Voice Framework



Analysing the Child's Problems Using the Inner Voice Framework

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.

Let us look at each element of the framework in detail:

Context: Context 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?

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. Or, in case of sexual abuse you may see that the sexual abuse has led to serious emotional distress in child A, the experience is of coercion and violence in her case, while child B, seems 'normal' and shows a lot of aggression towards the mental health professional or child care service provider because she was 'in love' with the perpetrator and 'wants to go back to him' (as a result of the sophisticated grooming techniques employed by the perpetrator). 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.

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. (Recall the activity about the Bombay local train). 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'. At a given point a person may have multiple inner voices.

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.

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.

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.

Activity: 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.
- Tell them that they cannot repeat the emotion or the behaviour i.e. if another participant has already said it.
- 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.

Susan Wieland's Internalization Model

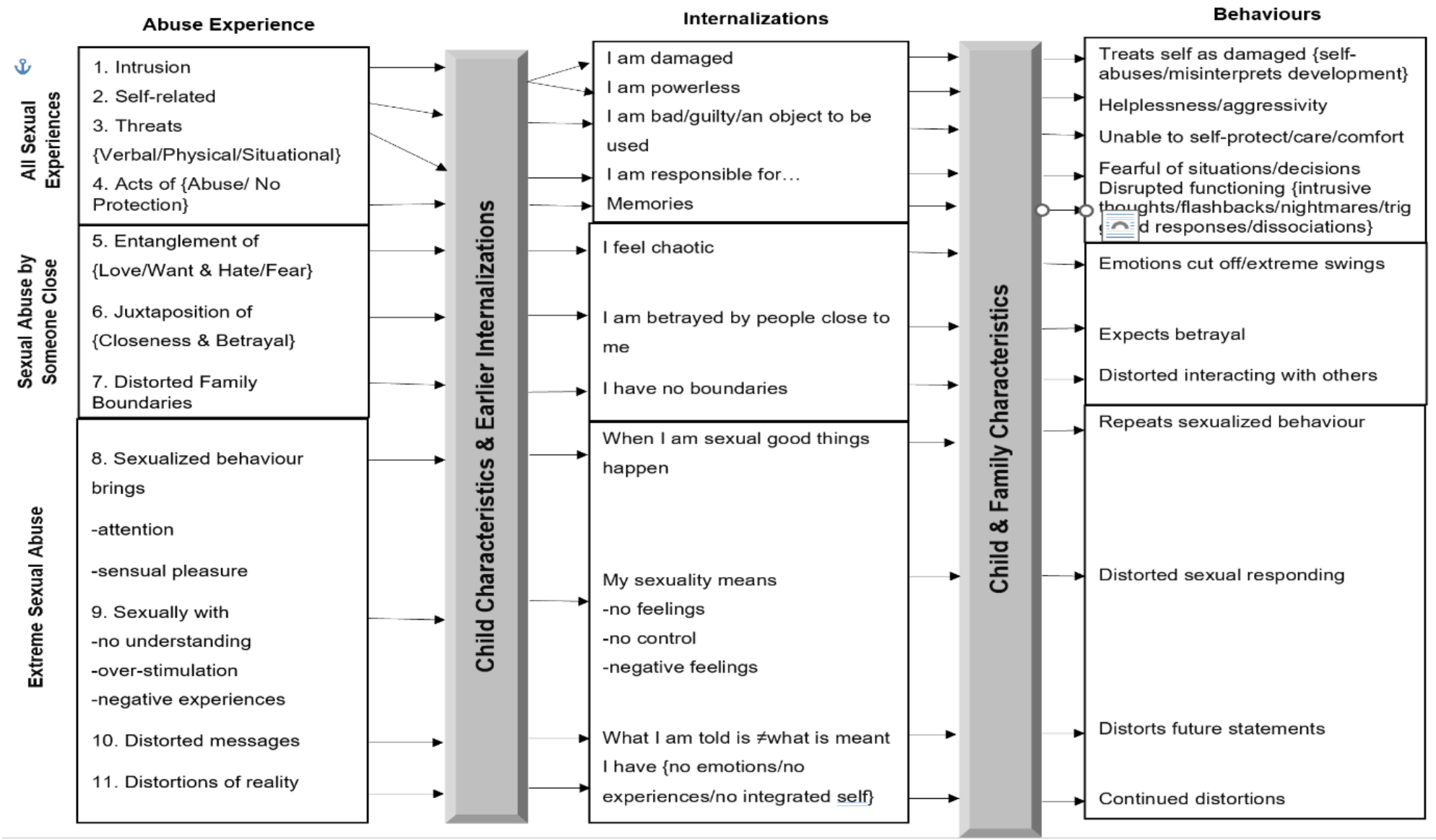
The inner voice framework that we have worked with is reflected in Susan Wieland's Internalization Model, contained in her book "Hearing the Internal Trauma-Working with Children and Adolescents Who Have Been Sexually Abused". As a child experience her world, she absorbs information, consciously and unconsciously, information in regard to herself and her relationship with the world. From a neurological perspective, a child's sensations and perceptions become either implicit memories i.e. not constructed with words, or explicit memories i.e. facts and events, emotional associations, sensorimotor responses, and stress responses that are established in the implicit memory are then recorded in the explicit memory. Such previously acquired information and emotional associations are processed along with new experience, in accordance with the developmental level of the child.

As Melanie Klein said, in psychoanalytic terms, "the outer world, its impact, the situations the infant lives through, and the [persons] he encounters are not only experienced as external but are taken into the self and become part of his inner life." She also said that once a situation is internalized, "it may become inaccessible to the child's accurate observation and judgement" but continues to exist and influence the way the child sees himself or herself and his/her world, even if he/she is told by others that the world is not necessarily that way. Thus, as a child internalizes experiences of self, and self in relation to others (as applicable also in Bowlby's theory of attachment), the child creates an internal working model, which forms a base from which the child interacts with the outer world. The taking in and processing of the meaning of outer experiences as they relate to the self is what Wieland calls 'internalizations.

The internalization model thus enables mental health workers to better understand and address the child's inner world and experience. The experience of abuse alters the child's internal sense of self, and of the world—which in turn affect the ways in which he/she responds to his/her environment. As abuse-related internalizations are addressed, the negative internal experience of self and the world, due to abuse, shifts—and consequently, leads to emotional and behavioural changes.

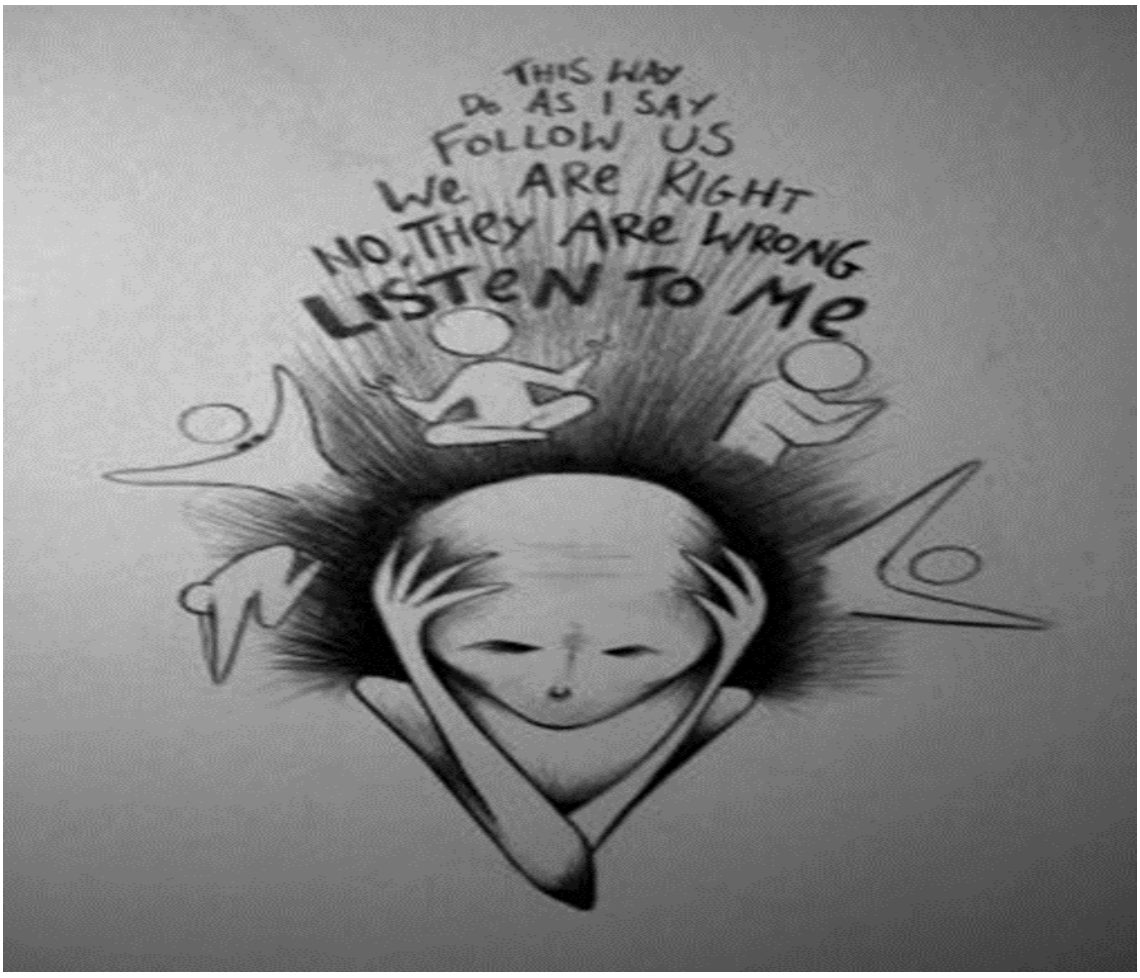
The internalization model therefore describes: (a) the child's abuse experience; (b)the child's internalizations resulting from this experience; (c) the child's behaviours arising from the internalizations. (See Figure below). The manner in which the child experiences the event is influenced by the child's developmental level, his/her temperament, present understanding of the world (internalizations from earlier experiences).

Internalization Model: What a Child Experiences When Sexually Abused [Source: Susan Wieland (1998). 'Hearing the Internal Trauma]



In summary, it is important to understand events of trauma in children's lives, using the Inner Voice Framework because…

- Interventions for sexually abused children commonly focus on behaviours/ sign and symptoms 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.



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

Method: Case study analysis

Material: Flip chart sheets and markers; case studies (see 'Additional Material'—or use any case studies that the group brings).

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 analyse 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 behaviour and/or forwards from context).

Context	Experience	Inner Voice	Emotions	Behaviours

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 behaviour. So, a context and behaviour 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 behaviour…so the crux of problem analysis lies in being able to accurately identify or listen to the child's inner voice.

An Example of How to Use the Inner Voice Analytic Framework

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**	**Emotions**	**Behaviours**
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? Maybe I was a little attracted to him…maybe 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

Suggested Reading

- Perrone-Bertolotti, M., Rapin, L., Lachaux, J. P., Baciu, M., & Loevenbruck, H. (2014). What is that little voice inside my head? Inner speech phenomenology, its role in cognitive performance, and its relation to self-monitoring. *Behavioural brain research*, *261*, 220-239.
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- Rizzo, T. A., & Corsaro, W. A. (1988). Toward a better understanding of Vygotsky's process of internalization: Its role in the development of the concept of friendship. *Developmental Review*, *8*(3), 219-237.
- Holodynski, M. (2013). The internalization theory of emotions: A cultural historical approach to the development of emotions. *Mind, Culture, and Activity*, *20*(1), 4-38.
- Eisenberg, N., Cumberland, A., Spinrad, T. L., Fabes, R. A., Shepard, S. A., Reiser, M., ... & Guthrie, I. K. (2001). The relations of regulation and emotionality to children's externalizing and internalizing problem behaviour. *Child development*, *72*(4), 1112-1134.
- Camodeca, M., & Coppola, G. (2016). Bullying, empathic concern, and internalization of rules among preschool children: The role of emotion understanding. *International Journal of Behavioural Development*, *40*(5), 459-465.
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- Zeman, J., Shipman, K., & Suveg, C. (2002). Anger and sadness regulation: Predictions to internalizing and externalizing symptoms in children. *Journal of clinical child and adolescent psychology*, *31*(3), 393-398.

Additional Materials

Inner Voice Framework – Summary

https://www.youtube.com/watch?v=J_j2djgBuRY

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

Case 1: An 8-year-old is being sexually abused by the school bus driver. He cries all the time and has nightmares and tells his mother that he does not want to go to school any more. One day, his mother (who does not know about the abuse) has forcibly brought him to school and the child tells you what is happening on the bus daily.

Case 2: A 15-year-old girl is suddenly doing poorly in academics and getting into arguments with her peers; when people get upset with her or ask her why she is behaving that way, she just bursts into tears. One day, you call and gently ask what is troubling her…she tells you that her uncle, who visits her home regularly, comes into her room each night and touches her genitals. [She also tells you later that her father's friend has touched her similarly once].

Case 3: A 10-year-old is an orphan child residing in a child care institution. He came to the counselor for treatment for behaviour problems, during the course of which he reported sexual abuse by one of the institution staff (other staff deny that this happened in their institution, saying child is lying).

Case 4: A 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 5: A 16-year-old girl rescued from sex trafficking is now in a child care institution. She was trafficked by her family. She has been in sex work for the last two years. She is angry and aggressive all the time. She is mistrustful of people and keeps talking about revenge. At other times, she says that her life is over—since her self-respect has been taken away. Institution staff also report that she 'dresses up' (wears make up) and tries to go up to the terrace, from where she signals to men/boys that she sees below…shouting out to them to catch their attention.

Case 6: A 15-year-old girl has been sexually assaulted by a 19-year-old boy; he first be-friended her, told her that he loved her and then engaged her sexually—she says that the sexual activity was without her consent. However, now she also tells her parents that she does not want a police complaint lodged against him and that she wants to be with him—to move out of home and live with him. She is sad and depressed but also aggressive at times, threatening self-harm if her parents do not allow her to be with the boy.

6. Essential Communication and Interviewing Skills with Children

Learning Objectives

- To develop essential communication skills for interviewing children.
- To lay the foundations for first level psychosocial responses to children.

Time

10.5 hours in all (over a day and a half)

[Rapport Building: 2 hours
Listening: 1 hour
Recognizing and Acknowledgement of Emotions: 3.5 hours
Acceptance and Non-Judgemental Attitude: 3 hours
Questioning and Paraphrasing: 1 hour]

Do we have a culture of conversations with children?

To be able to talk to children about difficult and traumatic experiences, first we must be able to talk to children. Do we have conversations with children about everyday issues? Do we talk to them to ask what their views and opinions are and what they want or aspire to? Are we deeply interested in what children think and feel? Because, only then can do we have the basis to speak with them about sensitive issues such as sexuality, about difficult and traumatic experiences such as abuse.

Our's is a society wherein adult-child relationships are governed by instruction, sermonizing expectations, and obedience i.e. adults tell children 'You do what I tell you to…', 'Good children behave in certain ways…if you are good person, then you will do…' and 'I expect you to behave…do certain things and if you do not… [there will be consequences]'. In such a cultural milieu, how can we expect adults to be able to speak with ease about sexuality, about difficult experiences, about trauma…?

Therein lies the importance of being able to communicate with children…and in order to inquire or interview them, especially about difficult life experiences, we first need to be able to talk with them.

Skill 1: Rapport Building

- 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.

Concept

10-year-old X sits before the mental health professional/ child care service provider not saying a word. The mental health professional/ child care service provider 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 4 broad steps:

Activity: Rapport building

Method: Video clip viewing
Material: Video Clip

Process
- Play the video and ask the participants to observe the interaction between the professional and the child.

Discuss:
- Ask them about the what were some of the things said by the professional ...what were some of the steps followed?
-Which kind of inner voices will be addressed through the process?

introducing yourself; preliminary establishment of context; ensuring confidentiality; 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 mental health professional/ child care service provider s 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, especially in cases of child sexual abuse. How do you, as a mental health profession/nal/ child care service provider (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.

- **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 Counselling and Alleviating Fear

Children may be fearful about talking to a mental health professional/ child care service provider. 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."

Explaining your role…

In many contexts, the word mental health professional/ child care service provider has taken on negative connotations—especially as people threaten to 'send' a child to a mental health professional/ child care service provider for bad behaviour. So, you may want to re-consider the use of the term 'mental health professional/ child care service provider ' 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.

➢ Normalizing the phenomenon of getting help

As mentioned, may children have negative associations with the role of a mental health professional/ child care service provider as they think that 'only bad children' are sent to mental health professional/ child care service provider s 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 and reduce your worries."*

➢ Establishing a Therapeutic Alliance

Since children have not been believed or heard by many adults, they may assume or believe that the mental health professional/ child care service provider is ultimately going to say exactly the same things as their parents/ caregivers or teachers. That they will not be heard and their view point will not matter. Sometimes, they may remain silent or hold back because of these reasons. It is therefore, important that the professional instils confidence in the child that they are ultimately on the child's side and will believe the child no matter what.

Example:

- *"Different people see things in different ways... So it is perfectly alright if you see the issue differently from your parents/teachers... But given that they have expressed a concern, it would be helpful if we are able to respond to them and put forward our perspective. And we would be able to do this in a convincing way only if I have a chance to understand your perspective and story… and you and I together have some discussions… we then make a plan on how to explain your story and viewpoint to them."*
- *"Remember what I told you in our first meeting… That this part of our organization works only with children, not adults. While I will certainly listen to what your parents and teachers say and I respect it, what you think and feel is the most important thing to me!"*
- *"I also want to assure you, that I will not make any decisions without consulting you and discussing with you… I will not do anything without your permission."*

a) Preliminary Establishment of Context

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

Many children come to mental health professional/ child care service provider s or child care workers without really knowing what they are being asked to see the mental health professional/ child care service provider for; caregivers are often silent and do not tell the child what issue they want to consult the mental health professional/ child care service provider 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 counselling 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…"*
- *"These days, mummy has been observing that you are sad and not participating in activities as before…you look a little tensed and worried."*
- *"I have been observing lately that you get upset and there are lots of disagreements and fight between you and your friends …sometimes even with mummy and daddy."*
- *"I have been told a little bit about why you are here…let's take some time thinking about it so that we can find ways to work on your concern. Your class teachers 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 does not know)*
- *"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 every day and we will be spending time together to play and do stuff…whenever you feel ready and comfortable, you can tell me." (If the child is silent)*
- *"Sometimes it is difficult to talk about issues…perhaps you can tell me later or I will ask again because I am really worried…This is not about a complaint. It is about my concern and my worry that things might be disturbing you." (In case the child is silent and refuses to acknowledge the problem).*

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 mental health professional/ child care

service provider needs to allude to the problem in as much as he/she knows about it—because when the mental health professional/ child care service provider 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 mental health professional/ child care service provider and what the purpose is! So, while the mental health professional/ child care service provider 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 labelled; 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 mental health professional/ child care service provider 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.

c) 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 mental health professional/ child care service provider, 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 arise at some point, wherein the mental health professional/ child care service provider 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 mental health professional/ child care service provider has assured confidentiality; but the mental health professional/ child

care service provider 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 mental health professional/ child care service provider again. So, how to assure a child of confidentiality in a manner wherein the mental health professional/ child care service provider 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 like if I feel that it is hurting or harming you in any way and that we need other people's help to keep you safe or help you in different ways, I will only do it after consulting you and getting your permission—never without. In acts, I will try and ensure that you are there when I explain to your parents so that you can also speak or know exactly what I told them."

So, what is of key importance (as per the example) is the child's permission. The mental health professional/ child care service provider 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 mental health professional/ child care service provider 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.

Note: *We will return to a more detailed discussion on confidentiality issues in the context of mandatory reporting when the child may want certain issues not to be disclosed to the legal personnel.*

d) 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 mental health professional/ child care service provider. 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 counselling process i.e. used to work with the child in counselling and therapy sessions.

- **Ask child neutral, non-threatening questions to elicit information about his/ her likes/ dislikes and interests.**

Example:

- *"What did you eat today? What have you been doing all morning?"*
- *"Flip a coin: The mental health professional/ child care service provider 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 mental health professional/ child care service provider 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.
Example:

- 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 mental health professional/ child care service provider and child participate in it. Asking the child to draw a picture while the mental health professional/ child care service provider 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 mental health professional/ child care service provider is a friend, a person who is 'on their side'.

Activity: Skill-Building 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 mental health

Skill 2: Listening and Interest

- What are different levels of listening?
- How do we listen effectively?

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 way that conveys respect, interest, and empathy. This form oof listening might involve the counsellor to respond verbally. For example,

- Okay
- Hmm…
- Alright …
- Yes…

These expressions are non-judgemental and neutral expressions that can encourage and facilitate discussion.

Listening Dos and Don'ts …

Dos…

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

Don'ts…

- 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 behaviour, interest/disinterest, attitude of the mental health professional/ child care service provider towards the child. Hence, it is important for the mental health professional/ child care service provider 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. Behaviours like yawning can hint disinterest towards the child's experiences and sharing, resulting in interrupting the counselling process.

- Avoid fidgeting around while the child is speaking. For example: the mental health professional/ child care service provider must avoid shaking the feet, fiddling with pens, mobile, nails, and fingers. This interrupts the counselling process as it suggests anxiety and lack of confidence. As a result, the child might withdraw from sharing with the mental health professional/ child care service provider.
- Avoid writing or making notes, and completing procedures as they can hint disinterest and also distract the counselling 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.

Activity: Skill-building 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?

Skill 3: Recognition and Acknowledgement of Emotions

- How to identify and recognize emotions.

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

Concept

While listening to children as they narrate various experiences, counsellors 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 counsellor 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.

Ways in which we recognize and identify emotions…

- Non-verbal cues: facial expressions, gestures
- Verbal expressions: tone of voice, actual content of speech
- Other actions and 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…"

On another level, this technique, especially the acknowledgement 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 what. 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 behaviour); 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

Take another example—one where a child has lost his mother. If the child were to tell the counsellor that he was very sad, the worst response a counsellor 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 counselling is lost—and so is the relationship of the counsellor with the child because the child will not trust the counsellor 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 counselling). 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!

Activity: Understanding Children's Emotional Worlds

Material: Picture cards (refer to the picture cards provided in 'Additional sheet Materials at the end of this module).

Method: Story building

Process:

- Divide participants equally into groups.
- Provide one picture card to each team.
- Instruct participants, to view the picture card and identify the emotion that this child may be feeling.
- Following this, request them to come up with a 2- minute story, what may have happened to cause the child to feel the emotion in the child's voice. (e.g., "Today I was …I felt…")
- Upon completion, ask each group to narrate their stories in plenary.

Discussion:

- It is important to ask children about their experiences than to assume from their facial expressions…
- We must enter children's inner worlds, to understand their emotions.

Activity: Recognition and Acknolwedgement of Emotion

Method: Video clip viewing

Material: Video Clip

Process

- Play the video and ask the participants to observe the interaction between the professional and the child.

Discussion:

- Ask them: what were the emotions of the child?
- How were the emotions recognized by the professional?

Activity: Skill-building for Recognizing and Acknowledging Emotions

Methods: Listing and generation of response

Materials: Children's narratives (available in 'Additional Materials' at the end of this module).

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 and the age of the child while framing your responses.

(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.

Skill 4: Acceptance and Non-Judgemental Attitude

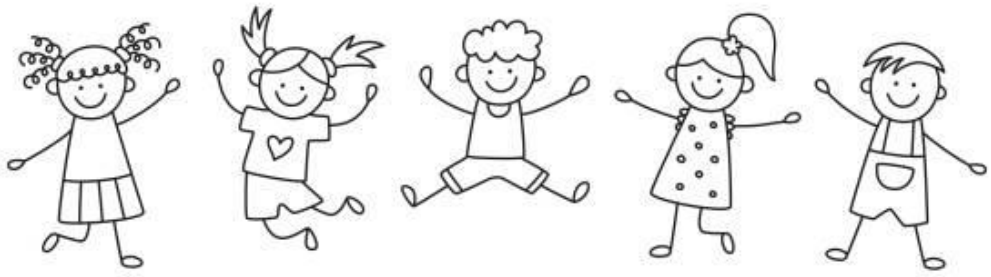
- What does non-judgemental attitude mean?
- How do we reflect non-judgemental attitudes in our communication with children?

Concept

To accept someone and to be non-judgemental is perhaps the hardest counselling 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 counsellor appears judgmental or disapproving, the therapeutic alliance (relationship between child and counsellor) is weakened or adversely affected because the child feels that the counsellor is not on 'my side'; consequently, the child may no longer wish to continue communication with the counsellor i.e. he/she may refuse to engage in further interactions. Children with conduct and behaviour 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 counsellor is judgemental, it only reinforces what they already believe and is unlikely to get them to be trusting of the counsellor 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 counsellors, 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 counselling 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).



Activity: Judgemental vs Non-Judgemental Attitude

Material: Video Clips (QR code for the video clips provided at the end of this module).

Method: Video clip viewing and discussion

Process and Discussion:

-View each of the 3 videos
-In which one is the child care worker judgemental/ non-judgemental?
-Why do you think so?
-What do you think are some of the elements of being judgemental/ non-judgemental?
-What do you think will happen next in the judgemental scenarios? In the non-judgemental scenarios?

Activity: Reflecting Upon Personal Biases and Opinions

Method: Group Discussion

Material: Issue-based matrices (provided in 'Additional Materials' at the end of this module)

Process and Discussion:

Divide into sub-groups.
Engage in discussion as follows:
Your (own) personal views and opinions and common public beliefs and opinions about the issue(s) mentioned
-If a child had this issue and you responded from a perspective of your personal views and beliefs, or common judgmental beliefs - what would the impact on the child be?

Discussion:

-What happens when we use personal beliefs/ viewpoints in our discussions with children?
-Will they help children change their behaviours…or…?
-We have the right to hold our personal beliefs/ viewpoints…but can we impose them on others? Why/why not?
-The meaning of non-judgemental attitude in counselling practice?
judgemental scenarios?

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 counselling practice—doing that is akin to instruction and advice, which are not the same as counselling. Non-judgemental counselling (and indeed counselling 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 counsellor cannot present his/her views at all. The counsellor 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 counsellor 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 SAMVAD- NIMHANS, 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 through a stage-by-stage discussion, also akin to opening each (new) window of thought. When we want to talk to children and adolescents about abuse, we do not directly speak about abuse—because not only is it a sensitive issue with which children can be uncomfortable, but also a complex one and one that is hard, particularly for younger children, to understand. A window approach therefore allows for discussions to gradually proceed, so that knowledge and understanding on relevant and related themes are transferred sequentially.

We start 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.
But before getting into the details of the framework, first let us examine our own perspectives on adolescent sexuality…what do you think…? *[Engage in a discussion with the participants]*

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

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

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

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

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

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

1. Acknowledgement of love/ attraction and needs/pleasures

"There is nothing wrong with feeling love and attraction for someone…everyone does and love and physical intimacy are wonderful…they are important aspects of human life. We cannot deny
the need for love and sexual intimacy—and must make space in our lives for them. The question is can we set aside everything else (such as education, everyday activities and life plans) and only focus on love and sex?"

2. Privacy

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

3. Consent and Boundaries

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

4. Relationships

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

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

6. Abuse

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

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

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

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

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

We will now use the approach 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].

Examples of 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?
- 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 doesn'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…)

Activity: Being Non-judgemental 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?

Statements
- 16-year-old boy sexually abuses a 6-year-old girl (your client is the 16-year-old boy).
- 16-year-old girl has run away with a 25-year-old and dropped out of school.
- The same 16-year old girl wishes to continue with the pregnancy she now has as a result of her relationship.

Skill 5: Questioning and Paraphrasing

- How to use open and close-ended questions in interviewing children?
- How to use paraphrasing in the counselling process?

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 mental health professional/ child care service provider 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 mental health professional/ child care service provider's inquiry not to be like a police inquiry, there are certain ways of asking children questions. Also, the mental health professional/ child care service provider's interview is not one long question-answer session with the mental health professional/ child care service provider asking question after question and the child having to answer each question. The inquiry process needs to be embedded within the counselling process; in other words, the mental health professional/ child care service provider 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.

Example of use of close-ended questions

Child: *He behaved badly with me.*
Counselor: *Did he touch you?*
Child: *Yes.*
Counselor: *Did he touch you in your private parts?*
Child: *Yes.*
Counselor: *Did you try to scream for help?*
Child: *Yes.*
Counselor: *And did someone come to help you?*

What do you observe from the interaction in the above example, 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 mental health professional/ child care service provider'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 mental health professional/ child care service provider assumes that it means only sexual touching; the mental health professional/ child care service provider'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.

Example of use of open-ended questions

Child: *He behaved badly with me.*
Counselor: *What happened?*
Child: *He touched me and made me uncomfortable.*
Counselor: Could you tell me a little more about that?
Child: *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?
Child: *I was so scared…I tried to scream…and then I ran from there…*
Counselor: *Sounds really scary. What happened next?*

From the example above, 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 counsellor is better able to understand events and issues from the child's perspective. Instead of merely getting concrete factual information, the counsellor 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 purpose is to detail out and event and understand how a child felt or responded, then open-ended questions are more useful. The counsellor'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 counsellor asks questions and the child has to answer.

Activity: Skill-building 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 and Discussion:

- 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).

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 every day?

    - **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 a very specific answer i.e. time. So the answer can only be morning/ evening or at 6:30 pm etc.*

Paraphrasing:

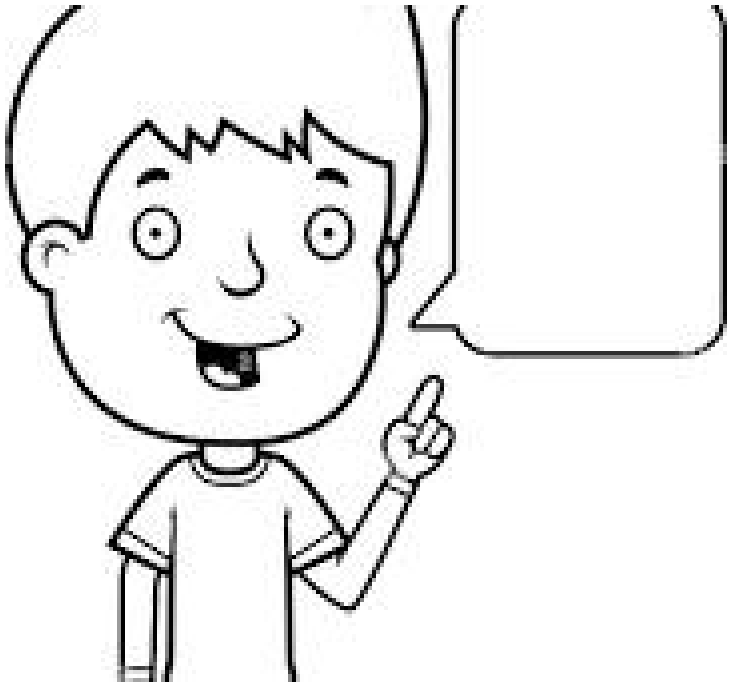
This is a skill of summarizing the content shared by the child to ensure and confirm that the counsellor has not misinterpreted or missed out any information provided by the child. This helps avoid incorrect inferences, conclusions and judgments being made by the counsellor. The child is also reassured 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

Example of Paraphrasing…

Counselor: *"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…"*
Sounds really scary. What happened next?

As you can see from this example, the mental health professional/ child care service provider 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…'



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

Method: Role play

Material: Children's narratives/statements

Process

- Divide participants into pairs; one participant assumes role of child and the other that of mental health professional/ child care service provider.
- 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 mental health professional/ child care service provider's inquiry and counselling.
  For example, the child says 'I do not feel like playing or doing anything'.
    - How would the mental health professional/ child care service provider 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.
  - Paraphrase what the child said.

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 Communicating with 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 mental health professional/ child care service provider, 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 understanding 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.

Suggested Readings

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Additional Materials

For Activities 'Rapport Building', 'Recognition on Acknowledgment of Emotions', and 'Judgmental vs Non-Judgmental Attitude'.

Rapport Building – Communication Skills

https://www.youtube.com/watch?v=hxeiPVyzkRU

Recognition and Acknowledgement of Emotions – Communication Skills

https://www.youtube.com/watch?v=k6pfVE0mnXU

Non-Judgemental Attitude – Communication Skills

https://www.youtube.com/watch?v=_I2iLIo3Kw4

Judgemental Attitude – Communication Skills

https://www.youtube.com/watch?v=e8uqEtHrvIQ

Judgemental Attitude – communication Skills

https://www.youtube.com/watch?v=zQ2DrpXkdps

Pictures for Activity 'Understanding Children's Emotional Worlds'


Doctor
Medical
Air force
Pilot
Aviation

Children's Narratives for Activity 'Skill-building for Recognition and Acknowledging Emotions'

A, age 6: "I do not want to go to school any more. That 'bhaiya' took me to a dark room and did bad things to me. It hurts here *[pointing to anal area]*…"

P, age 15: "Ever since he did those bad and dirty things to me, I feel really stressed. I keep thinking about them. Smoking marijuana and drinking alcohol help me forget about all that bad stuff."

J, age 16: "If I ever see him again, I will kill him…I want to do something that will get him into trouble. It's just not fair that nothing happens to him, while I have to suffer.

M, 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."

S, 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."

D age 14: "I feel dirty and damaged…like no one could ever want me or love me ever again. I hate myself too…I should have done something to stop him, stop it from happening…"

T, age 11: "I tried to tell my mother but she did not believe me. She said I was a 'dirty girl' for saying such things about my uncle. She told me never to talk about these things again."

Issue-Based Matrices for Activity 'Reflecting Upon Personal Biases and Opinions'

Issue 1	**Your personal beliefs/ opinions about the issue?**	**The Child you are dealing with**	**Impact on the child if you communicate your beliefs and opinions ?**
Gender and Dress		Girl wears short dress and goes out with friends; she gets sexually assaulted.	

Issue 2	**Your personal beliefs/ opinions about the issue?**	**The Child you are dealing with**	**Impact on the child if you communicate your beliefs and opinions ?**
Gender and Substance Use		Girl who is engaging in smoking & drinking alcohol.	

Issue 3	**Your personal beliefs/ opinions about the issue?**	**The Child you are dealing with**	**Impact on the child if you communicate your beliefs and opinions ?**
Adolescent's Engagement in Sexual Relationship		Boy has sexual relationship with classmate; he has run away with her.	

7. Assessment of Sexually Abused Children

Learning Objectives

- Assess child's mental health and developmental concerns (to understand psychological impact of sexual abuse).
- Provide first level responses for:
    - Safety and placement issues
    - Addressing initial trauma/psychosocial issues
- Make appropriate referrals to specialized mental health facilities.
- Use the developmental and mental health assessments to ascertain the child's capacity to provide evidence/ testimony as child witness.
- Elicit and document evidence for legal purposes.

Time

2 Hours

Concept

Before a professional enters the process of eliciting evidence, it becomes important that the child is assessed by the professional in the context of their developmental histories and lived experiences. After the incident of sexual abuse, there may be adverse physical, emotional, behavioural, and mental health consequences. The time right after the abuse is not the time to start enquiry about the abuse, neither is it a time to provide depth interventions. The first steps must involve assessing the child's mental health, understanding their context or the context in which abuse has occurred and providing some first level responses (reassuring the child of safety, giving the child comfort and hope, allowing the child to rest and relax). A child who is experiencing extreme anxiety, post-traumatic stress disorder (PTSD) or other mental health consequences after the abuse, might not be ready to engage in a conversation about the abuse incident and may not be ready to provide evidence. This may affect the quality of evidence and may even aggravate the symptoms / issues that the child may be experiencing post the abuse incident.

A psychosocial assessment of the child at an earlier stage which also captures the context of abuse, medical history or evaluation reports, child's history and details about family, abuse disclosure and then the sudden onset of emotional, behavioural and mental health issues in the child that may indicate trauma and abuse, may also form part of the evidence. These may be not be definitive indicators of sexual abuse, but can certainly support the evidence elicited later by the mental health professional. (recall the index of suspicion)

A psychosocial assessment therefore is not only important for enabling diagnostic conclusions, making decisions about treatment and interventions but is also important formulation a care plans, making placement decisions, eliciting evidence/ forensic interviewing and the provision of testimony in the court later. In a nutshell, a thorough assessment is critical for understanding the nature, breadth, and impact of child sexual abuse experiences and other trauma exposures.

The initial assessment begins by eliciting information about child's basic demographic details, facts about the abuse incident, changes in the emotional behavioural patterns of the child post abuse, social history including details about the living arrangements, family and caregivers, school, and information about any previous abuse incidents etc. Once the professional gets the basic facts it allows the professional to move forward.

Assessment of Problems and Symptoms

State Vs Trait

State emotions refer to those that are in response to the immediate situational context while the trait emotions are personality characteristics and refer to the ways in one sees the world. In each child or a group of children when you see the child, the child may be in a certain state they could be equanimous, crying, angry and sullen. It is important to assess and find out that how much of these traits are part of the child's personality and how much of these consequences of abuse. Some children may have trait or state anxiety both. The children who have trait anxiety may be more vulnerable or prone to abuse as they may not necessarily have some essential and critical life skills life skills such as refusal skills, assertiveness skills, ability to cope with stress, ability to regulate emotions etc. While some other children may not have any trait anxiety, but they may develop state anxiety after abuse incident.

It is also important in assessment to find out about the nature and severity of the abuse which includes finding out whether the abuse was a single incident or if there have been multiple incidents of abuse, if it has been perpetrated by a single perpetrator or if there have multiple such experiences with multiple perpetrators, if the abuse has been contact or non-contact, genital or non-genital, penetrative or non-penetrative. This has implications not only assessing the mental health impact on the child and their treatment but also for legal purposes. The quantum of punishment also would depend on the nature and severity of the abuse. In many cases of child sexual abuse there may also be a compounding of the crime – there could be physical injury, threatening and violence by the perpetrator, child labour trafficking etc.

Assessment Of Impact – Understanding Trauma Dynamics

Using Finklehor's traumagenics model a systematic understanding of the effects of child sexual abuse can be developed. Four traumagenic dynamics--traumatic sexualization, betrayal, stigmatization, and powerlessness--are identified as the core of the psychological injury inflicted by abuse. These dynamics can be used to make assessments of sexually abuse children and to anticipate problems to which these children may be vulnerable subsequently. (Refer to the details provided in the chapter on ABCs of child sexual abuse to understand more about Finkelhor's traumagenics model and the traumatic impact of child sexual abuse)

Assessment of Impact of Trauma on Developmental Trajectory of Child

The experiences of childhood trauma such as that of abuse can also have affect the development of a child or derail their development trajectory. It may lead to developmental delays or impairment in one or multiple areas of functioning such as social/ inter-personal, emotional, behavioural, cognitive. The professional may assess the child post abuse for issues in the following areas of functioning - responsiveness, attentiveness, attention, level of executive functioning, memory dysfunctions, emotional regulation, developmental regression and academic problems or sudden onset of learning difficulties.

Assessment of the Family System

An important factor in the reporting of abuse, child's treatment and recovery would be the nature of the family system that the child is a part of. It becomes important during the assessment to understand the role of family in the child's life and the level of support provided by them to the child. While assessing the family system one may look at the following:

Family as a reacting system (or a supportive system)

Different families may have different kinds of reactions to the abuse incident. The reactions may also depend on whether the abuse has taken place within the family or outside the family (by a stranger, in the school etc.). While one family may react with a supportive approach and tell the child that the abuse should not have happened and now that it has happened they will be with the child and do the best to manage and handle all the difficulties he or she is facing, there could also be another family that does not believe and may make blame the child for the abuse, they may transfer the blame to the child by saying things like "we had warned you or asked you to not go there…now see what happened because you did not listen" or "you must stop watching all the nonsense …you mind has become too dirty, you don't think twice before saying something" "you are too sensitive…your uncle must have joked, he cannot ever do this" "are you sure this happened? Do you not think about your family before saying or doing the things you do?". While some families may believe but may get into a severe state of shock, the family environment may become full of sadness and grief, there may be absolute silence in the family as if mourning someone's death and then the child's inner voice may become that "I am responsible for all this" therefore contributing to the child's problems. On the other hand, some families may get angry or may talk about the abuse incident too much making it the single most important thing that has happened in the child's life.

Family as a pre -existing pathological system

Families are complex systems. The dynamics within a family system also determines the role they will play or the level of support they will show during the reporting/recovery process. Therefore, during the assessment process it becomes critical to find out about the dynamics within the family i.e., if there is a history of violence, alcoholism, marital discord within the family, divorce, separation, neglect by the parents (physical/ emotional), abuse, permissiveness, overprotectiveness, unpredictable parenting etc. The family because of their own issues, preoccupations and maladaptive patterns may not be ready to provide support to the child.

In these kinds of families, it would become important to address the maladaptive patterns and interactions, changing the emotional atmosphere, addressing the issue of unequal power dynamics within the family.

Assessing The Impact on The Parenting Capacities

No parent/ caregiver/ adult ever expects that their child will be sexually abused and therefore the disclosure of abuse by the child puts them in a state of shock as they are not prepared to deal with the disclosure and often times do not know what to do. Finding out about child sexual abuse therefore can be a very overwhelming experience. The abuse incident may lead to the feelings of failure, shame, guilt and even anger in the parents.

These feelings may result from the thoughts such as – "I am a bad parent," "How could I not keep my child safe?" "Oh! my child did not feel comfortable enough to come and tell me that all this was happening to them."

These thoughts may then affect the ways in which the parent responds to the child's trauma. While the child may need parental support and reassurance that although the abuse has taken place, it is in no way the child's fault and they will be there to support and assist the child in handling and managing the difficulties the child has been experiencing. However, these preoccupations with being a bad parent, compromise their abilities to provide reassuring responses. In fact, the child may sense their sadness, which may further give rise to inner voices such as "It is because of me now that my parents feel very sad" "My parents are in distress because of me" "My parents are so nice, they work so hard and they always care about me but I always create troubles for

them." These responses and the thoughts further aggravate the problem and hinder the treatment/ recovery process.

In this case therefore, it would be imperative to work with the family and prepare them to provide hopeful reassurances to the child and support the child through the treatment process while managing their upset.

Asking Questions for Assessment… Using A Windowed Approach

It is always important to remember that asking the right kind of questions is critical in order to elicit information about the incident and about the child's mental state. This may be uselful for the mental health professionals or child care service providers in order to understand what had happened and consequently, the impact it has had on the child's mental health. It is always best to not bombard the child with too many questions about the abuse. One may start with some general questions and open ended questions then move towards more specific questions about the abuse to understand the context of the child, family issues and dynamics, nature of abuse, the grooming process used by the perpetrator in a non leading may be non-leading. Refer to the framework on abuse enquiry in the chapter on eliciting evidence to learn more about leading and non-leading questions, issues related to suggestability and tutoring. The context in which sexual abuse occurs is important in the assessment process. Recall from the chapter on communication skills, the idea is to hear the child out and elicit more narratives. If the details and nuances are missed during the assessment, it also will affect the prognosis and recovery.

Some ways of asking questions questions in a graded manner, using a windowed approach:

- Can you tell me about your daily routine?
- Can you tell me about your best memory and the worst?
- Who are your favourite people? Tell me what you like about them and the activities you enjoy with them.
- Who are people you do not like? What are reasons you dislike them or why do they make you feel uncomfortable/ upset?
- Have you ever been upset or bothered by someone's behaviour towards you?
- Has anyone touched you in ways that you do not like?
- Has anyone touched your private parts and made you feel uncomfortable?

Understanding Context of Abuse …

Assessments must also include finding out about the child i.e. who this child is? what are their life experiences? are there any pre-existing psychiatric conditions? is there any kind of disability? what kind of family system does the child have? have there been any life events such as loss of a parent, accident, illness, bullying before the incident that have resulted in internalizing or externalizing problems? has there been a cumulative adversity i.e. other than the sexual abuse? how many emotional and behavioural symptoms are actually a result of the previous traumatic incidents? what are some of symptoms seen in the child after the abuse incident?

Remember, the context in which abuse has happened is very important for assessment and for treatment.

Ensuring Medical Examinations

During the assessment process it is important to enquire that the child has been medically examined. The primary aim of the medical examination is to address the health and wellbeing of the child after the abuse incident. A secondary purpose of the medical examination is to collect forensic evidence for police and court proceedings in a timely manner.

The children as was explained earlier may come to the medical professional / mental health professional/ child care service provider in the following contexts –

- When the abuse has been reported and the FIR has been filed.
- When the disclosure has not been made by the child and the child has come for assistance in context of either internalizing issues like anxiety, school refusal, dissociation etc. or sudden behavioural issues

In scenario one, since the reporting is done- check if the child has been medically examined after the reporting was done in compliance with the protocols and standard operating procedures laid down in conjunction with the POCSO Act. Add all the reports and medical documents of the medical examination as evidence to the child's file for court processes later.

In case the medical examination has not been completed because the disclosure was made for the first time during the consultation, in compliance with the protocols of the POCSO Act, 2012, immediately ensure that the child is referred and medical examination is done and all necessary medical assistance is provided to the child i.e. to ensure that there are no injuries, infections, post-exposure prophylaxis are given. Again, document all the processes and attach the reports of the medical examination in the case file.

**Note- In case the abuse had taken a while ago for e.g. 2 years ago or 7 months ago, in that case medical examination will not be useful as the evidence would have been lost due to a significant time gap between the occurrence of the incident of child sexual abuse and reporting of the abuse.*

Status Of Reporting And Legal Processes

Enquire during the assessment process whether the reporting of the sexual abuse incident has been done i.e. if the police, child welfare committee or the district magistrate have been informed. In case, the reporting has not been done work with the child and the family and inform them about the mandatory reporting provision. Follow the eight steps explained in the chapter on mandatory reporting. Remember, mandatory reporting is a process.

It is also important to make decisions about how soon the reporting should be done based on the level of risk and vulnerability for example, whether the child has been sexually abused home and the perpetrator continues to abuse the child versus the abuse happened eight months ago by a neighbour when the child visited grandmother's house in another city for a vacation. In the first situation the risk is immediate, in case the reporting is done immediately the abuse may continue while in the second case abuse the perpetrator has no access to the child and the abuse was a one-off incident, therefore some time before the actual reporting is done as there is no immediate risk to the child's safety. Safety and the protection of the child should be the primary concerns. Refer to the framework mentioned in the mandatory reporting chapter to understand more.

It is also important to make a note of the status of reporting in the case file and in case the reporting has not been done, the mental health professional/ medical professional/ child care service provider should explain and record the steps taken by them to enable the reporting process.

Activity: Let us look at some proformas…

Material: SAMVAD-NIMHANS's proformas and SOPs/Guidelines **(All the materials to be used for this activity are attached at the end of this module in the Additional Materials Section)**

Method: Discussion (of formats of assessment proformas)

Process:

- Take prints of the Individual assessment proforma and the standard operating procedures for implementation of POCSO, guidelines for identifying abuse and maltreatment in child care institutions.
- Handover the proformas developed by SAMVAD-NIMHANS to the participants.
- Ask the participants to read through the proformas. Give about 20-25 minutes to the participants to go through the proformas.
- Once the participants have gone through the proforma, take them through the proforma and the accompanying Standard Operating Procedures and Guidelines.

Discussion:

- Allow the participants to ask questions and seek clarifications parts or points from the proforma which are unclear to them or require further explanation.

Activity: Assessing children…

Material: Individual Assessment Proforma

Method: Script development (suggested scripts provided at the end of this chapter)

Process

- Ask the participants to look at the individual assessment proforma.
- Come to section 4 on Emotional and Behavioural Concerns of Children.
- Ask the participants to read each 'Impact of Event Questions'
- For each question ask the participants to develop simple questions that they will use to elicit information. Ask them to think of the age of the children they work with and use the communication skills.
- Tell them they have to tell what will they exactly say in order to elicit this information- 'the dialogue'

Discussion:

- Ask participants to share their questions in plenary.
- Explain that while younger children may be able to give some information, they may not be able to answer all questions. Therefore, it may be necessary and useful to elicit this information from the parents for corroboration.

Additional Assessment of the child …School Reports

While the school or teachers cannot be the primary source of information as they do not spend the amount of time that children spend with their caregivers and therefore may not be aware of the child's situation/ problems accurately, but they certainly are in position to observe behaviours and emotions that may result from trauma due to the sexual abuse experience. A mental health professional therefore may strengthen the assessment by requesting for a teacher's school report focus on the following:

Table: Signs and Symptoms of Trauma in the Classroom

Symptom Category	Symptoms	Classroom Examples
Physical	Recurring physical complaints, may be prompted by a similar occurrence	Repeatedly complaining of a stomach-ache, light-headedness, headaches, or other sickness when a similar prompt is given (i.e., working in groups or when the weather is bad)
	Hyper-vigilance/heightened startle reaction: an above normal state of alertness	Constantly looking around the room, checking behind oneself; may appear to jump or be startled at small or everyday noises
	Sleep disorders/recurring nightmares: sleeping too much or not enough	Consistently coming late to class, appearing exhausted or lethargic, resting head on desk repeatedly throughout the day
	Weight change: sudden gain or loss of weight	Clothes appear extremely tight or loose, change in type of wardrobe (i.e., usually wears fitted clothes but begins to wear only loose-fitting clothes)
Behavioural	Regression: returning to previous developmental behaviours	Younger children may return to sucking thumbs, older children may regress to temper tantrums or exhibit extreme separation anxiety from caregivers
	Changes in play: play patterns shifting to repeated play behaviours, role playing of the traumatic event, or restriction of play	Child who normally plays freely with different toys now plays solely with the blocks (building and knocking them down again and again), or does not play and instead sits alone, or assigns roles to other children or dolls to play out event
	Social isolation: withdrawal from normal social network	Chooses to sit alone, does not talk to others during breaks, avoids social interactions; quitting extracurricular activities
	Risk-taking: increase in behaviours that may cause harm to self or others	Hearing about child having unprotected sex, trying drugs, abusing alcohol
	Bids for attention: acting in a way to draw attention, through negative or positive actions	Suddenly becoming an overachiever or underachiever, acting out to draw attention
	Increased aggression	Yelling, becoming upset quickly, inability to stop aggression

Emotional	Difficulty regulating emotions/easily angered: emotions are not consistent or lack a logical flow	Mood swings, easily angered or irritated
	Fear: phobias that may seem connected and apparent to trauma or not	Fear of the recurrence of the trauma (i.e., rape victim afraid she will be raped again), fearing that one may not be able to heal
	Stress	Late or not turning in assignments, easily overwhelmed by new projects
	Distrust	Unwilling to work with partners or in groups, sitting apart from classmates
	Dissociation: splitting off from current consciousness	Student appears to "blank out," poor memory, highly inconsistent work
	Changed attitudes about people in general, life, and the future	Expressions of how humanity is generally "bad," expectations that another trauma will soon follow, lack of planning for the future
	Lack of self-confidence	Uncertainty in presenting knowledge verbally or in writing, lack of effort due to belief that it will not be adequate
	Trauma flashbacks: involuntary visual, auditory, and/or sensory memories of the traumatic event	May not see flashbacks within classroom; however, may see side effects such as low energy/motivation, lack of sleep, anxiety
Cognitive	Inability to focus	Fidgeting, frequently glancing around the room, not completing assignments/ readings
	Learning disabilities/poor skill development	Patterns of learning problems become apparent, accompanied by other trauma symptoms
	Trauma flashbacks: involuntary visual, auditory, and/or sensory memories of the traumatic event	May not see flashbacks within classroom; however, may see side effects such as low energy/motivation, lack of sleep, anxiety
	Dissociation: splitting off from current consciousness	Student appears to "blank out," poor memory, highly inconsistent work
	Changed attitudes about people in general, life, and the future	Expressions of how humanity is generally "bad," expectations that another trauma will soon follow, lack of planning for the future

Suggested Readings

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Additional Materials

Proformas and SOPs/ Guidelines to be used for the discussions as part of Activity 'Let us look at some proformas…'

Individual Assessment Format for Sexually Abused Children

SAMVAD
Support, **A**dvocacy & **M**ental health interventions for children in **V**ulnerable circumstances
And **D**istress
(A National Initiative & Integrated Resource for Child Protection, Mental Health, &

4. Emotional and Behavioural Concerns (Mental Health Issues)

1.
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2.
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an

Impact of the Event on Child:
Elicit information from the child and ask if the comments are true for the child in the past two weeks. If they did not occur during that time please tick the 'not at all' box.

Impact of Event Questions		Often	Sometimes	Rarely	Not at all
1.	Do you think about it even when you don't mean to?				
2.	Do you try to remove it from your memory?				
3.	Do you have difficulties paying attention or concentrating?				
4.	Do you have waves of strong feelings about it				
5.	Do you startle more easily or feel more nervous than you did before it happened?				
6.	Do you stay away from reminders of it (e.g. places or situations?				
7.	Do you try not talk about it?				
8.	Do pictures about it pop into your mind?				
9.	Do other things keep making you think about it?				
10.	Do you try not to think about it?				
11.	Do you get easily irritable				
12.	Are you alert and watchful even when there is no obvious need to be?				
13.	Do you have sleep problems?				

3.
(If
chi

Other emotional and behavioural impacts:
Elicit information from the child and/or caregiver (as applicable).
Ask if any of the (below) emotions and behaviours have been felt/observed following the event, and mark accordingly.

Emotions	Frequent feelings of fearfulness ('It might happen again' or 'something bad will happen to me/my family…')	
	Frequent feelings of sadness/depression	
	Feeling helpless ('I don't know what to do about most things now…')	
	Feeling guilty ('It was my fault')	
	Feeling irritable and angry	
Behaviours	Difficulty implementing activities for daily living (such as eating, personal hygiene, play, leisure activities…)	
	Clingy behaviour	
	School refusal	
	Self-harm and suicide (attempt)	
	Substance use	
	Runaway behaviour	
	High risk sexual behaviours (multiple partner relationships/unprotected sex)	

Additional Information on child's emotional and behavioural issues and developmental functioning (specifically behaviour changes i.e. how behaviour may have changed from before to after the abuse event):

5. Family History

(Child's living arrangements/parental relationships/child's emotional relations...domestic violence/parental marital conflict/illness or substance abuse in caregiver...)

6. Schooling & Academic History

(School performance/specific learning disabilities/school attendance)

7. Institutional History & Concerns (if applicable)

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

8. Child's Version of Events

8. Any Other Observations of the Child

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

9. Summary of Child's Problems

Disability (Physical/ Intellectual):

Psychiatric Diagnosis:

Medical Problem:

Context:

10. Implications for Child Witness Testimony

(Implications for developmental and mental health capacity to provide evidence/ testimony as child witness)

11. 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).

Standard Operating Procedures for Incorporating Child Psychosocial & Mental Health Care Aspects

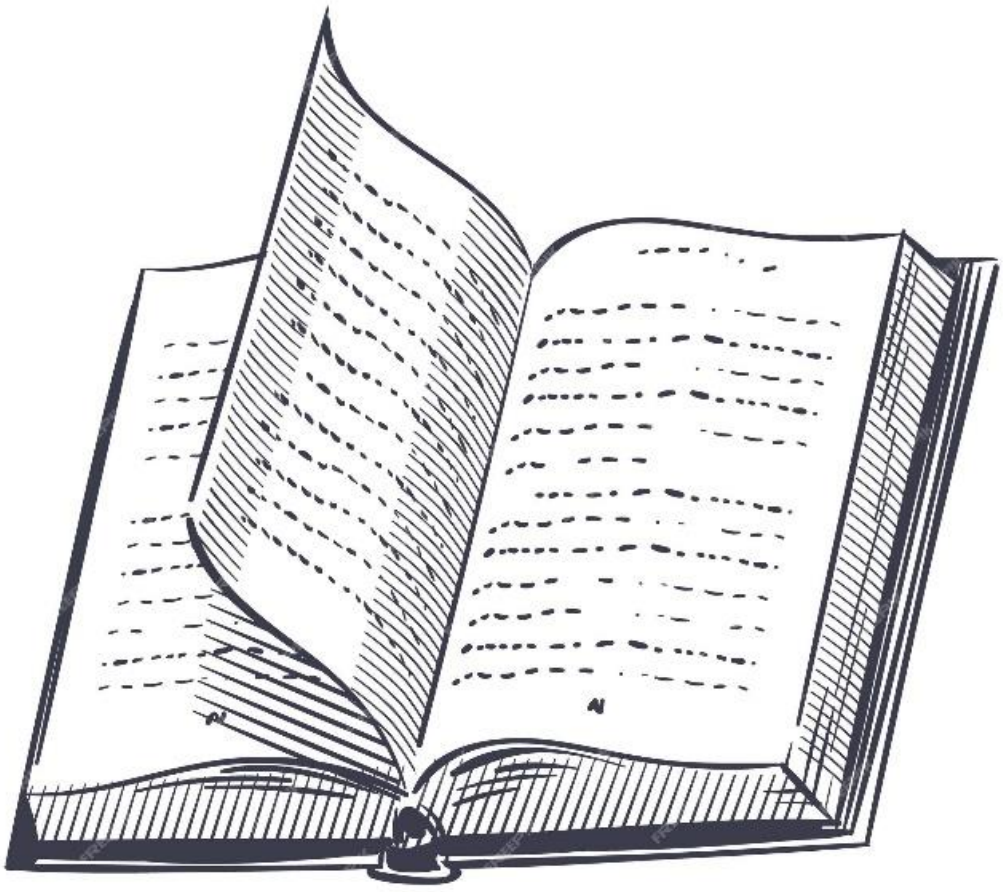
https://nimhanschildprotect.in/wp-content/uploads/2021/03/SOP-for-POCSO-NIMHANS.pdf

Medical Investigations for Children in Institutions

https://nimhanschildprotect.in/wp-content/uploads/2021/02/Medical-Investigations-for-Children-in-Institutions_1.pdf

Identifying Abuse and Maltreatment in Child Care Institutions

https://www.nimhanschildproject.in/wp-content/uploads/2020/03/Identifying-Trauma-and-Abuse-in-Child-Care-Institutions.NIMHANS-Guidelines.pdf



****Show the assessment report after all the proformas have been discussed.**

Developmental & Mental Health Evaluation of Children XXXXXXXXX

For Evidence Eliciting, Mental Health Assistance & Rehabilitation

Submitted by:

Agency XXXXXXXXXXXXXX

Date XXXXXXXXXXX

Sample Report

1. Background

Requesting agency, court order details

2. Objectives

The specific objectives of the visit were:

- To conduct mental health and developmental assessments for affected children in order to screen for mental health morbidity and ascertain the psychological impact of child sexual abuse (CSA).
- To use the developmental and mental health assessments to ascertain the child's capacity to provide evidence/ testimony as child witness.
- To assist investigative officers to interview and gather evidence from the children, using sensitive and child-friendly methods of interviewing.
- To provide first level responses to trauma and identified mental health issues, on an individual basis as well as to draw up recommendations for mental health and rehabilitation focussed interventions.

3.Target and Coverage

XXXXXXXXXXXXXXXXXX

Table 1: Children Interviewed by NIMHANS Team: Locations & Numbers, September 2018

Dates	Child Care Institution	Location	No. of Children Evaluated/ Interviewed
Total			

4. Support and Interventions

4.1. Mental Health & Developmental Assessment of Children

a) Screening for Mental Health Morbidity and CSA Impact in Developmentally Normal Children

Psychiatric assessments were conducted with each child, individually, to identify serious and impairing sequelae of trauma –such as self-harm behaviours, incapacitating anxiety, post-traumatic stress disorder (PTSD) symptoms. NIMHANS assessment proformas and protocols developed especially for assessment of children in care and protection (child care institutions) were used to not only identify mental health problems arising from recent abuse experiences but also to identify pre-existing mental health vulnerabilities and/or developmental problems, that would also need to be addressed during the course of treatment. This proforma was also used for interviewing children having speech and hearing impairment but no intellectual disability. (See Annexe 1 for proforma used).

In all, out of the total of 45 children, the mental status examination of 30 children could be assessed in detail (i.e. those without moderate to severe intellectual disability and/or severe mental illness). Although not strictly speaking neuro-typical, 3 children with speech and hearing impairments and 2 children with mild intellectual disability were included in this group: the former group had no cognitive impairments/ intellectual disability and could therefore respond to the assessment and interview questions using special techniques; the latter had very mild cognitive impairments, and adequate speech and communication skills, thereby they were able to respond to the assessment questions.

b) Assessing Children with Moderate to Severe-Profound Intellectual Disability and Severe Mental Illness

Of the 45 children,15 children (most of whom were listed in the YYY document as having some form of disability) had varying levels of moderate to severe/profound intellectual disability and/or severe mental illness; these children were also reported on this list as being unable to provide statements for Section 161 and 164.

The following two scales were used to assess the nature and severity of intellectual disability in these children:

- Developmental Screening Test (DST): This is used for measuring mental development of a child in terms of neurological and integrative behavioural implications, language and personal-social behaviour items. It is used as a tool in semi-structured interview with child and parents. It provides 88 behavioural items presented at appropriate age levels. Scores obtained on these items with IQ calculator are used to assess the level of development in the child.
- Vineland Social Maturity Scale (VSMS): This scale measures the differential social capacities of an individual. It provides an estimate of Social Age (SA) and Social Quotient (SQ), and shows high correlation (0.80) with intelligence. It is designed to measure social maturation in eight social areas: Self-help General (SHG), Self-help Eating (SHE), Self-help Dressing (SHD), Self-direction (SD), Occupation (OCC), Communication (COM), Locomotion (LOM), and Socialization (SOC). The scale consists of 89 test items grouped into year levels.

Further, information on the children's abilities and functionality were also obtained from the institution caregivers' observations and experiences of the children over the past few months.

For those children with severe mental illness, accounts of the child's level of functioning and observed behaviours were elicited from the caregivers of the institution, followed by mental status examinations (MSE) of the child. For those with severe mental illness, intelligence could not be assessed in view of their mental illness (that prevented the children from responding to the assessment scales and would have yielded inaccurate observations on the same).

<u>Note:</u> The ages of the children on the format reflect the ages provided on the YYY list (containing the Section 161 and 164 statements), as the NIMHANS team was given to understand that these ages were medically determined.

A comprehensive assessment report has been developed for each individual child and submitted to the YYY; each report contains the following information:

- Child's background (how the child reached XXXXXXXX shelter, previous family history, educational history)
- Emotional and mental health concerns and/or developmental disabilities
- An account of her abuse experiences (evidence as applicable—where child was able to provide it)
- Psychiatric diagnosis
- Care plan (for mental health assistance and rehabilitation)
- Implications for developmental and mental health capacity to provide evidence/ testimony as child witness

Table 2: Developmental & Psychiatric Issues in XXXXXXXX Shelter Home Children, September 2018

Mental Health/Disability Diagnosis		**No. of Cases**
Emotional Disorder (NOS)		
Post-Traumatic Stress Disorder		
Depression and other Mood/Emotional Regulation Issues		
Social Anxiety Disorder		
Severe Mental Illness (Organic Mood Disorder/ Psychosis)		
Autism Spectrum Disorder		
Intellectual Disability	Borderline intellectual functioning—Mild Intellectual Disability	
	Moderate/Severe/Profound Intellectual Disability	
Speech & Hearing Impairments		

*A given child may have had more than one diagnosis; only 2 children had no psychiatric diagnosis.

As shown in the table 2 above, in all 43 children had one or more psychiatric disorders or intellectual disability. Only 2 children, who stayed at XXXXXXXX shelter home for an extremely short duration, just before the institution was closed and the children removed, and who also did not have significant/ adverse family history, had no psychiatric problems. All psychiatric diagnoses are made according to international classificatory systems, i.e.; International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) and Diagnostic and Statistical Manual of Mental Disorders, 5thedition (DSM-5).

Adjustment Disorder is the clinical diagnosis made for several of the affected children as they have faced long term stress events, namely abuse and trauma, and they had emotional and behavioural issues pertaining to trauma and abuse experiences. (See box below for description of Adjustment Disorder with Predominant disturbance of other emotions.

F43.2 Adjustment disorders (as per ICD-10 Stress Related Disorders)

- States of subjective distress and emotional disturbance, usually interfering with social functioning and performance, and arising in the period of adaptation to a significant life change or to the consequences of a stressful life event (including the presence or possibility of serious physical illness).
- The stressor may have affected the integrity of an individual's social network (through bereavement or separation experiences) or the wider system of social supports and values (migration or refugee status). The stressor may involve only the individual or also his or her group or community.
- Individual predisposition or vulnerability plays a greater role (young age can be a vulnerability) in the risk of occurrence and the shaping of the manifestations of adjustment disorders than it does in the other conditions in F43.-, but it is nevertheless assumed that the condition would not have arisen without the stressor.
- The manifestations vary, and include depressed mood, anxiety, worry (or a mixture of these), a feeling of inability to cope, plan ahead, or continue in the present situation, and some degree of disability in the performance of daily routine. The individual may feel liable to dramatic behaviour or outbursts of violence, but these rarely occur. However, conduct disorders (e.g. aggressive or dissocial behaviour) may be an associated feature, particularly in adolescents.
- The onset is usually within 1 month of the occurrence of the stressful event or life change, and the duration of symptoms does not usually exceed 6 months, except in the case of prolonged depressive reaction (F43.21). If the symptoms persist beyond this period, the diagnosis should be changed according to the clinical picture present, and any continuing stress can be coded by means of one of the Z codes in Chapter XXI of ICD-10.

F43.23 With predominant disturbance of other emotions

The symptoms are usually of several types of emotion, such as anxiety, depression, worry, tensions, and anger. Symptoms of anxiety and depression may fulfil the criteria for mixed anxiety and depressive disorder (F41.2) or other mixed anxiety disorder (F41.3), but they are not so predominant that other more specific depressive or anxiety disorders can be diagnosed. This category should also be used for reactions in children in which regressive behaviour such as bed-wetting or thumb-sucking are also present.

4.2. Support to Investigative Officers to Elicit Evidence from Children

The inquiry regarding children's experiences of sexual abuse were embedded in the larger mental health and psychosocial interview conducted with each child individually. The Investigative Officers (IOs) of the YYY were present for this component of the interview. As agreed with the YYY officials in the initial brief, most questions regarding their experiences in the XXXXXXXX shelter were put to the child by the NIMHANS team, with the IOs asking for additional information and clarifications as required, including conducting photo identifications of the alleged perpetrators, with the children. Thus, the NIMHANS team assisted the YYY investigative officers to interview and gather evidence from the children, using sensitive and child-friendly methods of interviewing. As detailed below, specific protocols and specialized methods were used, to interview children, depending on their developmental and communication abilities.

a) Adaptation & Use of Guidelines for Establishing & Inquiring about Child (Sexual) Abuse in Child Care Institutions

In August 2018, when the child sexual abuse incidents in XXXXXXXX shelter home came to light, the Dept. of Women and Child Development, Government of Karnataka requested the Dept. of Child & Adolescent Psychiatry to develop guidelines and methods to identify and establish abuse in child care institutions. It was in response to this request that 'Establishing & Inquiring about Child (Sexual) Abuse in Child Care Institutions' guidelines document was written. Developed for monitoring child safety issues in institutions, it can also be used to conduct inquiry where abuse is suspected or reported. These guidelines were slightly modified and adapted to fit the context of the XXXXXXXX shelter home abuse case and used for interviewing children about their experiences of abuse within the shelter home.

**Refer to Annexe 2 for guideline document on 'Establishing and Inquiring about Child (Sexual) Abuse in Child Care Institutions' (adapted for use in XXXXXXXX Shelter Home Case ZZZZ)*

Note: Although contained in the guideline, levels 3 and 4 of inquiry were not used in the interviews (since they entail institution staff who were not necessary (or available), in this instance, for discussion).

b) Use of Non-Verbal Interviewing Methods with Children having Speech & Hearing Impairment

The children with speech and hearing impairment had not been schooled or trained in any formal sign language practices. Thus, conventional and usual gestures as well as art and dolls, were used to establish communication with them in the following ways:

- The team used gestures to introduce themselves to the child, including their objective of protecting her. Gestures were used to communicate that there would be a conversation in which the child can participate only if she is willing to i.e. there would be no pressure or coercion.
- The child would then be shown plain paper and colour pencils, some dolls and a file containing photographs of the perpetrators, indicating that any or all of these could be used by the child and the team to communicate/ express themselves.
- To obtain the child's background/ details on home, a drawing of a house was used along with gestures of a house (inverted V using arms) and pointing at the child and gesturing small size (when she was small).
- The team waited at every stage, for the child's gestures of response—and taking cues from that would ask further questions using gestures.
- Family figures were drawn—sometimes begun by the team and completed by the child. The child would also use actions to indicate certain events such as running away or train journeys.
- To distinguish between child's home and the XXXXXXXX shelter home: the child's home (already established through drawing or gesture), a firm shaking of head and crossing of arms was done to show 'no, not your home'; parallel gestures first pointing to the child and then to the children outside/ around were made, making gestures for a larger home and using gestures for far away. The child then re-affirmed that she had understood these gestures, by repeating the gestures, that they were referring now to the XXXXXXXX shelter.
- With reference to the XXXXXXXX home, the first prompt used was the hand gesture to indicate question. The team would wait for the child's response to this—if the child enacted crying or slapping of the face, punching, the question prompt was used again.
- Primarily, the prompt from the team was the question gesture; upon receipt of response from the child—either through gestural enactments or drawing/ art (or a combination of both), and in some instances the child also used dolls to show actions on it. When the child's response ceased, the team would replicate (imitate) the child's responses exactly, to confirm what she was trying to communicate—through vigorous nods of the head.
- Similarly, the child was shown the photographs of the perpetrators and inquiry was conducted in terms of whether she could identify them and what actions they engaged in. In the course of the interaction, the photographs were re-introduced two to three times, in random order, and the responses noted.

- In all gestural enactment, when the team replicated the child's actions, care was taken never to touch the child.
- During the course of the interaction, since children became very agitated, calming down activities and de-briefing was used, primarily using drawing and colouring or jigsaw puzzles and doll play. Gestures to communicate safety of the child and confidentiality were also used to reassure the child throughout the session.

Assessment for psychiatric issues, to check the child's daily functioning and emotional states were also done through gestures and art work—primarily pointing at the child and using actions.

4.3. First Level Responses to Children's Mental Health Issues

Responding to children's questions and confusions is a critical part of first level responses as this helps to alleviate further distress and anxiety, at least to some extent. Following mental health evaluations and eliciting of evidence, the team also provided brief first level responses to mitigate initial confusion and heightened emotional states (anger, sadness, anxiety) that a child may be experiencing. Simple emotional regulation and distress tolerance strategies were demonstrated to each child, including guided imagery, distraction and other relaxation exercises. Additionally, a great deal of validation/ acknowledgement of difficult experiences and emotions was provided during the course of the entire interview.

Many children were agitating to go home, and institution staff reported that children were engaging increasingly in self-injurious behaviours due to their unmet demands to go home. The YYY had informed the NIMHANS team that the children would be required to stay in the institutions until all evidence gathering processes were complete and the necessary FIRs were filed, and that these processes might take up to two months. The NIMHANS team conducted a brief group session with the affected children in one of the institutions, to help them understand why those who had homes and wished to return were being retained—simple explanations regarding legal processes and justice (which the children also desired) were provided; motivational techniques were used as part of the discussion to provide them with perspectives on how a little more time and waiting on their part could save many children's lives/ keep other children safe.

4.4. Collaboration with (Tertiary Care Facility) for Referral & Further Mental Health Assistance

Following discussions with the YYY on the children's needs for further mental health evaluations and interventions (including psychiatric medication), the team also made a visit to TCF to initiate conversations with the Dept. of Psychiatry, regarding possibilities of their providing continued mental health assessments to children who are referred for further interventions. The Dept. of Psychiatry has agreed to assist those affected children (assessed and referred by the NIMHANS team) requiring depth counselling and therapy, including further evaluation on a medium to long term basis. The NIMHANS team will collaborate with the TCF team providing them with all requisite training and intervention materials to work with child sexual abuse trauma.

An initial group of 9 children with severe and acute mental illness with medical and neurological co-morbidities have already been referred to Dept. of Psychiatry, TCF. Another 17 children, requiring mental health interventions, including further assessments, monitoring of mental health status, medium-to long term trauma-focussed therapy for resolution of PTSD symptoms, including severe anxiety and self-injurious behaviours, will be referred in the coming weeks; 6 children with intellectual disability will also require referral services for psychiatric, neurological and paediatric evaluation. **Thus, a total of 32 children have or will be referred to TCF, SSSSS for mental health services.**

5. Understanding Child Sexual Abuse Trauma & Linking it to Evidence

The mental health assessments as well as the evidence gathered from children requires to be located and understood in the larger context of the children's history, their life circumstances and experiences of neglect, abuse and trauma. Thus, some of the behavioural observations of the affected children are explained so as to enable the interpretation of symptoms and behaviours in terms of trauma and abuse experiences.

5.1. Dynamics and Processes of Child Sexual Abuse

The WHO guidelines adopt the definition of child sexual abuse formulated by the 1999 WHO Consultation on Child Abuse Prevention which stated that: *"Child sexual abuse is the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult (or another child) who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person. This may include but is not limited to the:*
—inducement or coercion of a child to engage in any unlawful sexual activity;
—exploitative use of a child in prostitution or other unlawful sexual practices;
—exploitative use of children in pornographic performance and materials".

Child Sexual Abuse is…
…an interaction between a child and an adult where the child is used for sexual stimulation.
…exploration of sexuality between a minor, traditionally understood as below 18 years of age, could be exploitative if the age difference between them is more than 5 years.
…not restricted to rape/penetrative genital contact.
…digital handling of the child's genitalia.
…non-genital forms of sexual touching.
…non-contact forms of abuse for the pleasure of the perpetrator such as exposing the child to pornography or taking nude pictures of the child.

**Digital handling refers to sexual abuse wherein no penile-vaginal contact occurred, but a child's genitals are assaulted by the perpetrator by use of hand or other objects.*

Based on the affected children's accounts, the following are some of the dynamics of how child sexual abuse was perpetrated in the XXXXXXXX shelter home:

(i) Exposure of children to sex videos (some children have reported that they were shown such films by institution staff, on mobile phones).

(ii) Coercion of children, by institution staff, to wear skimpy clothes and dance to 'dirty' songs while some of the institution staff/ CWC members watched; perpetration of physical abuse and violence if children refused to comply.

(iii) Engagement of some children, by perpetrators, in a gradual process of sexualizing the relationship over time (i.e. grooming). Children, especially at risk children within care and protection systems/ child care institutions, are particularly vulnerable to inappropriate manipulations and attentions. Children can recognize the various benefits and rewards from compliant sexual participation. Thus, some children have been inappropriately and prematurely indoctrinated to respond to their environments and significant others in a sexualized manner—also known as the process of sexualisation.

(vi) Penetrative sexual intercourse.

(vii) Frequent use of physical abuse and violence to:

- Directly coerce and hurt children to submitting to sexual engagement (rape).
- Intimidate, threaten and create fear in children, thereby forcing them to comply with any instruction given by institution staff (including in the context of sexual activity).
- Threaten children into maintaining silence about the goings-on in the institution i.e. to ensure that they do not tell anyone/visitors about their abuse experiences.

- Perpetrate sexual abuse—such as kicking/ hurting children in genital areas.
- Coerce children to take medications that apparently induced sleep immediately after, allowing for perpetration of sexual abuse on children who were then not conscious or in a position to try to resist.

(viii) Drug-facilitated sexual assault (DFSA), wherein children were administered medication each night, telling them that it was for de-worming purposes, following which children would fall 'into deep sleep', waking up with body pains, particularly in the areas of chest, stomach, abdomen and vagina. [Note: De-worming medication is not used on a daily basis—it is given, usually as a single dose, periodically to children, about once in a few months; one or two doses per year is the World Health Organization's recommendation].

Drug-facilitated sexual assault (DFSA) is a criminal act that is carried out by covertly administering a psychotropic substance to a person with the intention of impairing behaviour, state of awareness, perceptions, degree of consciousness, judgement, decision-making capacity or anterograde memory. DFSA victims often have 'patchy' memories or no recollection of what occurred while they were in an unconscious state.

DFSA predators have certain characteristics: they have access to sedating drugs and understand their effects; they have access to a setting where rape will not be interrupted while in progress; they are able to establish at least a small amount of trust with an intended victim. These characteristics are very much applicable in the XXXXXXXX case: the child care institution was continually accessible to the staff/ CWC members responsible for running it and whom the children trusted (or had to trust), since they were in the agency staff's care and protection; given the nature of the institution, there was also a doctor who was able to 'legitimately' provide access to requisite drugs.

5.2. Difficulty in Emotional Expression and Communication

It was observed that most children had difficulty responding to the components of the proforma that elicited information regarding their emotional states, namely anxiety, sadness/ depression and anger. While many of them were able to state that they felt worried and anxious in the XXXXXXXX shelter, they are unable to recognize and acknowledge feelings of continued anxiety about their future/ going home etc (which are their current concerns). Hardly any children, not even those who showed anger through non-verbal cues, were able to report anger issues; and very few of the children acknowledged feelings of sadness or depression. There are a few possible reasons for such limited abilities in emotional expression and communication:

- Nearly all children are from exceedingly difficult backgrounds of long-standing deprivation and neglect, in the recent past while in the XXXXXXXX shelter home, as well in their previous locations. They have thus had very limited opportunities for socio-emotional development, whether in terms of life experiences, through interpersonal/ family relationships or life skills training in schools and institutions. Consequently, they are not accustomed to socio-cultural milieus where emotional expression or communication was encouraged.
- Most of the affected children have lacked caregivers in the past, wherein the caregivers they have been absent, preoccupied, inconsistent, and/or abusive. In the absence of stable attachment figures, it is difficult for children to have felt safe and learnt appropriate emotional communication.
- Broadly speaking, in the context of trauma, children tend to have two types of responses: either they tend to become less communicative about their emotional states (sometimes even going into a 'freeze' response especially in the immediate aftermath of traumatic events) or they are unable to identify, label and regulate emotional states, which in turn, results in challenging behaviours in interactions with others.
- In the context of (sex) trafficking, more than other contexts of child sexual abuse, children have experienced repeated betrayal and exploitation by multiple people; consequently, their trust is almost completely destroyed and they tend to be extremely wary in their communication. This is one of the reasons that some children were either non-responsive in interviews or said 'I don't remember' or 'I

forgot what happened'—they are reluctant to disclose information about themselves or about the abuse, as they are unsure whether the (next set of) caregivers are trustworthy and whether the information they provide will be used against them. The trust issue is also what makes evidence gathering a challenging task with such children—especially when time is limited and we are reliant on cross-sectional assessments and evaluations.

5.3. Post-Traumatic Stress Disorder

The presence of post-traumatic disorder symptoms also serves as evidence that children have undergone traumatic experiences of physical and sexual abuse. Refer to box below for a summary of PTSD symptoms as per the Diagnostic Statistical Manual (DSM) 5. All neuro-typical[4] children interviewed (those without intellectual disability) were found to have symptoms suggestive of PTSD—such as general anxiety symptoms, self-injurious behaviour such as repeated cutting, externalising problems, aggression, depression, insecurity and problems with interpersonal relationships, including friendships and attachments.

Summary of ICD 10-- Criteria for Post-Traumatic Stress Disorder

A Exposure to a stressful event or situation (either short or long lasting) of exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone.

B. Persistent remembering or "reliving" the stressor by intrusive flash backs, vivid memories, recurring dreams, or by experiencing distress when exposed to circumstances resembling or associated with the stressor.

C. Actual or preferred avoidance of circumstances resembling or associated with the stressor (not present before exposure to the stressor).

D. Either (1) or (2):

(1) Inability to recall, either partially or completely, some important aspects of the period of exposure to the stressor

(2) Persistent symptoms of increased psychological sensitivity and arousal (not present before exposure to the stressor) shown by any two of the following

a) Difficulty in falling or staying asleep;

b) Irritability or outbursts of anger;

c) Difficulty in concentrating;

d) hyper-vigilance;

e) Exaggerated startle response.

Criteria B, C and D all occurred within six months of the stressful event, or the end of a period of stress. (For some purposes, onset delayed more than six months may be included but this should be clearly specified separately.)

Posttraumatic stress disorder is the one of the few psychiatric diagnoses in DSM-IV-TR or ICD-10 that requires the presence of a known etiologic factor, i.e., a traumatic event that precedes the development of the disorder. For PTSD to be present, the child must report (or there must be other compelling evidence of) a qualifying index traumatic event and specific symptoms in relation to that traumatic experience. All children, in whom PTSD symptoms were observed/ assessed, have provided accounts of physical and sexual abuse experiences (in varying degrees of detail).

While diagnosis of PTSD symptoms requires evidence that children have experienced traumatic events, and most neuro-typical children were able to provide details of their abuse experiences at XXXXXXXX shelter home,

[4]Neuro-typical children are those who do not have intellectual and cognitive disabilities or autism i.e. they are individuals of typical developmental, cognitive and intellectual abilities.

there were a few children who also tended to provide responses such as 'I cannot remember' and 'I don't know'. Such responses are, in fact, evidence of PTSD (and consequently of trauma experiences) because these children may be afraid, ashamed, embarrassed, or avoidant of disclosing traumatic experiences, particularly in an initial clinical interview. Avoidance may take the form of denial of trauma exposure and as such may be an indication of the severity of the child's avoidance symptoms rather than lack of trauma exposure.

Furthermore, while most children had some PTSD symptoms, they were unable to report or respond to inquiries regarding flashbacks, emotional distress after exposure to traumatic reminders and avoidance behaviours. One possible reason for this is already explained above in terms of children's difficulty with emotional vocabulary and communication; another possible reason is what is known as 'sleeper effects' of PTSD--whereby children are asymptomatic immediately after the abuse, but present with symptoms at a later developmental stage. Thus, all PTSD symptoms could not be elicited in a single cross-sectional interview and the affected children will require continued evaluation for PTSD over the coming months, by a psychiatric facility.

5.4. Self-Injurious Behaviours

Self-harm or self-injurious behaviours are an important symptom which may point to underlying PTSD. Self-injurious behaviours, which nearly all neuro-typical children were reported (and observed) to have, started in the XXXXXXXX shelter, already indicating that there was a context for distress. The accounts provided by the children regarding physical and sexual abuse, form the contexts for the behaviour. Children reported cutting themselves in XXXXXXXX shelter in order to a) protect themselves when they were approached by persons/institution staff for sexual engagement; (ii) try and get their demands to leave the institution/ go home, to be met.

Non-suicidal self-injury (NSSI), the direct and deliberate destruction of body tissue in the absence of suicidal intent, is the type of self-injurious behaviour that most children exhibited. Studies have found that NSSI, during adolescence, is particularly associated with childhood sexual abuse—and also that the presence or frequency of NSSI is not significantly associated with non-sexual abuse, including physical and/or emotional abuse. Children who have been sexually abused tend to re-experience trauma, and feel the need to use avoidance and numbing mechanisms, which would lead to NSSI behaviours.

Also, self-injurious behaviour, especially NSSI, although learnt and initiated in a particular context (during experiences of trauma and abuse), are likely to continue even after the abuse has stopped. This is because children who have suffered trauma have reduced affect or emotional regulation[5] skills. They are at risk for being more easily overwhelmed by emotional distress. They find it difficult to respond in a 'balanced' way, within a moderate range of emotions: the slightest provocation, even if unrelated to the event may produce extreme reactions characterized by excessive fear or anger. This is why the affected children continue to engage in self-injurious behaviours and at times in aggressive/disruptive behaviours. Events of trauma and abuse (especially when repeated or chronic in nature), not only have psychological impacts but also induce physiological changes-- repeated childhood stress and trauma experiences lead to alterations in central neurobiological systems leading to increased (mal)responsiveness to stress; this in turn increases the risk of psychopathology in both children and adults.

5.5. Implications for developmental and mental health capacity to provide evidence/ testimony as child witness:

[5]Emotional regulation refers to an individual's ability to regulate or control difficult emotions such as anger and anxiety.

Based on the mental health and developmental assessments conducted, the report contains comments on each child's ability to provide valid and reliable evidence (including later on, in Special Court).

Children with intellectual disability in the moderate to severe range are unable to provide verbal or non-verbal narratives of their abuse experiences as they lack the requisite developmental abilities, particularly with regard to cognition and speech, and will therefore be unable to provide evidence. Likewise, those with severe mental illness were also unable to provide evidence because the severity of the illness hinders cognitive functioning and communication.

Among children who did NOT have (moderate to severe/ profound) intellectual disability it was found, that most were able to provide accounts of physical and sexual abuse in the XXXXXXXX shelter. Children with speech and hearing impairments also fall within the broader sphere of those not having intellectual disability, and are consequently capable of providing valid and reliable testimonies, albeit through use of non-verbal communication methods. While nearly all these children may have psychiatric diagnosis such as PTSD symptoms, Depression, Adjustment Disorder with predominant disturbance of other emotions, or mood regulation issues, these mental health problems, all consequences of chronic abuse and trauma, do NOT preclude them from providing valid and reliable evidence.

That said, the same mental health issue may manifest in each individual child in a different way as there are temperamental (innate) differences as well as variations in children's previous life experiences in terms of family background. Consequently, despite having similar diagnosis, each child's reactions to the abuse and trauma experiences, and therefore her response to the evidence gathering process is different. For instance, a child who comes from a cohesive family, with secure attachment relationships and adequate care, may be more resilient in the wake of her XXXXXXXX trauma experiences, and so more willing to provide detailed accounts of the abuse, including the ways in which she personally experienced it. However, a child with a long standing family background of neglect, compounded by the XXXXXXXX trauma experiences, is likely to have blunted socio-emotional development, be less resilient, more anxious, more difficult to build trust with, and consequently less likely to provide detailed evidence, especially in a brief cross-sectional interview.

Such variations have resulted in two types of children, in terms of their capacity to provide evidence, with specific reference to the nature of evidence they provide:
i) Those who have the ability to provide valid & reliable (abuse) narratives and evidence about both events/ occurrences as well as experiences of the self-i.e. their evidence comprises of accounts of what used to happen around them/ in XXXXXXXX shelter, what they observed in terms of events and others' actions, as well as their personal experiences of abuse/ what happened to the self.
ii) Complete ability to provide valid & reliable (abuse) narratives and evidence but with a focus on events and occurrences rather than on self-i.e. their evidence comprises of accounts of what used to happen around them/ in XXXXXXXX shelter, what they observed in terms of events and others' actions, but they are hesitant to disclose abuse that they personally experienced—they either avoid discussing the abuse related aspects or describe how it happened to other children, saying that it did not happen to them.

Table 3 below categorizes the 45 children that the NIMHANS team assessed and interviewed for mental health and evidence gathering purposes, into 7 categories. The characteristics (in terms of functionality and ability) of each category are described, along with the implications for evidence provision.

Table 3: Developmental & Mental Health Impact on Children's Abilities to Provide Evidence

Category	Characteristics	Implications for Evidence Provision (by Child)	No. of Children
Category 1	**Children with Moderate to Severe and Profound Intellectual Disability:** • Cognitive capacities much below age	Complete inability to provide (abuse) narratives and evidence.	

	• Have inadequate speech/ communication/ cognitive capacities • Marked impairment in day-to-day functioning and age-appropriate tasks/engagement.		
Category 2	**Children with Severe Mental Illness:** • Such as severe (organic) mood disorder and psychosis. • No clear time-place-person orientation. • Inability to engage in meaningful communication. • Severe mood/perceptual (hallucinatory) issues that render them dysfunctional in day-to-day functioning and age-appropriate tasks/ engagement. • (Long-standing, untreated) co-morbid neurological conditions such as epilepsy.	Complete inability to provide (abuse) narratives and evidence.	
Category 3	**Children with Below Average Intelligence—Mild Intellectual Disability:** • Cognitive capacities slightly below age. • Have adequate speech/ communication/cognitive capacities. • Independent in day-to-day functioning and self-help skills • Due to difficulties with advanced reasoning and higher order perspective taking, they tend to be less inhibited and so less likely to withhold information—consequently sharing narratives more openly.	Have the ability to provide valid & reliable (abuse) narratives and evidence both about external events/ occurrences as well as experiences of the self.	
Category 4	**Children with Speech & Hearing Impairment:** • Independent in self-help skills and activities of daily living • Have age-appropriate cognitive and intellectual abilities. • However, they have speech and hearing impairments, necessitating non-verbal communication with them (through use of sign language and art).	Have the ability to provide valid & reliable (abuse) narratives and evidence on external events and occurrences linked to self.	
Category 5	**Children with socio-emotional skill deficits:** • Many came to shelter at a relatively younger age, when identities were at a formative stage. • Are drawn from backgrounds of chronic neglect and did not have adequate nurturance and developmental opportunities at shelter also. • Consequently, did not develop age-appropriate socio-emotional skills, despite having normal/ age-appropriate intellectual/ cognitive capacities. • Within this category, there are 2 sub-categories of children: (a) Those with significant socio-emotional	Complete ability to provide valid & reliable (abuse) narratives and evidence but with a focus on external events and occurrences rather than linked to self.	

	communication difficulties i.e. emotional and behaviour problems relating particularly to social skills—consequently making them anxious/ inhibited/ reluctant to engage with new persons. (b) Those having socio-emotional developmental problems leading to emotional disorder, but tending to also be more bold and outspoken, by nature, and therefore able to give adequate amounts of information regarding events and occurrences in the shelter home but are reluctant to provide information regarding (traumatic) experiences of the self.		
Category 6	**Children with near-normal socio-emotional skills:** • Many of them came to shelter at a relatively older age/ late adolescence, when identities were better developed. • Drawn from backgrounds of chronic neglect but had near-normal social and emotional development. • Have developed mental health issues such as post-traumatic stress disorder/depression/emotional regulation issues in the shelter, due to experiences of abuse and trauma. • Despite trauma-related mental health issues, many are resilient and are able to engage socially and are willing to speak about their difficult experiences.	Complete ability to provide valid & reliable (abuse) narratives and evidence both about external events/ occurrences as well as experiences of the self.	
Category 7	**Children residing in XXXXXXXX Shelter Home for relatively very short period:** • Came to shelter in the last month or two of its existence (before children were removed from there). • Had no intellectual or developmental disabilities. • They spent shorter duration ranging from a few weeks to a few days at the shelter home. • Therefore, their knowledge and (first-hand) experiences of the shelter are limited. • They are able to provide some information from hearsay (what they have been told by other children), and some based on their observations of other children's behaviours.	Complete ability to provide valid & reliable (abuse) narratives and evidence but are limited by short stay and knowledge of shelter.	
Total No. of Children			

6. Recommendations and Ways Forward

As stated in the initial Supreme Court order, it is strongly recommended that the Government of ZZZZ engages 3 accredited institutions i.e. NIMHANS, TCF, SSSSS and CCCC, to provide psychosocial, mental health and rehabilitation assistance to the affected children in the manner described below.

Distinguishing between Mental Health Assistance and Rehabilitation

(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.

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 the case of XXXXXXXX shelter home children, rehabilitation is also linked to issues of repatriation and reintegration.

[Note: **Life skills group sessions are NOT focussed on trauma-related therapy**—they focus on generic issues such as social and emotional skills, to enable children to acquire WHO life skills such as communication, assertiveness, self-awareness, time-management, decision-making and inter-personal relationships. These are conducted using common everyday contexts of the children, to enable them to take perspectives on daily life and living i.e. trauma events and themes are not used in such life skills sessions unless they are conducted by qualified mental health professionals who are skilled to provide trauma-related responses].

6.1. Mental Health Assistance in the Context of Child Sexual Abuse

In the immediate aftermath of traumatic events (not least of which have been intrusive interviews and questioning by media and various other agencies, of the affected children in ZZZZ) attempting to initiate in depth trauma focused therapeutic interventions is not a useful beginning. This is not the time for intensive trauma exploration and processing.

Furthermore, abuse-focused interventions alone are insufficient and healing and recovery can take a long time. In the interim, it is therefore important to recognize the importance of maintaining children's developmental trajectories—which are (as previously discussed) disrupted by experiences of trauma and abuse. Enabling children gradually to return to daily schedules and activities such as school and play helps to restore:

- Normalcy and balance.
- Predictability (something that is lost in the abuse situation due to the lack of predictability of abusers and of abuse events).

While children in the PPPPP institution now have a structured routine and have gradually acquired emotional stability, those in BBBB and SSSSS child care institutions are still in a state of emotional/ mood dysregulation and require an environment where they are able to gain some equilibrium, before entering into depth therapy.

Abuse-focused interventions to facilitate trauma resolution and long-term healing need to be implemented at a later stage, when children have overcome the initial acute distress of sexual abuse. They also need to be implemented by skilled and qualified mental health professionals who can effectively modulate the pace of trauma-focused therapy, deal with obstacles like escalating distress and self-harm behaviours and prescribe psychiatric medication as and when required.

Detailed individual mental health assessments of the XXXXXXXX children have shown that this may not be an opportune time for group therapy. In fact, for highly sensitive issues such as child sexual abuse, group therapy although used, is conducted after extensive assessment and preparation i.e. after understanding the children's readiness to participate in such sessions.

Furthermore, any therapeutic work that inadvertently leads to greater distress in children by re-traumatizing them can unsettle children in the medium-term. This may also impact the children's abilities to provide evidence in the Special Court trial that will ensue in the upcoming two months. In other words, mental health assistance and evidence are very much linked in the context of sexual abuse.

In the light of the above-described rationale, please find below our recommendations, made on the basis of detailed mental health evaluations of individual children:

(i) NIMHANS has already had 2 meetings with the Dept. of Psychiatry, TCF, SSSSS. **The TCF team is willing to work in collaboration with NIMHANS to assist the children as necessary.** The Dept. of Child & Adolescent Psychiatry, NIMHANS is the only independent specialized child psychiatry department in the country and manages cases of child sexual abuse on a regular basis. Thus, all therapeutic and training materials developed by NIMHANS will be shared with the TCF team to better equip them to respond to the children's needs and any support or guidance whether through a visit or via phone will be provided by NIMHANS.

(ii) Referral letters have already been sent (on 5th October 2018) to TCF and to the Dept. of Social Welfare, Government of ZZZZ, for an initial group of 9 children, with severe and acute medical and psychiatric needs for TCF to provide urgent assistance to them. These are children with severe and acute mental illness, with co-morbid medical conditions, requiring urgent psychiatric medication and/or medical and neurological care.

(iii) The mental health assessments conducted by NIMHANS, for each child, will be shared with Dept. of Psychiatry, TCF SSSSS. These assessment proformas contain care plans and suggestions for further assessments, psychiatric medication and psychotherapy in keeping with each child's individual needs. Those children requiring further mental health assistance may be referred to the TCF team, who will work with the children, providing necessary mental health care and inputs.

(iv) After the initial round of emergency referrals already sent to TCF, NIMHANS will notify TCF about other children who require medium to long term psychiatric and mental health assistance, including psychotherapy, and further clinical evaluation and treatment for mental health disorders. As mentioned, these **children will require depth individual therapy,** when they have overcome some of their current intense agitation.
Note: Liaising with TCF SSSSS, a local institution will ensure that regular and sustained care is provided to the children over a longer period of time, as required (versus occasional visits by organizations not located within the state—which will not be useful to the children).

6.2. Mental Health Assistance from Other Agencies

Following the rescue and placement of the children from XXXXXXXX shelter home, the Dept. of Social Welfare, Government of ZZZZ engaged an NGO (in coordination with UNICEF), to assist the affected children with mental health and psychosocial issues arising from their experiences of trauma and abuse.

At the time NIMHANS was contacted for assistance, based on the Supreme Court order, the NIMHANS team requested the Dept. of Social Welfare, Government of ZZZZ, to send the reports of the work completed by the NGO. This was in order for the NIMHANS team to be able to build on the work already initiated by the NGO, rather than duplicate services already provided or contradict any messages the children may have received through their prior engagements and participation in sessions with the NGO staff.

Upon studying the reports provided by the NGO, the NIMHANS team has noted several concerns about the nature and type of interventions provided by the NGO—these are documented in detail in **Annex 3** on '**Issues and Concerns regarding Mental Health Interventions by Other Agencies'.** Based on these reports and the understanding thereof, it is NOT recommended that non-governmental agencies (other than CCCC) engage in interviewing children/ providing trauma-based therapy and other mental health assistance to the affected children.

However, NGOs may be engaged under the guidance and supervision of CCCC to assist the affected children with various rehabilitation activities (erstwhile described). Indeed, this would be both useful and critical as many NGOs have specific mandates and skills in vocational training, non-formal education and other areas relevant to rehabilitation.

6.3. Re-Location Issues

It was both observed by the NIMHANS team and reported by the child care institution staff at HHHH Grih, SSSSS that the affected children were getting into frequent fights between themselves and with others, as well as engaging in self-injurious behaviours. In BBBB, the Balika Grih houses some of the affected neuro-typical children (i.e. children without disability or those who are perfectly functional), who by virtue of being with children with moderate to severe/profound intellectual disability and/or severe mental illness, do not have suitable developmental or training opportunities. These unstructured environments, which many of these children in SSSSS and BBBB institutions have, with nothing to do all day will only lead to an increase in emotional distress and consequent difficult behaviours; for children who already have emotional regulation issues, due to trauma, such environments will not be helpful in facilitating healing and recovery.

The NNNN society, PPPPP, has the most suitable environment for the rehabilitation of the affected children. Upon discussions with the caregivers and observations of the children, it is apparent that all the elements required for the children's initial healing and stabilization are present: 24/7 individual care, vigilance, structured daily routine, caregivers and counsellor to assist with ventilation and validation of children's trauma experiences, daily group sessions that focus on generic life skills (not on issues of trauma).

Thus, it is recommended that as the environment and care there is structured in ways that assist children with coping with extreme distress, thereby promoting readiness for depth therapeutic inputs (from TCF) at a later stage, affected children from SSSSS and BBBB institutions be shifted to the PPPPP child care institution as follows:

- Those who do NOT have intellectual disability and severe mental illness (such as psychosis/organic mood disorder i.e. those who are functional)
- Those who have speech and hearing impairments but do NOT have intellectual disability.

In all, about 17 children (5 from BBBB Balika Grih and about 12 from HHHHGrih, SSSSS) require to be re-located to the children's home in PPPPP. The capacity of the PPPPP institution is 50 children and they currently have 25

children only. The caregivers at this institution have expressed their willingness to house and care for all the affected children (i.e. those without intellectual disability and severe mental illness), provided they are supported with 5-6 additional staff housemothers/counsellors as per their requirement). It would be helpful if CCCC could facilitate this process of re-location of children and additional staff for this home, along with the Government of ZZZZ.

Note: Children who are placed in Asha Kiran Home, SSSSS do NOT require to be re-located as they have adjusted to the institution set up there, and this institution, like the one in PPPPP, is able to provide the children with structured daily routines, play time, opportunities for education etc.

6.3. Rehabilitation Services for Children after Re-Location to PPPPP

It would be helpful if CCCC's engagement in PPPPP (after all children are shifted there) takes the form of the rehabilitation activities erstwhile described i.e. support to the institution caregivers on education, creative activities, vocational training, leisure and entertainment, and generic life skills sessions (which the caregivers there are already conducting for the children on a regular basis). Especially given the current staff shortages, it would be useful if the CCCC team could help the caregivers with structuring of daily routines, implementing developmental and recreational activities for the children, particularly as the (new) group of children are moved from SSSSS and BBBB into the PPPPP institution.

NGO, PPPPP: How their Approach to Psychosocial Assistance Works

The caregivers when interviewed, provided detailed descriptions on how they had coped with the initial trauma reactions and consequent behavioural issues that the affected children had come with--physical and verbal abuse of each other and of others, including property destruction. The caregivers had used daily routine and structuring the day, gentle persuasion to engage the children in play and leisure activities (always jointly implemented) to assist the children to adjust to the new environment; they had coped with more complex issues such as the children's self-harm behaviours in a non-critical/non-judgemental ways, gently asking the children to turn in sharp objects after play time outside. In order to establish trust and rapport, as well as to maintain 24 hours vigilance, they had transferred their sleeping space/ arrangements to that of the children's dormitories and spent many weeks/ nights soothing the children when distressed and then listening (without advising), as the children gradually trusted them enough to provide accounts of their abuse and trauma experiences. The caregivers reported how children's behaviours of physical and verbal abuse, of property destruction and self-harm gradually decreased, over a period of 2 to 3 months. The children now take pride in cleanliness and neatness as the idea that this is 'their home' (as the caregivers have constantly reiterated) has taken root; they are reported to be enthusiastic about their non-formal education classes, leisure and play time, and other daily activities. When the NIMHANS team interviewed the children, at the outset, every child spoke of how different this institution is from their previous one, how they love being here and enjoy everything about it, from the food to the activities they are engaged in. Above all, they spoke of great affection and regard for the institution caregivers, many of them saying that they did not wish to leave their caregivers, even to go home to their families; this is indicative of how the children also have opportunities here to develop attachment relationships—critical to emotional regulation skills and overcoming of traumatic experiences.

6.4. Rehabilitation and Developmental Interventions for Children with Disability & Severe Mental Illness

The environment and care conditions in Balika Grih, BBBB are far from ideal. The caregivers appear to be over-worked and under-skilled, as they care for a large number of children, most of whom have severe disabilities. It would be useful if CCCC, in collaboration with the Government of ZZZZ, helped to (re)organize the institutional care in the following ways:

- Staff orientation and training on children with disability (incl. approaches to working with children with disability)
- Ensuring that the medical treatment is supervised/ that there is treatment adherence (also through enabling access to a paediatrician and nurse for the institution).
- Organizing access to a physiotherapist, a speech therapist and special educator for the children.
- Helping the caregivers to organize a structured daily routine for the children; suggesting and organizing ways meaningful developmental and stimulation activities that would be individualized for each child (in accordance with her disability level)

Given that other agencies involved are keen to assist in the rehabilitation efforts, it would be useful to share yesterday's note as well as this one with not only the Hon'ble Supreme Court but also with the Dept. of Social Welfare, ZZZZ, the YYY, and CCCC, all of whom are involved in this case in various capacities.

6.5. Repatriation

Repatriation of the children i.e. sending them back to their homes and families may also be undertaken by CCCC. However, they will be able to commence efforts in this area only after the legal/ trial processes are completed (based on direction from the YYY). This is likely possible after 2 months' time.

The NIMHANS team will share the family history/ locations of the children's homes with the CCCC team in order that the latter may assist in the repatriation process through tracing of children's families and decision-making as to which children can return home (some of them cannot as they are either unable to tell the whereabouts of their home or are not willing to go home due to neglect, abuse and exploitation that has occurred in the family context).

Some issues for consideration and interventions for implementation during the process of repatriation:

- The decision to send the child back to 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 she is able to manage any questions that are asked of her whereabouts/ experiences when she goes home (if unprepared for such questions and situations at home, it will create great anxiety in the child). For instance, CCCC and institution counsellors would need to prepare the child for going home, and the questions family members/ others may ask ('where were you all these months? What were you doing there?). The responses that the child could give may be scripted and rehearsed with the child: 'I was in a children's shelter home…I didn't like it there…people were not nice at all—they used to beat and hurt us…am relieved to be out of there now.' It should be explained to the child that there is no obligation on her part to explain in great detail what happened to her at the XXXXXXXX shelter home etc—her comfort is paramount, (unless she really wished to tell someone particularly close o important to her—the idea is not 'you have to tell' or 'never tell anyone'—it is about the child's comfort).
- The child's parents/ family may also require to be prepared—at least to be broadly informed that the child had difficult experiences in the previous institutions, that she sometimes recalls them and becomes distressed. They need to also be told about some basic techniques to help her manage her distress/ soothe her, should any distress symptoms occur when she goes home.

- The child should be enabled to continue treatment at TCF, SSSSS, (for any child who is undergoing treatment there) even after she goes home—with support from her parents and assistance from Govt. of ZZZZ.

6.6. Special Court Trial

Based on our observations, the institution caregivers' observations and knowledge, as well as the children's accounts of their mental health issues, our understanding is as follows:

- Nearly all children have emotional and mood issues, including post-traumatic stress disorder (PTSD) symptoms. The nature of PTSD symptoms is such that the child experiences vivid recollections and flashbacks and experiences considerable distress, especially when exposed to places and people associated with the traumatic events.
- A group of children who were placed in Asha Kiran Home, SSSSS, exhibited intense distress, also asking to leave this institution; consequently, these children were re-located to another child care institution. Some children later told institution caregivers that they had experienced such high distress there due to the architecture of the home which resembled that of the XXXXXXXX shelter (again, a consequence of PTSD symptoms).
- Given the nature of the alleged abuse that they experienced i.e. including high levels of threat and physical abuse, there is still a considerable fear amongst the children, due to which eliciting evidence from them, even in the institutions where they are now located, is challenging.
- Due to their experiences of betrayal in the context of alleged abuse, the children have tremendous difficulty trusting persons around them. For instance, even a few months after their removal from the XXXXXXXX home, they are hesitant to take any medication given to them (for day-to-day ailments) by their current caregivers, for fear of being sedated, as they report happened to them in the XXXXXXXX shelter.

In the light of the above, if the trial proceedings for the XXXXXXXX Shelter Home Case are conducted at the Special Court in XXXXXXXX, where the children may have to make an appearance/ participate in some of the proceedings, there is likely to be difficulties and challenges in terms of providing the requisite evidence. It is not advisable to take them back to XXXXXXXX, the place that for them is associated with traumatic events as the distress that the children will experience will hinder them from providing evidence; furthermore, as stated, due to trust issues, there is likely to be hesitation and reluctance to travel to XXXXXXXX (for fear that they may be returned to the shelter home there).

Based on the above-described concerns, we recommend the following:

i. The Special Court trial proceedings for the case be located in a neutral location (such as SSSSS).
ii. The utmost care is taken when children are asked to identify the alleged perpetrators i.e. even the use of one-way glass/ mirrors is inadvisable as the children are unlikely to respond, given the degree of fear and trauma that they continue to experience. It is suggested that perpetrator identification is done through pictures and/or videos only.
iii. Given their PTSD symptoms and the level of children's fears, the NIMHANS team be permitted to prepare the children for trial (nearer that time) in the following ways:
    - Courage and confidence building
    - Knowledge of court procedures (so children know what to expect)

These can be done through the use of creative methods such as art, story-telling and role play, in group sessions with the children, shortly before trial procedures begin for them.

Note: Preparation of the children will in NO way include tutoring or telling children what to say in the court. The focus of preparatory sessions will be purely on mental health/ psychological readiness to participate in trial proceedings.

As the Dept. of Child & Adolescent Psychiatry, NIMHANS deposes in POCSO cases, in court, as expert witness, should there be such a need in the XXXXXXXX case, the Head of Department, Dept. of Child & Adolescent Psychiatry, NIMHANS, would be willing to undertake to represent the team and depose as special witness as required.

Annexe 1

Assessment for Children in Institutions/Childcare Agencies
Dept. of Child & Adolescent Psychiatry, NIMHANS

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 relations

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/ Child's report)

9. Feelings and Emotions

9.1. 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**.**

9.2. 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).

0	1	2	3	4	5	6	7	8	9	10

ii) At 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.

9.3. 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?

9.4. Post-Traumatic Stress Disorder (PTSD)

10. Any Other Observations of the Child:

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

11. Summary of Child's Problems

Disability (Physical/ Intellectual):

Psychiatric Diagnosis:

Medical Problem:

Context:

Implications for developmental and mental health capacity to provide evidence/ testimony as child witness:

12. 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).

Annexe 2

Establishing and Inquiring about Child (Sexual) Abuse in Child Care Institutions

Guidelines for Use in XXXXXXXX Shelter Home Case ZZZZ

(Excerpt from Guidelines for 'Identifying Abuse and Maltreatment in Child Care Institutions' developed by Dept. of Child & Adolescent Psychiatry, NIMHANS for Government of Karnataka)

Dept. of Child & Adolescent Psychiatry, NIMHANS, September 2018

Note:

The following questions for inquiry are to be used in conjunction with and after necessary developmental and psychiatric assessments have been administered to affected children—so as to first understand and determine children's capacities to respond to the issues/ questions in this guideline.

Level 1: Observation of Signs & Symptoms

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

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

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

Level 2: Discussions with Children

Introduction	• *My name is……. I work in a children's hospital. My job is to work with children and ensure that they feel safe and protected…and to help them if they have any difficulties or are hurt in any way. Part of my job is also to make sure that children's institutions are run well and that children are looked after.* • *I know that many people have probably questioned you already and that it has been difficult for you to have to narrate your experiences—it is not easy to talk about hurtful and difficult experiences.* • *But the government has taken very seriously the incidents that occurred in your previous institution…because no one has the right to hurt children. So, in addition to the police, whom you may have also spoken to, the government has brought in one the biggest legal bodies/ organizations in the country—this organization (YYY) wants to understand your views and experiences, so that the people who were hurtful can be caught and punished.* • *When children get hurt (like you have), it is never their fault. And I want to assure you that whatever you share will not be shared with other children or institution staff—so you don't have to be afraid.* • *So, while it may be difficult, it is my request and appeal to you to help us with some information about your previous institution and the things that happen there. May I proceed to ask you some questions about it…?* • *If at any time you feel tired or uncomfortable, you can ask me to stop…and we can come back to it later.*
General Questions	*- Tell me about how you spend the day…what activities do you do from the time you wake up…?* *- Tell me about the different rooms and spaces in your institution…where do you eat? Where do you sleep? Where do you play/ do your homework?* *- What time do you eat dinner? And what happens after that…? What do you all do?* *- What are some of the things you like best about being in this institution?* *- What are some things you find difficult about being in this institution?* *- Tell me something about each of the caregivers who are in this institution…we can*

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

Level 3: Medical & Psychiatric-Mental Health Records

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

Level 4: Individual Interviews with Caregivers

Introduction	*My name is……. I work in the child and adolescent psychiatry department at NIMHANS (a hospital that works with mental health/ neurological issues). Part of my job is also to make sure that children's institutions are run well and that children are looked after—so we do work with CWCs, child care institutions across the country, through different state governments.* *I am here today, as you are perhaps aware, as part of the Supreme Court orders/ on YYY's request and the ZZZZ government's invitation. Our team is here to conduct some mental health assessments of the children and to help YYY with evidence gathering from the children. Your observations of the affected children—their emotional states/ behaviours-- would be useful for us to better understand and assist the children.*
Questions	*-Have you noticed any injuries/ health issues in the children? Tell me more about it?* *- Have you observed injuries?* *- Have children reported any injuries/ health problems to you?* *- Any sudden or unusual behavioural changes in the children? Sleep patterns/ feeding patterns/ socialization/ daily activity/ sudden onset of bed-wetting?* *- What measures have you taken to help children access treatment for injuries/ health problems and/or psychological problems?* *- Have children reported any misbehaviour to you about any staff here? Or have you observed any staff behaving in ways that you feel are not child-friendly?*

Annex 3

Issues and Concerns regarding Mental Health Interventions by Other Agencies

Following the rescue and placement of the children from XXXXXXXX shelter home, the Dept. of Social Welfare, Government of ZZZZ engaged an NGO (in coordination with UNICEF), to assist the affected children with mental health and psychosocial issues arising from their experiences of trauma and abuse.

At the time NIMHANS was contacted for assistance, based on the Supreme Court order, the NIMHANS team requested the Dept. of Social Welfare, Government of ZZZZ, to send on the reports of the work completed by the NGO. This was in order for the NIMHANS team to be able to build on the work already initiated by the NGO, rather than duplicate services already provided or contradict any messages the children may have received through their prior engagements and participation in sessions with the NGO staff.

Upon studying the reports provided by the NGO (these reports are available with the Government of ZZZZ), the NIMHANS team has the following concerns about the nature and type of interventions provided by the NGO:

- **On Assessments & Diagnosis:**
  - The NGO report does not indicate what assessment proforma and protocols were used, so it is unclear as to how the children were assessed for psychiatric disorders or how the NGO arrived at various conclusions about the children's mental health issues. Specific psychological scales are generally not used (as the NGO team has done) in the first instance—there is a rationale for selection of scales, based on clinical impressions that are first arrived at through means of history-taking.
  - It is technically incorrect to conduct IQ assessments, as the NGO team has done, for children who have undergone severe trauma and abuse, in the immediate aftermath of the traumatic events. Given the adverse impact that trauma can have on children, including their socio-emotional and cognitive states, it is often difficult to get children in this state, to respond to standardized IQ test questions. Thus, the results of IQ testing in children in a state of trauma are not valid or reliable—the results of IQ testing will be inaccurate as the child's difficulty to respond (due to trauma) can be misinterpreted as low IQ. Thus, where necessary, following detailed clinical assessments, decisions regarding IQ testing can be made but must be implemented only when enough time has passed to allow for the child to receive opportunities for healing and recovery as well as to return to normal daily functioning. For children who have moderate to profound intellectual disability (such as for those in BBBB shelter home), IQ tests are unlikely to be the appropriate tools for assessment. For such children, wherein the disability is more overt and pronounced, more detailed developmental assessments require to be done—so as to obtain a nuanced understanding of these children's (dis)abilities in the five domains of child development, namely physical (locomotor), speech & language, social, cognitive and emotional development.
  - A list of names of children and their mental health problems has been provided by the NGO, in their report. Problems and diagnoses such as 'externalising behaviours with hostile and instrumental aggression' are not valid psychiatric diagnoses. When children have irritability, anger, and violent behaviours towards others in the context of severe abuse and trauma (as the affected children have), such symptoms constitute post-traumatic stress disorder (which would be the appropriate diagnosis); they cannot be interpreted as conduct disorders (a type of externalizing behaviour disorder). Such misinterpretations and erroneous diagnosis will prove detrimental for the children as incorrect diagnosis will also lead to incorrect interventions.

- **On Interventions:**
  - First level (assessment) and intervention needs to focus on children's need for psychiatric medication, based on the extent and severity of trauma in each child. Certain high-risk behaviours such as self-injurious behaviours are not a matter of counselling and therapy alone, especially in children who have undergone severe trauma, and are likely to have serious mood dysregulation issues. The NGO team, which appears to have been comprised of gynaecologists and psychologists, was not equipped to assess and make recommendations for pharmacotherapy-related interventions—which (for those children requiring it) need to be administered first, for children to be in mental states that enable them, then to be receive or be responsive to other counselling interventions. There is no psychiatrist on this NGO team to assess and respond to psychiatric medication needs of the children (many of whom continue to require this assistance).
  - In several group interventions documented in the report, there was no theoretical or conceptual basis for the design and implementation of interventions: for example, there is no context in the case of these children, for conducting activities on 'understanding & developing empathy'. There was little connect between the objectives of the session and the activity itself. The report does not detail how children's art or narratives were used to process abuse and trauma.
  - Techniques such as asking children to return to the past and imagine 'significant life events' are problematic given the nature of the situation: when a team knows that therapeutic assistance is not going to be provided on a regular, continuous, sustained, medium-to-long term basis, it is unethical to get children to begin exploring traumatic events in this manner; it is also harmful to engage in such activity given the poor support systems available to the children i.e. any difficult feelings or behaviours that such activities trigger then may spiral out of control, with the institution staff neither having the skills nor resources to manage children who may get into depressive states. [In fact, one of the institution staff was reluctant to have the NIMHANS team engage with the children—she said that *'when outside teams and people like you come and talk and interact with these children, they become very aggressive…they become worse, after you leave.'* One possible reason why children's difficult behaviours get heightened following such 'therapy' sessions as conducted by the NGO are that traumatic memories are triggered and there is no one thereafter, to help the children manage their difficult emotional states].

In the light of the above, it is advisable for the Dept. of Social Welfare, Government of ZZZZ, to refrain from eliciting the assistance of organizations that do not have the requisite expertise and technical skills to respond to highly specialized issues such as child sexual abuse and trauma; continuing to engage agencies such as the one referred to above will only result in (further) child right violations if children who have already undergone such gross rights violations and trauma are hindered from availing of appropriate and skilled assistance; furthermore, the affected children are at increased risk of developing mental health morbidity in the medium to long term if the state fails to provide them with timely and skilled assistance (already delayed) at least now, moving forward.

Suggested scripts and Questions for Activity	
Impact of Event Questions	**Sample questions/ suggested questions**
Do you try to remove it from your memory?	*Do you find it hard to not think about it? Sometimes when you try to do other things to not think about what happened do you feel that the thoughts still come to you?*
Do you have difficulties paying attention or concentrating?	*When you are sitting in class is it difficult to pay attention to what the teacher is saying? Do you think again and again about what uncle did while teacher is teaching? Do you feel sometimes you go blank and have no idea about what the teacher was teaching or saying?* **If a child says that I don't pay attention because class is boring etc. you can make a note about the challenges/ attention issues and rule out that the inattention is not because of PTSD*
Do you have waves of strong feelings about it?	*Some people when they think about things that happened feel very angry or very sad…Do you also get very angry, very sad or upset about what happened when you think about it or when someone says something about it?*
Do you startle more easily or feel more nervous than you did before it happened?	*Do you feel more scared and more nervous than before it happened? Do you feel that sometimes even when you hear a small noise you feel very scared?*
Do you stay away from reminders of it (e.g. places or situations?)	*Do you feel these days that you do not wish to go near the playground (the place where the incident happened) anymore?*
Do you try not talk about it?	*Do you try not to talk about it or you feel you should not talk about it?* *I see that you do not want to talk about it? Why is it so?*
Do pictures about it pop into your mind?	*Does this incident keep coming to your mind? If you close your eyes, do you think that this incident keeps on coming to your mind? Do you see uncle or that incident when you close your eyes?*
Do other things keep making you think about it?	*Do things or other people around you sometimes remind you of uncle or what happened?*
Do you try not to think about it?	*Do you try and think that you do not want to think about it? But it keeps coming to you?*
Do you get easily irritable?	*Do you think small-small things these days make you very upset and angry? Do you think others don't easily understand what you try to do and that also makes you angry?*
Are you alert and watchful even when there is no obvious need to be?	*Even when you are with your mummy and daddy do you feel scared about what happened? Do you feel that you need to be very careful or it will happen to you again?*
Do you have sleep problems? *(to check for sleep disturbances)*	*What time do you go to sleep? Does it take long to fall asleep? Why is it difficult to fall asleep? Once you go to sleep is that okay? Or do you keep getting up?* *Do you sometimes have bad dreams?*

8. Immediate Family and Systems Responses in Child Sexual Abuse

Learning Objectives

- To develop an understanding of the significance of a multi-disciplinary response in systemic interventions in CSA cases.
- To outline issues for consideration in working with families of sexually abused children.

Time

2 Hours

Concept

A. Medical Examination and Interventions

One of the first interventions, in the immediate aftermath of the abuse, is for medical interventions to be provided. The goals of the physical and medical examination of the sexually abused child are three-fold:

- To identify abnormalities (injuries, infections and possible pregnancy) that warrant further diagnostic efforts or treatment.
- To obtain specimens to screen the patient for sexually transmitted infections, and/or pregnancy.
- To make observations and take specimens that may corroborate the patient's history of victimization i.e. gather forensic evidence for potential use during case investigation and prosecution.
- To make observations and take specimens that may corroborate the patient's history of victimization i.e. gather forensic evidence for potential use during case investigation and prosecution.

Medical Interventions

Consider…

- Treatment of injuries, including surgical interventions in case of violent abuse that may have caused substantial damage to anal and vaginal areas.
- Administration of antibiotics and other drugs for sexually transmitted diseases and/or other infection.
- Administration of HIV/AIDS testing and prophylaxis—particularly in there are risks of the perpetrator having multiple sexual partners. It would be important to liaison with a (Paediatric) Anti-Retroviral Therapy (ART) centre for these interventions.
- In case the child/adolescent is under 20 weeks pregnant, discussions about abortion may need to be done with the child/adolescent and her caregivers. It is advisable to liaise with a gynecologist/ obstetrician at this time.

Medical Examination & Tests

Physical Examination

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

Forensic Examination

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

Pregnancy Tests

- Ensure that a urine pregnancy test has been done.
- In case the results are false negative, it would be best to obtain an additional gynecological opinion.

Note: The suggested medical and examination tests are applicable in the immediate aftermath of a CSA incident or episode i.e. not one that may have been reported months after.

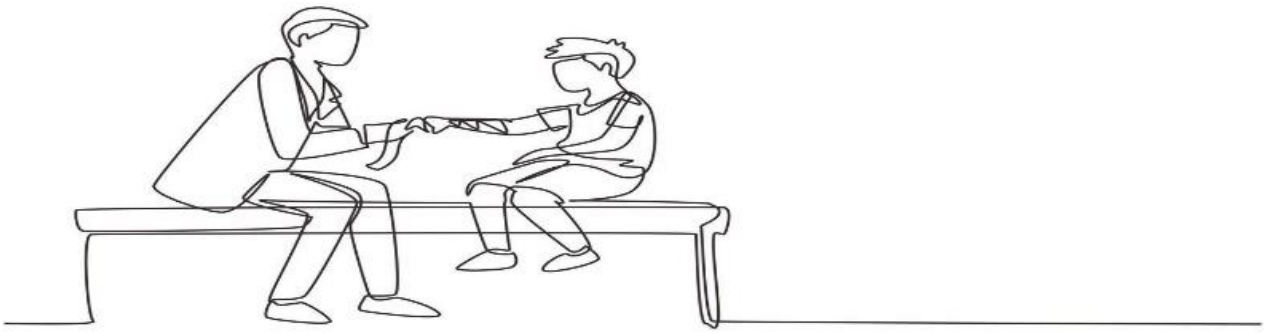
Obtaining Child's Consent for Medical Procedures

Obtaining consent and cooperation from a child, and particularly an adolescent, for medical examination and interventions can often be challenging. The reasons why children are reluctant to cooperate may pertain to: (i) viewing medical examinations (particularly of the private parts) as being similar to the actions of the perpetrator; (ii) fear of the unknown, including that medical procedures might be invasive or painful; (ii) fear of the discovery of

pregnancy. In the light of these fears that children and adolescents may have, and the sometimes even (self)harming behaviour that children may impulsively resort to in these circumstances, it is never advisable to proceed with medical examination, without adequate preparation of the child. Refer to Box X for a possible script for use with children, to help them understand the nature and purpose of medical examination, and to reassure them that any health issue is treatable i.e. that you (or a parent/caregiver) will accompany them to the medical facility, and be supportive of them, no matter what the outcomes are— such preparation and reassurance is likely to increase the chances of the child cooperating in these procedures.

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

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



Working with Adolescent Girls on Pregnancy Issues

Often, knowledge about adolescent brain physiology and functioning i.e. relating to high impulsivity, emotionality, and impaired decision-making and social judgement is applied to children in conflict with law. However, these neuro-developmental issues also make it challenging to work with adolescent girls in the context of sexuality and pregnancy, particularly when the latter is a result of a (perceived) romantic relationship, with or without elements of grooming, occurring in peer or adult-child relationships—and girls may persist in their decision to continue with the pregnancy. However, despite the many practical considerations that health workers may have about the pregnancy, thereby favouring medical termination of pregnancy, there is a need to work with the child ensuring her participation and consent, to the maximum extent possible, in decisions in this regard.

A balance between the child rights and her best interests may be ensured by engaging her in discussions that centre around: (i) an acknowledgement of her desire (to maintain the pregnancy); (ii) her life plans and dreams, in terms of education, employment and career and future (romantic) relationships vis a vis the time and investments that an infant/ child would entail; (iii) finances and child support that would be required to raise the infant, so that she/he has opportunities for optimum growth, development and education. Ultimately however, it would be the decision of the adolescent, no matter what our opinions might be—and therefore, if the adolescent decides to proceed with the pregnancy, it would entail helping her prepare for the birth of the child, and making the necessary social support arrangements, including liaising with her family. Furthermore, in order that the adolescent does not, even at a later point in time, feel limited by her (previous) decisions, it would also be helpful to also let her know of possibilities of placing the infant in adoption, after birth.

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

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

**Remember to apply the 'Non-Judgemental Attitude' frameworks we learnt under 'Communication and Interviewing Skills with Children'!*

Placement and Safety

Depending on where the abuse occurred and who the perpetrator is, it is essential to immediately take measures to protect the child from further abuse. This is especially applicable when the perpetrator is a family member or a person known to the child, and where the abuse has occurred at home or in places the child frequents on a daily or regular basis (such as school/ tutorials etc). Even in instances where the child and/or family are not willing to file an FIR with the police, it is imperative to take actions the keep the child safe i.e. remove the child from being in

contact with the perpetrator. These may necessitate (temporary) measures such as making alternative living arrangements for the child, with relatives/ extended family with whom the child feels safe and comfortable. In case the abuse has occurred at school, the child may be permitted to stay away from school until such time as other processes, legal and psychosocial, are in place; at a later stage, a change in school may also be considered, should the child and family wish not to return to the same school.

However, it is critical to involve children (particularly adolescents) in the decisions regarding these living arrangements i.e. inform them of the risks should they continue to be where they are, explain the imperative to be elsewhere (at least temporarily), offer options where available, to ensure that the child is comfortable. Please note that, despite child care service providers' best intentions about the safety and well-being of the child, when decisions have been made unilaterally and children have been coerced into arrangements that they are not in agreement with, it has resulted in serious issues such as self-harm and suicide. However, also remember that safety i.e. stopping the abuse, is our primary consideration—and nearly always, must take precedence over children's rights to consent, and participation in (placement) decisions, and also over-ride considerations of children's mental health and well-being.

Ensuring the Child's Safety…

Should the child…

- Return home and stay with parents/family?
- Be sent to relative's house?
- Be placed in child care institution?
- Where did the abuse occur?

This depends on…

- Who was the perpetrator? (a family member child was living with/ stranger…?)
- Where would the child be safe?
- Where would the child FEEL safe?
- Child's decision?

Note: Acting on child safety concerns, and placement, is also contingent upon disclosure and reporting. In case a child has not disclosed abuse to his/her parents, or child and family are reluctant to report abuse to relevant legal authorities, it might be difficult for the service provider to take the necessary measures for safety and placement. In this case, negotiations with the child (and family) would be called for in order to facilitate the requisite disclosure and reporting (See module on Mandatory Reporting for methods of engagement), that in turn would enable placement decisions for the child. While the recommendation is for service providers to make serious attempts to engage in the necessary persuasion and negotiation processes, time is of essence, and so in the interests of the child's safety, there maybe circumstances where service providers may be need to over-ride child and family reluctance to disclose or report.

Working with Families

Activity: Child Safety & Placement

Method: Discussion

Materials: Cases or situations (some are provided below but others may be invited from participants).

Process and Discussion:

- Present the following case scenarios one by one, in plenary:
    - S is a 10-year-old child who was sexually abused by her school teacher. She comes from a supportive family, with parents who are keen to assist her.
    - Y is a 13-year-old boy who was sexually abused by his sports coach during his football training practices.
    - X is a 15-year-old girl who was sexually abused by her uncle who lives in the same space as her/her family.
    - J is a 14-year-old girl who lives in a residential school. She enjoys being in this hostel and has a very good rapport with the staff. She went home for the summer holidays, to her family, and was abused by a next-door neighbour. She returns to the school after the holidays, which is when she reported the abuse to the school counsellor.
- Discuss the following in each instance:
    - What placement decisions may be best, in each scenario, and why?
    - Is there any other information that you might wish to seek and consider whilst making your decision?

There are several reasons why one of the early responses to CSA entails working with the family. A child or adolescent, as a minor, is dependent for every need, including those of safety, on the family. Therefore, the cohesiveness or functionality of a family, and its relationship with the child is one of the key determinants of the type of support that the child will receive, ranging from his/her abuse experience being believed, to access to medical and mental health assistance, opportunities for reporting and legal aid, and finally, access to justice.

How a child internalizes her CSA experiences I.e. the emergent inner voices, are contingent upon family responses, particularly as naturally, the child spends the majority of her time with family and caregivers, and the impact of CSA is therefore likely to play out maximally in her living space i.e. the influence of mental health service is likely to be relatively circumscribed, in terms of time and space. Parenting a child who has survived CSA can be incredibly challenging, as dealing with PTSD symptoms and other emotional and behavioural reactions in the child,

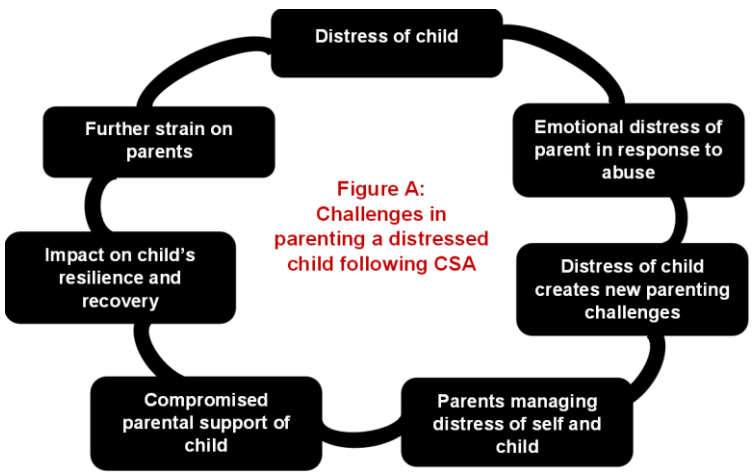


Figure A: Challenges in parenting a distressed child following CSA

in not just the immediate aftermath of abuse, but even in the months and years later. This is because the impact of CSA, depending on the effectiveness of the interventions provided after the abuse, and the degree to which mental health issues were resolved, may continue and change, based on the developmental stage of the child. This is because children often continue to try to make sense of the abuse experience, over time, and based therefore on external stimuli (particularly family responses) that they may receive. Take for example, a case of a child who was sexually abused at preschool. While interventions maybe employed at the time, to address her PTSD symptoms, even as trauma memories fade, anxiety responses and related emotional regulation issues can persist. As a result, other stressful or challenging experiences, later on, begins to invoke anxiety responses, and the child might present with anxiety disorder. Thus, parental responses, and their understanding of CSA impacts, influence the child's mental health even at a later time in the child's life. On a related note, families' responses to abuse i.e. in terms of how believing and supporting they are, also impact the child's attachment and trust in the family, again, influencing the child's relationship with the family, well into adulthood.

However, family systems, with their own dynamics, may also have limited abilities and resources to adequately support their child. Non-offending carers (NOCs) experience high levels of distress and increased isolation after their child has been abused, feeling responsible or even guilty for their 'inability' to protect their child. Furthermore, whilst caring for their child and protecting them from further harm NOCs are often compelled to navigate: (i) new and confusing systems (such as child protection procedures, police investigations etc); (ii) challenging family dynamics (such as relationship breakdowns, relocations, issues with siblings). Hence, and true of any child mental health problem, it is critical to partner with families, in order to assist the child. As in other instances, NOC very often need their own psychological support; it is well-established that positive mental wellbeing for NOCs lead to positive outcomes for children and NOCs who are well supported can in turn support their children well.

What Parents & Caregivers need to understand…

- **The importance of belief**

Where the perpetrator is biologically related or the non-abusive parent or caregiver shares a close relationship with him, the caregiver may struggle to believe or come to terms with the abuse their child. This denial is a common initial reaction to any traumatic or upsetting discovery, to be considered when assessing parental capacity (especially in the immediate aftermath of discovery). However, parental belief in the child's abuse experiences, immediately post-disclosure, and in the long term serves as an integral factor in positive outcomes for children. In fact, post-disclosure responses of parents can strongly impact attachment and shape parent-child relationships: when adults consider the 'unthinkable' and believe the child's account, and do not subsequently hold the child responsible for what happened, it could potentially strengthen relationships of attachment between parent and child; conversely, when parents ignore a child's account or actively indicate that they disbelieve the child, the relational consequences can be as far-reaching as children in later life, as adolescents and adults, adopting

Activity: Identifying Themes in Family Responses

Method: Listening to the voice of an (adult) person who had experienced CSA

Material: Audio clip (QR code for the clip provided at the end of this module)

Process and Discussion:

- Listen to the clip i.e. the voice of an (adult) person who had experienced CSA
- What issues come to mind as you listened to this experience of CSA, particularly in terms of family responses and positions on abuse?

distant positions vis a vis their parents, and rarely seeking their help or advise in complex of troubling life situations.

Thus, for these reasons, not least of which are to have parents help children deal with the immediate aftermath of the abuse (i.e. PTSD and other emotional and behavioural consequences), that working with caregivers to cultivate and develop a belief in the child's abuse account, becomes critical. Furthermore, given that children are minors, and younger children require assent and older children and adolescents are dependent on their families for care and protection, familial belief is not only a precursor, but a necessary factor in facilitating mandatory reporting processes and legal interventions.

- **PTSD reactions in child… how child's emotional state impacts daily routine and activities of child**

Feelings their child may experience of fear, anger, loss, self-blame and shame and how these emotions combined with emotional dysregulation, may manifest as difficult behaviours—which are different for different individuals, depending on the interplay of dynamics of CSA as well as parental responses to the abuse. Such behaviours may range from restlessness and anxiety, depression and self-harm behaviours to anger, aggression, substance use and high risk (or socially inappropriate)[6] sexual behaviour. These emotions and behaviours may also impact a child's abilities to engage in self-care and other daily routines of school and play. It would be useful to help them understand how and why their child is behaving a particular manner—and how they may respond at these times i.e. by reminding the child to use the first level responses that may have been taught in therapy—such as relaxation exercises and following daily routines, so as to restore a sense of security and predictability in the child's life. Refer to the two boxes below on how to work with families and caregivers to understand the affected areas of socio-emotional functioning of their child, as well as possible reasons for this.

[6] By socially inappropriate sexual behaviour, we mean sexualized behaviour, particularly as occurring in young children who have been sexually abused.

Box: Socio-Emotional Skills Inventory—For Use with Caregivers of Abused Children

Ask caregivers…how does your child do in each of these areas? Rate each area on a scale of 1 (easy) to 5 (very hard). You can use the ratings as a source of information, to select areas and activities to promote socio-emotional interventions.

Socio-Emotional Skills	1	2	3	4	5
Developing Trust: How does your child do with…					
• Connecting with others?					
• Creating friendships with peers?					
• Maintaining friendships?					
• Understanding others?					
Managing feelings: How does your child do with…					
• Recognizing their own feelings?					
• Managing big feelings?					
• Identifying helpful coping skills?					
• Using helpful coping skills?					
Problem Solving: How well does your child…					
• Solve challenging problems by (him)herself?					
• Identify or find solutions to problems?					
• Ask for help when they are stuck?					
• Take a risk and try new things?					
Empowerment: How well can your child…					
• Identify personal strengths?					
• Take the perspective of others?					
• Make his/her voice heard?					
• Take care of his/her body and mind?					

- **Long term Consequences of CSA**

  Parents caregivers need to understand that CSA not only has immediate emotional and behavioural impacts on children, but that it could also continue to impact their children's lives in adolescence and in adulthood. You would need to help them understand that any type of abuse experience, emotional, sexual or physical, hinders the child from acquiring the tools needed to cope with stress, and to learn new skills to become resilient, strong, and successful. So, an abused child may have a wide range of reactions, including depression and self-harm, anxiety, withdrawal or aggressive behaviours that may persist for long periods of time. As they get older, they may show learning difficulties, use drugs or alcohol, try to run away, refuse discipline, or abuse others. As adults, they may develop marital and sexual difficulties, depression, or suicidal behaviour. These are the reasons why seeking mental health assistance, and helping children avail of therapeutic assistance on a sustained basis is important.

Understanding Behaviours that Children might have in the Aftermath of Trauma

Fight Examples	Flight Examples	Freeze Examples
▪ Argumentative ▪ Impulsive ▪ Defiant ▪ Inattentive ▪ Lacking self-control ▪ Agitated ▪ Quick to react	▪ Avoiding others ▪ Restless ▪ Inattentive ▪ Scared ▪ Worried ▪ Jumpy ▪ Disorganized	▪ Withdrawn ▪ Numb ▪ Inattentive ▪ Worried ▪ Stuck ▪ Obsessive ▪ Non-responsive

What these behaviours might really be saying…

- I see this person or situation as a threat.
- I don't feel safe.
- I am not sure I can trust you.
- My emotions are dangerous.
- I am worried what might happen.
- I can't solve this problem.
- Others don't understand what I am going through.

- **Assistance to process parental experiences of CSA**

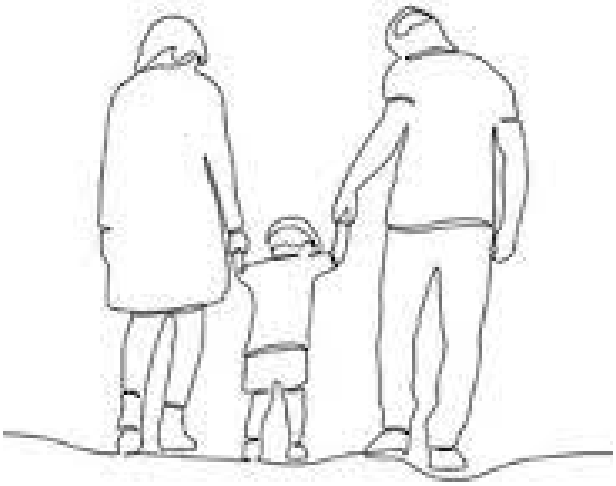
Early sexual victimization can also have lasting negative effects on parenting in adulthood. Poor parenting and family environments have negative effects on children resulting in another generation of children who are themselves sexually victimized. In particular, research has shown that mothers who report sexual victimization during childhood or adolescence are more likely to have a child who has also experienced sexual abuse for the various reasons: (i) negative consequences of sexual victimization (e.g., poverty, early pregnancy, depression, trauma symptoms, and substance use), on the mother which create a harmful environment for the child, thereby increasing the child's risk of victimization; (ii) Mothers who experienced childhood victimization engaged in harsher and more physical punishment of their young children (due to maternal depression), thus adversely impacting attachment relationships and placing the child at risk of CSA; (iii) there is also some evidence that mothers who experienced early sexual victimization may be more permissive as parents and fail to set appropriate limits with their children. It would therefore be important, where applicable, to explore caregivers' childhood experiences of abuse, its mental health impact and subsequent consequences for parenting, child protection and responses to their children's abuse experiences.

What to tell parents and caregivers…

- Do not ignore or undermine a child's statements and innocuous remarks.
- Believe what your child tells you.
- Do not to blame the child.
- Tell the child that the abuse was not the child's fault. Explain to the child about the measures that are being taken to make the child feel safe at home and at school.
- Do not blame parents for not being 'vigilant' or 'alert' enough.

(Remember how CSA occurs and how perpetrators can groom children…CSA can happen to children in caring, careful families too!)

- Show openness to the child sharing his/her experiences by saying," When you want to tell me about what happened, how you feel about it, I am ready to listen."
- Get the child back to maintaining regular home (mealtime, bedtime) and school routines.
- Help child to practice relaxation exercises.
- Discussion on how to report to relevant authorise (Child Welfare Committee if necessary), and access and medical/ psychological help systems.
- Ensure that the child is provided with emergency medical services (EMS) (within 24 hours of filing the FIR) provided by state Registered Medical Practitioners (RMP) in government hospitals.
- Seek counselling from child mental health experts in government institutions to ensure that psychosocial assistance and healing interventions are provided to the child; and that evidence gathering and other legal processes are embedded within the healing context.
- Encourage parents to be balanced in their care after CSA…over-protection not desirable as it can increase children's anxieties.



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Additional Materials

Audio Clip for Activity on 'Identifying Themes in Family Responses'

Molested When Dad Was in The Hospital

https://www.youtube.com/watch?v=drMPkpFGn7c

9. First Level Psychosocial & Mental Health Interventions: Developing Scripts for Responses to Children

Learning Objectives

- To provide psychosocial interventions in the immediate aftermath of sexual abuse—so as to prevent (further) mental health morbidity.
- To develop verbal responses to children's initial confusions and queries about child sexual abuse experiences.

Time

3 Hours

Concept

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

The Importance of First Level Psychosocial Responses to Child Sexual Abuse

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

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

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

Initial Response to Children's Queries and Confusions

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

Professionals many times, may be empathetic to children who are sexually abused, but sometimes despite the empathy and understanding struggle to respond to when children disclose about their abuse. They may feel overwhelmed, or sometimes may not know what to say to children when children narrate their sexual abuse experiences/ or when children break down or cry while sharing these experiences. We may therefore, get completely silent or say something like "I am so sorry…it (the abuse) won't happen again, we will keep you safe", "what happened to you was very very bad, we will make sure he gets punished for hurting you…" or "don't be sad…what has happened has happened …focus on your studies now", "I am with you, just forget about whatever happened and move on". While many of these responses have a good intention to distract the child from traumatic feelings the problem with these responses is that these responses are not balanced. These responses are more avoidant and do not actually address the fears and worries or the inner voices that may be causing anxiety in children.

It is important to carefully think about the following as we respond to children-

- Can we really ever guarantee that the abuse incident will never happen again and despite our best efforts, can we always keep child safe? There may sometimes be situations that may be out of our control. Think about what will happen if the child experiences something similar (sexual abuse) or is threatened or violated by the abuser again…what will happen to your therapeutic relationship with the child? What about child's inner voices them? The idea is not to tell the child that we absolutely cannot guarantee anything because that would be devastating, but to reflect and see if we can provide balanced responses to children.
- We are aware that the court makes its decisions based on the evidence and sometimes despite the efforts from the child, the lawyer and the mental health professional, an acquittal may happen due to lack of evidence. What kind of impact would it have on the child when we say that if they say the truth and tell the judge everything the person (abuser) will definitely get punished. What do you think will be the inner voices of the child if the case actually results in acquittal?
- Or when we say don't be sad and forget about what happened. Are these really legitimate responses? Can a person ever hit a delete button and forget about their traumatic and difficult experiences?

Therefore, as we respond to children it is important that our responses are – truthful, comforting and reassuring and is appropriate for the child's developmental age and child's experience. Let us try writing some scripts and practice providing first level responses.

Examples and Suggested Scripts for First Level Responses

Activity: First Level Responses to Children's Experiences of Sexual Abuse
Materials: Case studies
Method: Case study analysis and discussion.
Process:

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

Discussion:

- Ask each sub-group to present their list of questions and responses in plenary.

Invite the others to attempt responses also and provide comments and feedback.

Case 1: An 8-year-old is being sexually abused by the school bus driver. He cries all the time and has nightmares and tells his mother that he does not want to go to school any more. One day, his mother (who does not know about the abuse) has forcibly brought him to school and the child tells you what is happening on the bus daily.

Inner voices:

- *I am scared of driver uncle.*
- *I don't want to go to school.*
- *Why did driver uncle do this to me, I am dirty boy now…*
- *What was that strange thing driver uncle did to me?*
- *Why does mummy not understand me?*

Response:

You know sometimes people like driver uncle are bad people. They do bad things to children and sometimes even to older people. They don't think about how what they do can hurt others. They are uncaring. I believe, if anyone would have been in your place they would also have been scared and they may also would not have wanted to go to school. Maybe you are worried that driver uncle will hurt you again if you to the school and go in the school bus. I can talk to mummy so that you can be at home for a few days to rest and relax and do something nice to take your mind off this.

I also feel that since you have not told mummy about this that is why she thinks that driver uncle is good or she made you go to the school when you didn't want to. I understand that you may have your reasons for not telling her, and maybe we can talk about those. We can also then tell mummy about what driver uncle did. We can even tell your teacher in school so that they remove driver uncle so that you don't have to be scared of him in on your way to the school or in the school. And in a few days when you are ready to come back to school maybe we can ask mummy and daddy to bring you to school for a few days or weeks till you feel okay.

Case 2: A 15-year-old girl is suddenly doing poorly in academics and getting into arguments with her peers; when people get upset with her or ask her why she is behaving that way, she just bursts into tears. One day, you call and

gently ask what is troubling her…she tells you that her uncle, who visits her home regularly, comes into her room each night and touches her genitals. [She also tells you later that her father's friend has touched her similarly once].

Inner voices:

- Why does this happen to me again and again?
- Is something wrong with me
- Is it my fault…

Response:

Sometimes things happen by chance. It has got nothing to do with you. Imagine a war situation, when bombing occurs the bomb is not directed at a particular house. It is a matter of chance that the bomb lands on that house. Similarly, if a house gets robbed and a few months later the house gets robber again. Do you think it's the owner's fault or they invited the robbers into their house …or is again a matter of chance. What if these owners had the best security system in place but it still happens…can they be blamed for the robbery?

Just like these situations, when someone hurts you, it is not your fault or it is not because something is wrong with you. These people are bad people they look for children who are available. It could have been anyone in your place.

Case 3: A 10-year-old is an orphan child residing in a child care institution. He came to the counsellor for treatment for behaviour problems, during the course of which he reported sexual abuse by one of the institution staff (other staff deny that this happened in their institution, saying child is lying).

Inner voices:

- I don't have parents that is why everyone is doing this to me …
- No one will believe, I am bad they don't like me…they will obviously say its my fault.
- What if they remove me from the institution if I tell them?

Response:

We see many children they may come to us and report these experiences. Many of them also live with their parents and some do not have parents. So, this can actually happen to anyone irrespective of whether they live with their parents or without them. I understand that you have had some problems with the staff here and you have had issues with the children but that does not give anyone the right to hurt you. No one, no matter what has the right to hurt children. I believe you and I do not think it is your fault. I know that it must be hurtful that some people did not believe you when you told them about the problems, sometimes people do not believe because they do not have information and therefore, they are unable to understand.

You know there are also special rules and laws in the country to keep children safe. If we go ahead and report the police, they will remove this person from the institution. He will not be allowed to come back. We will also ensure that you have a safe place to live and are not left alone. Just like this child care institution there are several other child care institutions. We can give you some options, of course you can choose to stay in the same institution, but if you feel unsafe in any way then we can show you these other institutions. You can go and visit these institutions and uncle will definitely not be there.

Case 4: A 15-year-old girl has been sexually assaulted by a 19-year-old boy; he first be-friended her, told her that he loved her and then engaged her sexually—she says that the sexual activity was without her consent. However,

now she also tells her parents that she does not want a police complaint lodged against him and that she wants to be with him—to move out of home and live with him. She is sad and depressed but also aggressive at times, threatening self-harm if her parents do not allow her to be with the boy.

Inner voices:

- He said he loved me …then why did he do this to me?
- I love him and I don't want him to get into trouble.
- I don't want to be away from him and live …I will die without him.

Responses:

I see that this person told you that he loved you and it is a great feeling when someone says that because everyone wants to be loved and cared for. I understand that you may be confused or sad or even angry because you are not with him and maybe you also feel that no one understands you at the moment. Maybe you have a lot of questions in your mind about what has happened and you even miss him. I can help you by discussing some of your thoughts about this situation, your parent's concerns. We can even then think of ways in which you can feel better and less stressed about everything.

We can talk more about relationships and I can share some ideas with you in which you can differentiate between good and bad people and choose who to trust and make decisions about engaging with them as a friend or in a relationship, so that you can make more solid decisions and avoid getting hurt in the future. I want you to know that I am on your side and I want the best for you…

**Use the window approach framework with the child to get into more discussions with the child to talk about boundaries, privacy, consent, relationships, health, and safety and finally abuse.*

Case 5: A 16-year-old girl rescued from sex trafficking is now in a child care institution. She was trafficked by her family. She has been in sex work for the last two years. She is angry and aggressive all the time. She is mistrustful of people and keeps talking about revenge. At other times, she says that her life is over—since her self-respect has been taken away.

Inner voices:

- Why did this happen to me?
- I have lost my honour
- What will I tell people if I ever go back home…everyone will know what has happened to me and what I have done.
- I will never get married, or have no relationship or future. (could be a common inner voice of many adolescents who are rescued from trafficking)

Response:

I don't know why your family made the decision to send you away but I know that it has been very difficult for you. When people who are closest to us make decisions that can hurt us or do things that can hurt us…that can naturally make us feel angry and make us feel like no one can ever be trusted. You are absolutely justified therefore in feeling angry. But remember there are different kinds of people in the world…some who have also gotten you out of these difficult situations.

I also understand your worries about going back home…well you do not have to tell everything to everyone. You can simply tell people that there were some difficulties back at home and you had to go out and work and you did not like it…the working conditions were not as you had imagined to be and therefore you decided to come back

for good. And just because a criminal act was committed against you, that does not mean that you cannot be married or fall in love…you absolutely have the right to fall in love and be married.

***To provide perspective on the issue of losing honour, get the child to do the exercise in the next box* - Where does my self-respect and honour lie *and engage in discussion*.

Responding to Young Children's Sexual Abuse Experiences

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

It was my fault…Maybe I could have prevented or stopped it from happening.
"Of course, it was not your fault. It was his fault and wrong-doing. He was bigger and stronger than you, so it would have been difficult for you to stop him. But you still tried to do your best and that counts for a lot—it shows how brave you are."

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

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

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

(In case child is hesitant to tell parents/ caregivers…) I don't want to tell my parents…they will get angry and punish me…or they may think that I am lying.
"I see that you are afraid that your parents might disbelieve you and be upset with you for talking about what is happening. But if you allow me, I can help you explain to them what happened…the reason I feel it is important they know about this is that they can then help to stop the hurt and keep you safe."

Preparing the child to give legal evidence (such as the magistrate's statement as per Section 164, POCSO)…
"As we said, no one is allowed to hurt children. If they do, we have rules in our country about how people should behave with children. If someone breaks those rules and harms children, then action will be taken against them—by the police and judges. [Just like we have rules about stealing and breaking into people's houses—where also the police and judges will catch people who do that and take action against them]. So, we need you to tell the judge what this person did/ how he hurt you…the judge may ask you a few questions which you don't have to be scared of. S(he) only know so that s(he) can protect you and other children from bad people who hurt children. I/ your parents will be with you, so you will not have to meet the judge alone…"

Responding to Adolescent's Sexual Abuse Experiences

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

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

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

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

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

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

Activity: Where does my self-respect and honour lie? **

Material: Paper and colours

Method: Art and narrative

Process

- Ask the child to take a blank page.
- Ask the child to draw a picture of their self-respect or dignity. (Ask them to think and draw- What shape or form does it take? What colour is it? How big is it?)
- Help the child with the prompts and ask them to do the following sentence completion activity.

I am XYZ's Self Respect

- I am …
- I feel…
- I live in…
- It is difficult for me when…
- People hurting me makes me feel…
- It will help me if…
- Other people see me as…
- I feel destroyed when…
- I wish that…

Discussion

- Can we give a special name to the self-respect?
- When the difficult voice says 'XYZ' about you or your respect, what does the special self-respect voice say? Or What can this special voice say to make the self-respect feel better?
- Develop alternative inner voices to help the child change the inner voices about their honour and dignity.
- Ask where does the self-respect reside in their body? Is it a body part like their – hand or feet or neck…etc. or if it is the mind.
- If the self-respect indeed lies in the mind - Can someone else touch it? Or can another person take it away?
- Share perspective that a girl/ woman's honour does not lie in vagina and therefore the idea that if they have been sexually abused, they lose their hour or dignity is also flawed. Remind that the honour or dignity is in our minds, it cannot be taken away. It is about how we see things, what we make of them…it is about our thoughts and feelings. A person who hurts the other person loses the honour or dignity and not the one who has been hurt.

Suggested Readings

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Additional Materials

Case studies for Activity on 'First Level Responses to Children's Experiences of Sexual Abuse'

Case 1: An 8-year-old is being sexually abused by the school bus driver. He cries all the time and has nightmares and tells his mother that he does not want to go to school any more. One day, his mother (who does not know about the abuse) has forcibly brought him to school and the child tells you what is happening on the bus daily.

Case 2: A 15-year-old girl is suddenly doing poorly in academics and getting into arguments with her peers; when people get upset with her or ask her why she is behaving that way, she just bursts into tears. One day, you call and gently ask what is troubling her…she tells you that her uncle, who visits her home regularly, comes into her room each night and touches her genitals. [She also tells you later that her father's friend has touched her similarly once].

Case 3: A 10-year-old is an orphan child residing in a child care institution. He came to the counsellor for treatment for behaviour problems, during the course of which he reported sexual abuse by one of the institution staff (other staff deny that this happened in their institution, saying child is lying).

Case 4: A 16-year-old girl rescued from sex trafficking is now in a child care institution. She was trafficked by her family. She has been in sex work for the last two years. She is angry and aggressive all the time. She is mistrustful of people and keeps talking about revenge. At other times, she says that her life is over—since her self-respect has been taken away.

Case 5: A 15-year-old girl has been sexually assaulted by a 19-year-old boy; he first be-friended her, told her that he loved her and then engaged her sexually—she says that the sexual activity was without her consent. However, now she also tells her parents that she does not want a police complaint lodged against him and that she wants to be with him—to move out of home and live with him. She is sad and depressed but also aggressive at times, threatening self-harm if her parents do not allow her to be with the boy.

10. Other First Level Psychosocial & Mental Health

Learning Objectives

- To learn techniques and methods for containment of anxiety immediately after the child sexual abuse experience.

Time

2 Hours

Concept

Children who have been sexually abused first and foremost require time to rest and recover from traumatic experiences. They may therefore be encouraged to play, listen to music, do art activities purely for recreational purposes—to keep them entertained but at the same time also occupied (so that they are not sitting idle and constantly thinking about the traumatic experience). Play activities also help children with emotional regulation. Parents and caregivers must be encouraged to spend quality time with children, playing with them and reassuring them about their safety, but not trying to extract details of the abuse. First level psychosocial responses to sexually abused children consist of a range of interventions from ensuring the child's immediate safety to responding to children's anxieties regarding the abuse, to rest, relaxation, leisure and maintenance of the child's developmental trajectories (as detailed below).

Relaxation Exercises

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

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

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

Belly breathing

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

Calm Breathing

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

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

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

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

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

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

Resuming Daily Routine and Developmental Activities

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

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

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

Setting Up a Sleep Routine

It may be common for children or adolescents to struggle with sleep after their difficult and traumatic experience of sexual abuse. Among the most common consequences of stress and trauma are disruptions of sleep – these may include shorter sleep duration, difficulty falling asleep, frequent awakenings, nightmares, sleepless nights, and early-morning wakefulness. As the bedtime approaches, as the surroundings become quieter, the thoughts about abuse may whizz through their mind, making it difficult to fall asleep or stay asleep due to nightmares relating to the abuse. Due to the anxiety that they may experience in the night particularly around bedtime, some children (even the older ones) may even insist on sleeping in the same bed with the caregiver. One of the ways to contain anxiety is to ensure that the sleep cycle is maintained after the difficult experience. Sleeping adequately will ensure the child is rested and relaxed.

Sleep Rituals…for Caregivers to Implement

- Finish dinner early (an hour before the bedtime)…work with the child to make the bed.
- Put a clean bedsheet, pillow, and a blanket (in case the weather is cold). Allow the child to keep and choose bedsheet that they like. (for e.g. with their favourite colour, design) for sleeping.
- Keep a separate pair of night clothes. Get the child to take a warm bath or wash her/his feet, hands and face and change into the night clothes.
- Give the child scented soaps, bath oils ((depending on his/her preference).
- Dim the bedroom lights.
- Lie down or sit next to the child, and read a book or talk about their day. Remember, the conversations must be light and not distressing.
- Sing to the child, or sing with the child. In case, the child likes listening to music, some soft and soothing music can be played in the background.
- Tell the child that you will be there till he or she goes to sleep, or if the child insists you may even sleep in the child's bedroom for a few days so that the child feels safe (however, explain to the child that it is only a temporary arrangement).

Do and Learn Activity: Yoga Nidra

Material: https://www.youtube.com/watch?v=Liclug_lHkY

Process:

- Have the child lie down in a comfortable position.
- Use the deep breathing techniques; ask them to breathe in and out.
- The child can put their hand on their stomach as they breathe to feel the movement of their stomach.
- Remind them that when they breathe in the stomach goes out and when they breathe out the stomach goes in.
- Ask the child to tightly squeeze the body muscles and the gently relax them. You can say, *"Relax every muscle in your body by squeezing and releasing them…make a fist…tighten it …as much as you can…tighter …tighter and now release…Tighten your shoulders as much as you can…tighter, tighter, and now release…*
- Take the child through the relaxation activity, focussing on each body part and muscle in the body.
- Take a pause for about 3-4 seconds as you move from one body part to another.
- As the exercise finishes ask them to take a few deep breaths and open their eyes.
- Yoga Nidra scripts and guided sessions are available on YouTube. You can experiment with different scripts.

Sample Script

Tell the child, *"As you hear the different parts of your body mentioned, repeat the name of the part silently, move all of your awareness into that part of your body, tighten the muscles in that body part and gently release. Notice the movement from one part to the next"*

Right hand thumb … 1st finger … 2nd finger … 3rd finger … 4th finger … palm of the hand … back of the hand … wrist … forearm … elbow … upper arm … right shoulder … armpit … chest … waist … hip … groin … buttock … thigh … knee … calf … ankle … heel … sole of the foot … top of the foot … right big toe … 2nd toe … 3rd toe … 4th toe … 5th toe. Left hand thumb … 1st finger … 2nd finger … 3rd finger … 4th finger … palm of the hand … back of the hand … wrist … forearm … elbow … upper arm … left shoulder … armpit … chest … waist … hip … groin … buttock … thigh … knee … calf … ankle … heel … sole of the foot … top of the foot … left big toe … 2nd toe … 3rd toe … 4th toe … 5th toe.

Move your awareness to the top of the head … forehead … right temple … left temple … right ear … left ear … right cheek … left cheek … right eyebrow … left eyebrow … eyebrow center … right eye … left eye … right nostril … left nostril … whole nose … upper lip … lower lip … chin … jaw … throat … right collarbone …left collarbone … right chest … left chest … heart center … upper abdomen … navel … lower abdomen … tailbone… right buttock … left buttock … the entire spine, from the tailbone to the base of the skull … right shoulder … left shoulder … back of the neck … back of the head … crown of the head.

Now feel the whole right arm … the whole left arm … both arms together … the whole right leg … the whole left leg … both legs together … the entire upper body … the face … the head … the body … the whole body … your entire body.

Explanatory Models of Somatic Pains

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

Children may also have fainting spells and black-outs when they feel overwhelmed with anxiety relating to the abuse event and wish to avoid or dissociate from event and its memories[1]--fainting and black outs are a mechanism to cope with or avoid situations that provoke high levels of anxiety. It is important to help caregivers understand that children in such situations are not lying or pretending or being dramatic.

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

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

Caregivers should be advised to:

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

Explanatory Model for Children

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

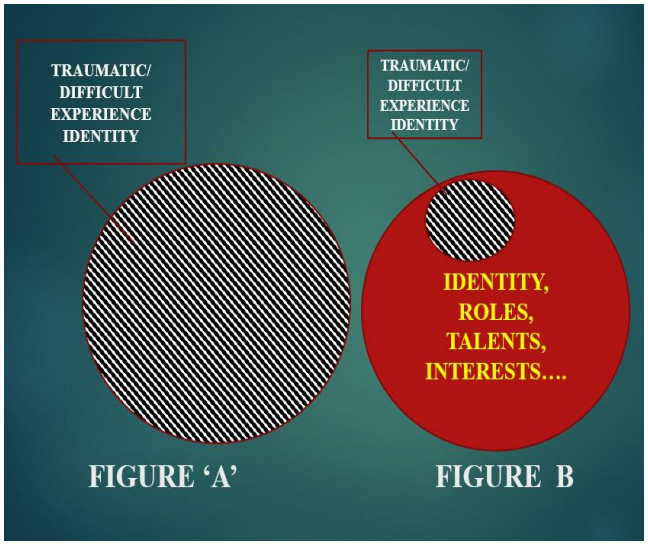
Explain the mind-body relationship
Example 1: What happens when some children become very tense about an exam? They sweat, their hands shake and they have butterflies in their stomach, stomach ache etc. These physical symptoms do not occur by themselves or in isolation…but they also do not occur because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

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

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

Identity Exercises

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



See diagram alongside: figure 'A' shows a child's identity when it is fully occupied by abuse and the child thinks 'I am the girl who was sexually abused'; figure 'B' shows a child's identity when interventions are provided to transform the child's identity and the child is able to think 'Sexual abuse is one life experience— and a very difficult one but I am more than my abuse…I am a sister, a daughter, a student, a citizen of the country…I am a good singer, a helpful friend…a girl who

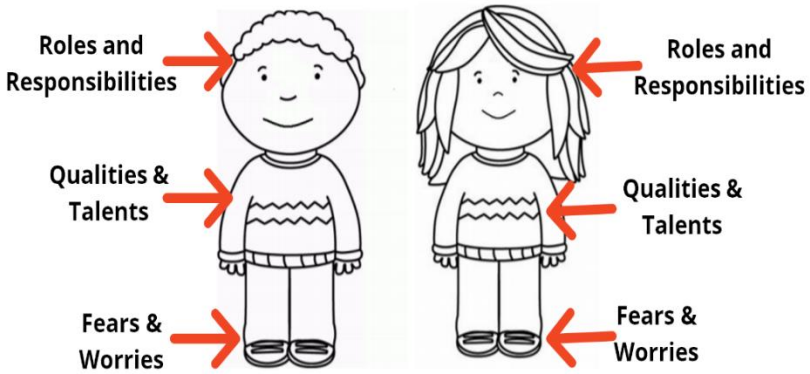
is interested in sports and dance, a lover of animals…' Thus, figure B shows the child's identity as it is when she is able to see herself as much more than a person who has been abused…and recognize that her identity is made up of roles, qualities and talents, interests, wherein abuse is just one part of her life and identity.

If interventions are provided, a sexually abused child's identity moves from A to B i.e. the abuse experience which occupied the whole identity in A gradually shrinks (it may not completely go away as it cannot always be forgotten) to become what it is in B.

Activity: Who am I?
Material: paper and pencil
Process:

- Draw a body outline (as shown in the next slide) and explain that "this is you"
- Divide the figure into four parts, telling the child that 'this represents different parts of you'.
- Write in the following (on different parts of the body drawing, for example, roles & relationships on the head, qualities & talents on stomach, fears & worries on feet.
    - Roles & Relationships (as a teacher, student, family member, friend…)
    - Qualities & Strengths (things you are good at, characteristics, special gifts you have)
    - Fears & Worries/ traumatic experience (things that make you scared/ sad…)

- Discuss with the child:
    - Identity is how you perceive yourself.
    - Identity is not just what you don't manage to do i.e. your worries, fears and failures or your bad experiences. Similarly, X (child's name) is not equal to his/her abuse experience…abuse is not the only thing that makes you who you are…it is one experience in your life.
    - Identity is also your roles, your gifts, your talents, your efforts, your perseverance…
    - You can also use the above explained visual/ figures A and B to explain identity and abuse to the child.



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11. Towards Healing & Recovery

Learning Objectives

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

Time

6.5 Hours

Concept

Trauma Informed Care

Trauma Informed Care (TIC) is considered a comprehensive multilevel approach that shifts the way organizations view and approach trauma. A program, agency or system that is trauma-informed is one that: (i) understands the impact of trauma i.e. recognizing signs and symptoms; (ii) acknowledges the potential paths for recovery by integrating knowledge of trauma into policies, procedures and practices. It involves validation and recognition of the effects of traumatic events, common coping strategies, and effective treatments. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), TIC is centred around the following key principles:

- Safety—Promoting a sense of safety involves a conscious effort to ensure that children feel physically and emotionally safe.
- Trustworthiness and transparency—Agencies and mental health service providers/counsellors must approach decisions with transparency and to engender trust in affected children (particularly in the wake of betrayal and loss of trust that occurs in CSA).
- Social support—A supportive social network, by way of families and other care providers such as in child care institutions can be critical sources of support. Together they contribute, through various means, to the healing of children impacted by abuse and adversity.
- Empowerment, voice, and choice—Developing plans of action for children and adolescents requires patient-centered approaches that offer them options, and allows them to participate in decisions that impact their lives, so as to restore agency and ensure empowerment (this is important, given the loss of agency and disempowerment that CSA caused to them).
- Cultural, historical and gender issues—Interventions must take into consideration and strongly address socio-cultural and gender stereotypes and prejudices that are likely to impinge on healing processes.

TIC helps provide a widespread understanding among caregivers in the home, school, and community, including in child care institutions that a child's inability to regulate emotions or behaviour does not mean the child is "bad," but rather that the social environment is not meeting the needs of the child in some way and that the child is likely to have had extremely difficult experiences, that he/she has been unable to contend with. TIC therefore not only applies in more overt trauma contexts where CSA and other forms of maltreatment is known to have occurred; it is exceedingly important to apply this lens within juvenile justice systems, in the context of children in conflict with law—where children's difficult social behaviours are often explained by (early)childhood trauma and resultant

vulnerabilities and risks. Thus, TIC approaches enable systems and stakeholders to focus on what is most important–for example, what is triggering the child, and how to help the child self-regulate. Narrative therapy approaches and Trauma-Focused Cognitive Behavioural Therapy, amongst others, helps children develop a trauma narrative, allowing parents, service providers, and other caregivers to provide appropriate support through a shared understanding of the child's unique experience with trauma.

Activity: Exemplars of Trauma-Informed Care

Objective:

- Understanding and identifying trauma-informed care in therapeutic communications with children and adolescents.

Material: Demo Videos (QR codes for videos available at the end of this module).

Process:

- Let us consider the TIC approach in the context of children and adolescents who are trafficked from sex work…to understand how the above-described principles may be applied…
- View the videos

Discussion:

- What specific elements of trauma-informed care did you find striking?
- What do you think healing processes need to address?
- Extend the discussion to children in the context of sex trafficking…wherein raid, rescue, repatriation, reintegration and redressal are the interventions commonly discussed.
    - What about reclamation of self (and of affirmative sexuality)?
    - Elements of reclamation entails a focus of healing & recovery:
        - Therapy for Extreme Trauma and PTSD
            - Working through difficult feelings
            - Making sense of abuse experiences…moving from confusion to clarity
            - Reclaiming identity and self-hood
        - Counselling on Sexualization
            - Learning about personal safety
            - Life skills education on happy, healthy, safe sexual behaviours
            - Reclaiming affirmative sexual identity
        - Addressing (Other) High Risk Behaviours and Conduct Issues
            - Learning coping/stress management skills
            - Learning emotional regulation skills (and relaxation techniques)
            - Life skills education & training on substance use/conflict resolution/decision-making

**Moving forward, we are going to engage in skill building exercises, to understand what each of these healing and recovery interventions means in (child mental health) therapeutic practice.*

Narrative Approaches

"Trauma narratives are relevant for the way they are told and received" (p.13). To be clear: trauma itself cannot be reduced to a narrative, but narratives are how people engage in retrospective meaning-making of their traumatic experiences. This retrospective meaning-making can be an important site of healing and can engender networks of care and support."

–Ellison, 2014[7]

Narrative approaches are helpful in the implementation of trauma-informed care interventions as they allow opportunities for children and adolescents to share narratives and reflections in ways that build new understandings (to the self) through trauma discourse. Such a discourse on trauma provides building blocks for young people to construct counter-narratives that can challenge socio-cultural stereotypes, prejudices and indeed perceived individual deficits in themselves. It can provide a socio-cultural (re)framing about how the gaps are within social systems, and it is these inequities and injustices that need to be 'fixed' and that 'we are not bad or broken people'.

John Briere's Self-Trauma Model also elucidates the importance of developing a coherent narrative, as one of the interventions in addressing childhood trauma. The fragmented recollections of traumatic events, which often lack explicit chronological order, are likely to cause additional anxiety, insecurity and derealization in contexts of incomprehensible events; this in turn, may hinder trauma processing. Research shows that when trauma survivors are assisted to provide a clearly articulated, well-organized and detailed account of their trauma experience, their trauma symptoms are likely to decrease. This is because they have the space to give voice to their stories, and their experiences are believed and validated; and a coherent trauma (or abuse) narrative increases the child's sense of control over his or her experience, reduces feelings of chaos, and increases the sense that the universe is predictable and orderly. Also, when the therapist provides responses (recall the session on first level responses and how CSA may be explained to children), children are better assisted with emotional and cognitive processing of their fears and anxieties. They may thus even receive some degree of 'closure' as therapist responses might 'make sense' and fit into their models of understanding. Furthermore, eliciting a coherent narrative, including the meaning that the child has made of the abuse experience (as suggested by Sandra Weiland's Internalization Model), provides a platform to shift the narrative i.e. change the (distressing) inner voices.

Helping children (re)construct coherent narratives of the trauma experience, and to re-author problem stories, may be done through the use of art or letter writing (see activities below). Such methods serve as a way to create alternative narratives thereby facilitating the re-telling of problem stories by 'externalizing' the problem—so that children see themselves as separate from their problems. The creation of alternative narratives helps shift the focus for children to be fighters of something external to themselves as opposed to the conventional process wherein the child thinks he/she needs to change internally. Externalization of this nature may help create solutions and identify realities they may not otherwise have considered.

[7] Ellison, T. L. (2014). An African American mother's stories as T.M.I.: M.N.I., ethics, and vulnerability around traumatic narratives in digital literacy research. International Journal of Qualitative Methods, 13, 275-292.

Trauma-Focussed Integrated Play Therapy

Many traumatized children, for instance, become too terrified and even paralyzed to provide narratives. However, even young children experience and remember trauma in non-verbal, visual, auditory, kinaesthetic, visceral, and affective modalities, but has difficulty 'thinking' and processing the experience. Expressive therapies, of which play therapy is one type, does not rely on verbal communication. Therefore, play therapy can offer opportunities for trauma processing to young children or those with developmental delays, or those who feel unable to, or unwilling to, engage verbally. It also helps to (re)construct trauma narratives, helping children gradually make sense of what happened to them, and allowing for therapeutic responses to be provided in ways that help them feel safe again, and to form attachment bonds and social connections again. The Trauma-Focused Integrated Play Therapy model is implemented in the following way:

Phase 1 sets the therapy context, allows the therapeutic relationship to build, encourages a period of exploration by the child client, and most importantly, creates opportunities for the child to access reparative resources and activities. The mental health service provider or therapist…

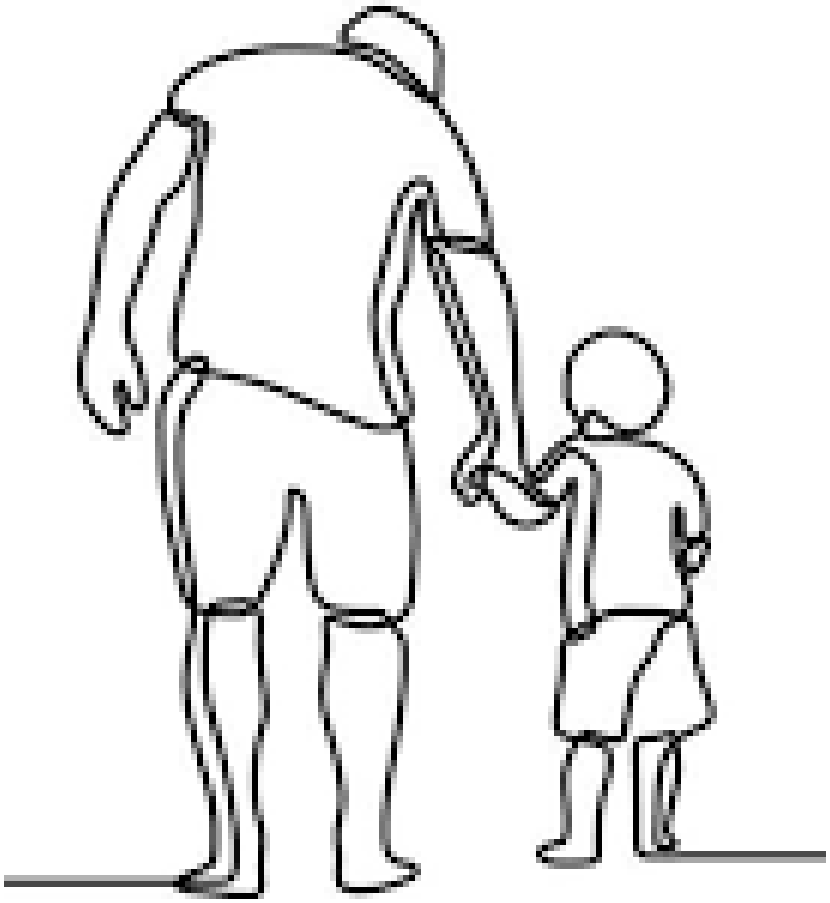
- Familiarizes the child with the setting, the structure, and offers a nondirective play therapy stance, that can feel like a relief and restore a child's sense of personal control.
- Shows the child around, or introduces child to the play room, asked for his/her ideas about why he/she have come to treatment (and if inaccurate, the child is given the accurate context of why he/she are in therapy).
- Simply allows the child to choose what she/he wants to do, what she/he wants to play with, and how long she/he wish to spend with any single activity.
- Provides reflective and empathic communication, follows the child's lead, and provides unconditional acceptance.
- Allows the child to explore, to find comfort in their play, and eventually, to encourage and welcome children's use of symbolic play to manifest concerns or confusions, worries and joys.

Phase 2 addresses traumatic material directly with the intent of creating a trauma narrative and restoring control and mastery, wherein the mental health service provider or therapist…

- Guides the child through a more directive exploration of his/her abuse, to create a narrative of what occurred, how he/she felt and thought about it.
- Facilitates the overriding goal which is for the child to clarify his/her thinking, express feelings through words, actions, or symbolic play, and achieve a certain sense of mastery over the thinking and telling of something that might have been intolerable earlier.
- Uses methods and techniques may entail games, sand play, art or use of toys/puppets to help them tell what happened to them, what they thought and felt, what they did or wanted to do.

Phase 3 of treatment is to encourage positive social interactions, identify coping strategies, refine new skills, and affiliate with others, wherein the mental health service provider or therapist…

- Focuses on the child's restoration to age-appropriate social contact, identification of important resources in a variety of settings, and helping the child balance his or her view of the abuse.
- Helps the child view the abuse in perspective, by exploring the trauma and clarifying a number of issues including that the responsibility for the abuse being with the abuser.
- Helps to restore trust so that the child does not expect to be victimized in the future (and can thus feel less afraid), also by identifying helpers who are available to listen to and respond to his/her concerns and worries.
- Aims as clearing or resolving doubts and confusions that can cause shame or fear or guilt have been resolved so that the child has the best possible understanding of the abuse that he/she can have given his/her age and cognitive abilities.



Activity: Therapeutic Interventions for Trauma

Objective:

To engage in skill-building exercises, to understand healing and recovery interventions in (child mental health) therapeutic practice.

Material: (i) Art-Based Activities for Developing and Shifting Trauma Narratives & Internalizations; (ii) Letter-Writing therapeutic activity; (ii) Activities for Trauma-Focused Cognitive Behavioural Therapy (excerpts/ samples provided below)

Time: 5 hours

Process:

- Assuming that you have a group of facilitators for the training, assign two to three activities (within each of the above-mentioned categories) to a given facilitator.
- Each facilitator may set up a work station (preferably in different rooms or at least in different corners of a large space).
- Work stations may thus be titled 'Art-based methods for Shifting Trauma Internalizations', 'Letter Writing in Therapy' and 'Trauma-Focused Cognitive Behavioural Therapy' (with further sub-divisions).
- Trainees/participants may be divided into sub-groups (of about 7 to 8 persons per sub-group) and requested to move from one work station to another, to obtain an understanding and exposure to the afore-mentioned therapeutic methods.
- A sub-group may spend about 30 minutes in each work station, engaging in approximately 2 to 3 therapeutic activities.
- At each work station, the designated facilitator: (i) provides a brief overview of the activity; (ii) gives the instructions to take the participants through the activity (so they understand/ experience how it is done; (iii) discuss the processing of the activity as it needs to be done with children.

Discussion:

- Following the exposure of all participants to all work stations, the group re-convenes.
- In plenary, they are asked to share their comments and experiences of the time spent in learning therapeutic methods…these may be linked back to the introduction provided on various trauma intervention approaches.

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- LaMotte, J. (2011). Psychotherapeutic techniques and play therapy with children who experienced trauma: A review of the literature. *Undergraduate Review*, *7*(1), 68-72.
- Frances Waters DCSW and LMFT (2005) When Treatment Fails with Traumatized Children … Why?, Journal of Trauma & Dissociation, 6:1, 1-8, DOI: 10.1300/J229v06n01_01

Additional Materials

Videos for Activity on 'Exemplars of Trauma-Informed Care'

Trauma Informed Care Part 1

https://www.youtube.com/watch?v=v48OEXJcLF4&t=5s

Trauma Informed Care Part 2

https://www.youtube.com/watch?v=T7450JocdCg

My Own Grandfather Sexually Abused Me (Quint)

https://www.youtube.com/watch?v=Q6WDuRQLYjU

For Activity on 'Therapeutic Interventions for Trauma'

A. Art-Based Methods for Developing and Shifting Trauma Narratives & Internalizations
(Excerpts and adaptations of activities adapted from Karp, C.L., Butler, T.L. (1996). Treatment Strategies for Abused Children—From Victim to Survivor (Interpersonal Violence: The Practice Series). Sage Publications. USA).

Activity: Memories, Nightmares and Monsters
Objective: Exploration of trauma

Materials: paper, pencil, colours/crayons

Process:

- Explain to child: *"Remembering everything that has happened is not easy. Remembering can be hard to do because it is painful to think about things you wish didn't happen. Sometimes when things are too scary, you forget or "block" memories, which may make you think that nothing happened. Your dreams may be a way of helping you remember scary things. Scary dreams or nightmares are very frightening, but if you let them, they can help you learn more about things that have happened and about your feelings. So, we are going to do some things that will help you learn how to talk about the things you remember, and about your*

feelings…if you have scary dreams or nightmares, you could learn new ways to get help. If you have 'monsters that scare you, you may learn how to tame them and be more in charge."

- *Part 1: Invite child… "draw a picture about a dream that you can remember".*
- *Part 2: Invite child… "draw a picture of a dream that made you happy.*
- *Part 3: Invite child… "draw a picture that made you feel scared".*
- *Part 4: Invite child… "draw a picture of 'your monster'".*
- *"Part 5: Invite child…"draw a picture of a cartoon helper that can be your special helper or super power".*

Discussion:

- Each of the above pictures, parts 1,2,3, and 4 should be followed by a discussion to elicit a (coherent) narrative of the traumatic event and how the child interpreted it, including the attributions that the child may make, and emergent feelings…
    - Tell me what the picture shows…who are these people? What is happening here?
    - Acknowledge the child's experience and feelings in each instance—also interjecting the narrative with positive responses such as 'how brave of you to…' to help the child see other perspectives in his/her story.
- With regard to part 5, discuss: Who is your hero? How can he/she help you reduce or deal with difficult memories…help you when you feel scared?

Activity: Secrets
Objective:

- Helping to tell the difference between happy or fun and scary or worrying secrets.
- To use words to share scary secrets.

Materials: paper, pencil, colours/crayons

Process (A):

- **Explain to the child:** "It can be fun to be surprised, like at a surprise birthday party, that everyone has kept secret. Safe secrets are fun to keep for a short period of time, like a surprise birthday party. Difficult or unsafe secrets can make you feel worried—and its okay to tell someone you trust about the things that make you feel scared or worried. It is important to know and understand the difference between fun secrets and scary or worrying secrets…and we are going to talk more about this today".
- **Tell the following story to the child:**

Samantha was 11 years old. She thought she was old enough to go to summer camp like her friends. Instead, her mother told her that she was going to stay with her grandparents again. This made Samantha feel very upset. She didn't like going there anymore. The summer was a hard time for her mother because her mother and step-father got divorced. She depended on her parents to watch Samantha and her younger sisters.
Samantha hated leaving her neighbourhood where she spent her time playing with her best friend, Jamie, who lived in the same apartment building. She especially hated the "special" times when her grandfather would take her fishing. It was there when he first touched her in her "private places". He told her it was their "secret" and that no

one would believe her if she told. Samantha was confused. She used to like the special times they spent together but wished he would not touch her that way anymore.
As Samantha packed to go to her grandparents, she wondered if her grandfather did anything like that to her mother. She wondered if she should tell her mother. After all, this wasn't a fun secret like Jamie's birthday party.

*[Alternatively, use the "To Tell or Not to Tell" story from SAMVAD's Child Sexual Abuse Prevention & Personal Safety available at https://nimhanschildprotect.in/wp-content/uploads/2021/03/CSA-prevention-Module-7-12-yrs-Activity-4.3-To-tell-or-not-to-tell-1.pdf]

Discussion (A):

- What is the difference between safe and unsafe secrets?
- What was the fun or safe secret in this story?
- What was the unsafe or difficult secret in this story?
- What do you think Samantha should do? [What dis Pinky and Chintu finally do about the secret they had? Was it a good idea?]

Process (B):

- Invite the child… *"draw or write about how secrets make you feel".*
- Invite the child… *"draw a picture of a place where you feel safe to share difficult secrets".*
- Invite the child… *"draw a picture of people you can share your difficult secrets with."*
- Invite the child… *"write or tell a story about a child who was afraid to tell his/her difficult secret…you can begin with 'Once upon a time…'"*

Discussion (B):

- Explore the dynamics of threat and blackmail in the abuse process—helping the child to understand that anyone who threatens us or tells us to keep secret that make us feel worried or scared is not a good person.
- Explain to child:
    - "Many times, people who hurt kids tell them "not to tell". Sometimes they may say they will "hurt you, hurt your family, or something terrible will happen". When this happens, it can be very scary to use words and actually tell someone your secret".
    - "But it is important for you to know that you are worth being loved, that your safety is important…so it is helpful for you to tell the 'scary secret' to someone you trust…so that they can ensure that you are safe and not hurt."
- Discuss 'safe people' and safe spaces' (in reference to the child's drawings/ pictures) with whom the child can share secrets with…why does the child feel safe in these spaces/ with these people?

Activity: Letting Go of Guilt and Shame

- **Explain to the child:** *"You may feel like it was your fault when others were hurting you. Their words and actions may make you feel guilty and full of shame. It is not your fault when others make wrong choices and hurt you. So today we are going to talk about this, so you realize that it is not your fault."*
- **Invite the child… "draw a picture of who hurt you and what you would like to say about being hurt."**
- **Ask the child to complete the following sentences:**
    - *Sometimes I believe it was my fault because…*
      But it was not my fault because…
    - *Sometimes I believe it was my fault because…*
      But it was not my fault because…
    - *Sometimes I believe it was my fault because…*
      But it was not my fault because…
    - *Sometimes I believe it was my fault because…*
      But it was not my fault because…

Discussion:

Help the child understand…

- Everybody wants to be cared for and loved. The problem is that not everyone knows how to show feelings in healthy ways. Sometimes others end up saying or doing hurtful things.
- It is very confusing when someone you trust hurts you instead of keeping you safe. This person may even have made you feel that it was your fault…and that you should be ashamed.
- But we are not responsible for the mean or hurtful things that others may sometimes do to us. So, you don't have to continue to worry about them or what happened…it was never your fault.

Activity: Working through Stuck Feelings

Process (A):

- Explain to the child: We have talked about your difficult and hurtful experiences, and also many of your feelings about them. But you may have some more feelings about what happened. It is important to talk about these feelings as you start to feel them…because they might make you feel 'stuck'. But by using words to talk about them, you can get 'unstuck'.
- Ask child to…
    - *"Think about the things that make you feel sad. Make a list of them…or draw a picture of things that make you sad.*
    - *Complete the sentence:* "I feel sad when…"
- Next, ask child to…
    - *"Think about the things that make you feel scared. Make a list of them…or draw a picture of things that make you scared".*
    - *Complete the sentence:* "I feel scared when…"
- Then, ask child to…

- *"Think about the things that make you feel angry. Make a list of them…or draw a picture of things that make you scared"*.
- *Complete the sentence:* "I feel angry when…"

Discussion:

- Acknowledge the child's feelings of sadness/fear/anger following each of the above activity processes.
- Tell the child that you are glad he/she is sharing some of these difficult feelings with you (though it's never easy to talk about difficult feelings).
- Explain how when we do not talk about these feelings, and we keep them within us (often pushing them deeper and deeper, trying to avoid them), they never actually go away…and like a pressure cooker, if there is no place for the steam to escape, will burst, we also 'explode' from time to time…bursting into tears, or getting really angry, for instance.
- Explain that it is normal and legitimate to have such feelings when people have done mean and hurtful things to us; that it is good to talk about these feelings as they arise…because talking about them helps us get them out of our minds and bodies, little by little…and that's how we also slowly start feeling better, happier…and can move forward (leaving behind the painful things that happened).

B. Therapeutic Use of Letter-Writing

Activity: Letters from the Future

Objective:
Using a creative counselling technique of having children/adolescents write letters—to themselves or others—from a future context.

Method: Letter writing

Process:

- Return to the childhood trauma that you remembered on the first day.
- Now write a letter to yourself…imagine that you have grown to be an older, and wiser person (about 5 to 10 years later).
    - What do you think that this wonderful, older, wiser you would suggest to help the current/younger you get through this current phase of your life?
    - How would he/she tell you to view or understand the problem you have?
    - What would she/he tell you to remember as you move ahead?
    - What would he/she suggest that would be most helpful in healing from the past?
    - What would he/she say to comfort you?
    - How would he/ she tell you to take care of yourself and nurture yourself?

Alternative methods:
The child/adolescent may be asked to write a letter to a fictional friend who may have disclosed sexual abuse to him/her. The letter may focus on: advice, suggestions, or support for use during the difficult period after disclosure…the child's learnings (through his/her own experiences) about abuse.

C. Trauma-Focused Cognitive Behavioural Therapy (TF-CBT)

TF-CBT incorporates elements of cognitive-behavioural, attachment, exposure therapy, and family therapy models to address the unique needs of trauma-affected children. It has been used successfully to treat children with a variety of trauma experiences, including complex trauma. TF-CBT components are summarized by the acronym PRACTICE: **psychoeducation and parenting skills, relaxation, affective regulation, cognitive coping skills, trauma narration, in vivo mastery[8], conjoint child-parent sessions, and enhancing safety and future development.** Try out the activities (below) focussed on affective regulation and cognitive coping skills…(drawn and adapted from *Phifer, L.W., Sibbald, L.K. (2020). Social-Emotional Toolbox for Children & Adolescents—116 Worksheets and Skill Building Exercises to Support Safety, Connection and Empowerment. PESI Publishing and Media. USA*)

Activity: Dealing with Emotional Triggers or Reminders

Objective:

- To recognize emotional triggers or reminders of the traumatic event.
- To cope with these triggers in alternative ways.

Material: paper, pencil

Process:

- **Explain to child:** "When difficult or frightening events happen to us, the sounds, sights, smells that we experienced at that time may come back to us at a later time, again and again. Usually, we see or hear or smell something…or it could be people, places or actions… that reminds us of that painful time when we felt unsafe…and then it feels as if the 'danger' event is going to happen all over again. Our mind and body have certain reactions to this fear. Let us explore some of these triggers and reminders in your case…and see if we can find some helpful ways to cope with them".
- Ask the child to write or draw…What types of reminders or triggers cause uncomfortable or unsafe feelings in you?
    - Sounds (eg-loud voices, slamming of a door, the noise of a car…)
    - People (eg-strangers, certain features of a person…)
    - Places (eg- specific spaces…)
    - Actions (eg- being unexpectedly touched on the shoulder…)
    - Other triggers
- In each case, encourage the child to write or speak about, his/her reaction to the trigger…is it…
    - Fight (eg- you (want to) refuse what you are being asked to do/ yell/scream/ hit someone/break or throw things, hurt or harm yourself…)
    - Flight (eg- you (want to) running away, hide, avoid the place or person, become restless, cannot concentrate…)
    - Freeze (eg- you feel stuck in a certain part of the body, feel cold or numb, physical stiffness or heaviness of limbs, like it is difficult to breathe, feel faint, numb and withdrawn…)

[8] helping the child overcome their avoidance of generalized reminders and work towards mastering more specific reminders i.e. developing a hierarchy of reminders to work with the child to gradually master feared stimuli, working from least feared to most feared.

Discussion:

- Explain that in the aftermath of a difficult and traumatic event, it is but natural to have such feelings and reactions.
- However, they may not always be helpful to us i.e. these feelings and reactions themselves may create other problems for us. They might make us feel more uncomfortable or they might get in the way of our daily activities (such as school and play) or make our inter-personal relationships (with family and friends) difficult.
- It is therefore important to know and recognize these triggers or reminders…so that we can do something at the time, to feel better i.e. safer or more comfortable/ less fearful.
- What can we do to try to feel better? Discuss activities that the child enjoys doing or what helps him/her feel soothed or calmed…such as listening to music, doing some cooking, going for a walk, playing, drawing and painting…(as age-appropriate and in accordance with child's interests).
- Suggest or teach the child techniques of deep breathing and guided imagery.

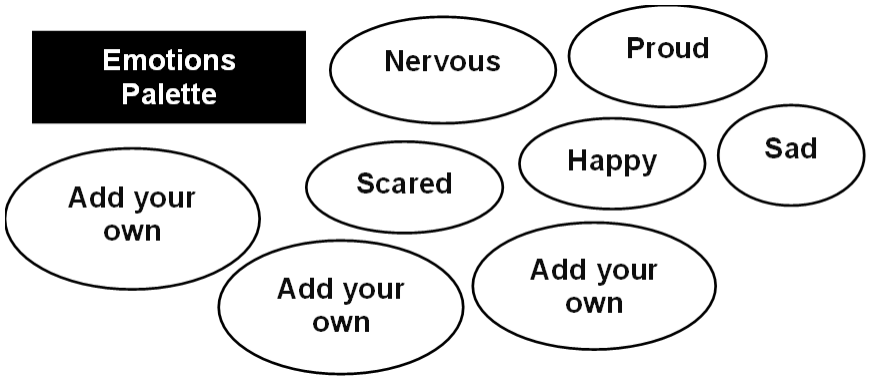
Activity: Emotions Palette: How Do You Feel?
Objective:

- To enable greater awareness on emotions.
- To facilitate identification and expression of emotions.

Materials:
Paper and colours/crayons

Process (A): Creating the Emotions Palette

- Explain to child: "Just like artists and painters use a palette of emotions to express their work and thoughts (through a picture), you can create an emotional palette to help you express your thoughts and moods. We are now going to create a colourful palette of emotions or feeling words.

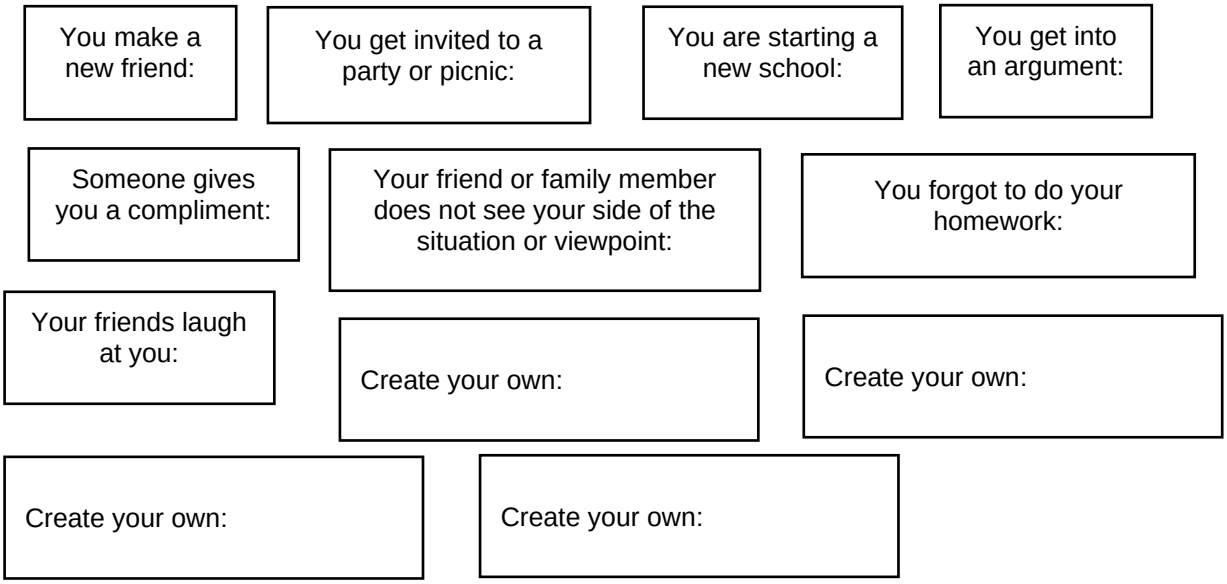


- Provide child with a sheet of paper with a few emotions written into circles…
- Ask child to colour in these emotion circles…and continue to add more circles with other emotions.
- The child may even add 'shades' (of light and dark within circles to indicate the degree of emotion…eg- scared vs terrified.
- Make as exhaustive a list as possible, of emotions…as many as the child can think of.
- Provide gentle prompts such as 'What is your feeling when…your mother makes your favourite food? …When your grandmother who you love very much comes to visit?

Alternative method: Use the 'Feelings Wheel' activity as explained in SAMVAD's life skills education manuals available at: https://nimhanschildprotect.in/life-skills-emotional-for-children-full-manual/ or https://nimhanschildprotect.in/wp-content/uploads/2021/03/Life-Skills-Adolesce-Socio-Emotional.pdf

Process (B): How You Feel

- Ask child to:
  - Read each scenario (in the boxes below) and write a feeling word in the box that matches how you feel.
  - Then colour in the box with the colour represented in the emotions palette.
- Encourage child to create additional scenarios relevant to him/her and colour these in too.



Discussion (A& B)

- The child may be encouraged to post his/her emotions palette next to him/her bed or on the refrigerator…where he/she can see it frequently.
- Explain to the child:
  - Building an emotional vocabulary helps you convey better how you are feeling, to others.
  - How different events and situations make us feel are personal to each of us—we each may feel differently in a given situation.
  - It is important to understand what feelings we have in different situations, so that we are then able to think how best to express them…in ways that help us feel safe and comfortable, without also hurting or upsetting others.

Process (C): Emotions and Body Language

- **Explain to child: "***Although emotions are felt in the mind, they can also affect how our bodies feel. For example, big emotions like anger or excitement can make your heart race and cause your mind to run at a million miles a minute. Other emotions like sadness can make our minds work slowly or wonder, and our bodies feel heavy and lethargic. We have talked about different emotions…and also the situations in which you feel them. Let us try to understand how your body feels or responds when certain emotions are felt by your mind…and look at how differently the body can respond to different feelings".*
- Take the child through the matrix below and ask him/her to identify how his/her body responds in case of each emotion. [If child struggles to imagine the emotion, make it more practical and relevant, by referring back to the emotional situations previously discussed…bringing these back for child to remember how his/her body experienced these emotions when they happened).

Body Responses	Happy/Excited	Calm/Peaceful	Angry	Worried	Sad
How do your hands feel? (Sweaty, dry, cool…)					
How do your muscles feel? (Clenched, tingly, relaxed…)					
What is your mind doing? (Wandering, racing, tired…)					
What is your heart-beat like? (fast, slow, normal…)					
How are you talking? (Loud, fast, slow…)					
How is your breathing? (Rapid, difficult, relaxed…)					
Other…					

Discussion (C):

- Explain to the child that each situation and emotion thus also causes bodily reactions.
- Talk about the mind-body connection…and how the body also 'feels' the emotions that the mind is thinking about. [You may also use the examples provided in the 'First level Psychosocial Responses module].
- This activity is also an opportunity to discuss dissociation with a child who might be experiencing this as a trauma symptom—helping him/her understand how extreme fear and anxiety can cause such difficulties i.e. that the body perse is not sick but that the emotions are causing the body to react in ways that make the body faint or black-out or certain body parts hurt i.e. the painful emotions cause pain in the body.
- Discuss that there are ways to lessen the painful emotions so that the bodily reactions also become less uncomfortable.

Activity: Coping with Feelings

Objectives:

- Identifying the intensity of emotions.
- Coping with 'big' and difficult emotions.

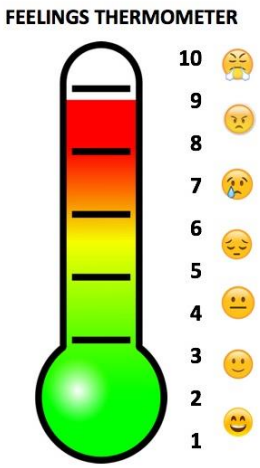
Materials: Feelings thermometer chart (shown below); coping mechanism cards (provided below)

Process (A): The Feelings Thermometer

- Explain to the child: *"Feelings, especially difficult feelings like fear and anger, can range in intensity (or strength) from light and manageable to heavy and out of control. So, people not only feel different emotions in different situations, but the degree of emotion also varies. Let us first do an activity to understand how you*

experience different degrees of feelings in different situations…especially when we have 'big' or difficult feelings, like fear or anger.

- Present the following chart to the child—with a 'feelings' thermometer, which measures how high the level of an emotion is (such as anger or fear).



Feeling (Anger or Fear)	Situations/ Events
I FEEL OUT OF CONTROL!	
This is making me furious! Or I am terrified!	
I feel upset. Or I feel nervous.	
Something is bothering me… I feel irritated. Or I feel worried.	
I can handle this.	

Process (B):

- Explain to child: There are many things we can do to manage big or difficult emotions. We call these as 'coping skills'—which are essentially tools we use to help us manage emotions and stay in control.
- Ask child to:
  - Explore the list of coping skills provided on the cards.
  - Use the feelings thermometer matrix created (above), and place the coping cards against each feeling and situation—to try to get through the stressful time… *"what coping skills would you use to help you get through different intensities of emotion?"*
  - As the child places the coping cards, discuss why he/she is selecting a given activity to cope, how and why this would help, including what (harmful) actions it may prevent the child from engaging in.

Coping Cards

Discussion:

- Discuss with child:
    - When we are faced with challenging or upsetting situations, we use our coping skills to bring back feelings of safety, calmness and control.
    - Many times, in the absence of these coping skills, we tend to use other actions to cope—such as yelling, screaming, breaking things…or self-harm and substances—in the hope that they will make us feel better. While such actions may help us feel better, this is only temporary…and they then create their own set of problems, making it even harder for us.
    - That is why it is important to use coping skills that help us stay healthy, and that neither hurts us nor others…such as the ones we have listed.
- Conclude the discussion by asking child to identify two most stressful feelings (in relation to current experiences) and identifying two new coping skills he/she would like to use, and complete the statements below:
    - *When I feel_____I will_____to be calm and in control.*
    - *When I feel_____I will_____to be calm and in control.*

Activity: Designing Your Own Coping Space

Objective:

- To create a safe personal coping space, to relax, re-connect and re-charge.

Material:

Paper and colours/ crayons

Process:

- Tell child: "*When we are confronted with difficult situations and events, or feelings, it often helps to have a space where we can feel safe, relax and calm our feelings. Let's design such a space for you today…"*
- Ask child to use the paper and colouring materials to draw and design the space, using the following prompts, as she/he works through it:
    - Where would your space be? (At home/ at school/ somewhere else…)
    - What colours would you want to decorate it with?
    - What type of light would it have? (natural/dim or bright lighting…)
    - What types of comfort items would you have? (toys, pillows, games, books…)
    - What kind of furniture would you have?
    - Would there be music? If so, what kind of music…?
    - What kind of scents would you want? (The smell of fresh air, of scented candle or *agarbatti*…)
    - Who might you (sometimes) allow into that space, to be with you?
    - What activities would you do in this space?
    - If you had to give this space a special name, what would it be?

Discussion:

- How do you think this space could help you?
- In what specific stressful situations would you use it?
- How do you think it might help with difficult events and feelings?
- The possibility of actually creating this space in the child's home…

[Note: This activity is best done with children who have the opportunity and resources to create such a space].

Activity: Mandala Colouring

Objective:

- To facilitate emotional containment and stress relief expressing creativity.

Material: Black and white print-outs of mandalas (plenty freely available on the internet!), colouring materials (crayons/ colour pencils)

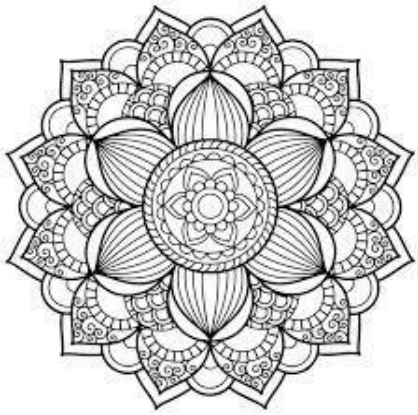
Note to facilitator: *Mandalas are circular geometric designs with repeating patterns. They are often used for meditation (in the traditions of Hinduism, Buddhism, and Jainism or Japanese lifestyle of Shintoism), and symbolize a feeling of wholeness. Carl Jung said that a* ***mandala*** *symbolizes "a safe refuge of inner reconciliation and wholeness". Colouring mandalas is an art therapy technique, aimed at relieving stress, and increasing focus through enabling creative expression. Colouring mandalas is often used therefore, as a method to reduce stress in the context of anxiety disorders and post-traumatic stress disorder.*

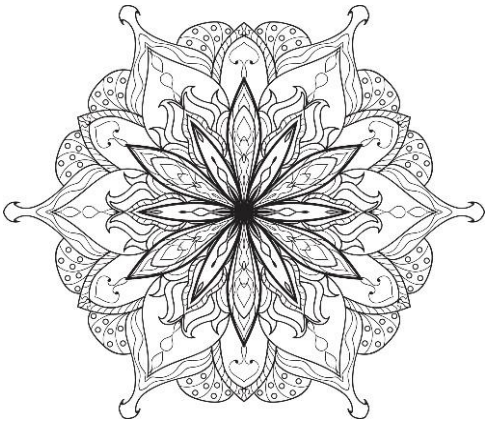
Process:

Provide child with a black and white image of a mandala.

Explain to child: *"What you see is a type of figure called a mandala. A mandala is a circular figure—in fact the word mandala, in Sanskrit, means circle. So, as you can see, mandalas are special circles that have unique meanings—because each mandala has different patterns. Mandalas can use different colours, but they all have something in common—symmetry…which means that if you fold this image in half, both parts will mirror one another.*

Ask child to colour it in…slowly, with the use of as many colours as possible, perhaps with a plan to use colours in ways that are balanced or symmetric (although not necessarily so).





Discussion:

- Help the child understand the colouring of mandalas as an emotional regulation strategy by explaining how:
    - Colouring a mandala requires much patience and focus…which means that we have to concentrate and be very much in the present (as opposed to letting the mind wander to other things).
    - Sometimes, when we are emotionally upset or stressed, colouring in a mandala helps to feel slowly calmer and more relaxed, and more in control of our feelings.
    - Because we need to pay close attention to the design of the mandala, and the colours we are using, colouring it in helps us concentrate better, also moving the mind away from other disturbing thoughts.

12. Long Term Interventions in Child Sexual Abuse (B): Awareness and Personal Safety Education

Learning Objectives

To use life skills approach to address safety and protection concerns of children by:

- Enabling them to understand and apply personal safety concepts in day-to-day life.
- Enabling them to recognize sexual abuse if and when it takes place and report the same.
- In case of sexual abuse, enabling children to provide narrative, on child sexual abuse in a gentle and non-threatening manner and then provide them with personal safety education in order to keep safe in future.

Time

4.5 hours

Concept

What Life Skills are about

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

In recognition of the importance of life skills and with a view to making it accessible to all children and adolescents, the WHO[2] and other national initiatives advocated strongly for life skills education to be made available in schools, through training of teachers and as part of school mental health programs[3]. See table below on details and specifics of life skills domains.

Activity: Perceptions and Knowledge

Material: None

Method: Theatre technique

Process:

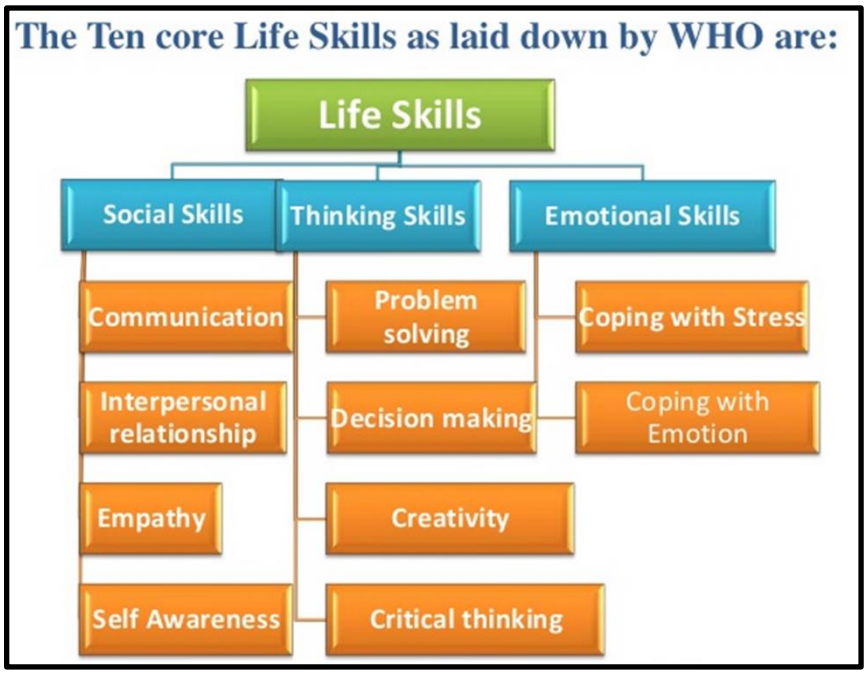
- Ask one participant to volunteer (before the session begins and do not explain anything to the participants yet)
- Ask the volunteer to sit with a slouch and hand on the forehead at a place where participants can see them as they enter the room.
- As participants enter the room just allow them to observe this person.

Discussion:

- Ask the participants what do they think would have happened to this person?
- Collect as many responses as possible.
- Explain that in this instance they could all be correct and there is no right or wrong answer.
- Explain that there are no correct answers. Because all of them shared their perceptions about what they saw.
- Explain that life skills education is about collaborative construction of knowledge through integration of multiple perceptions/ perspectives

Need for Life Skills Approach

Every child comes from difficult and traumatic circumstances; each child is unique in that he/she has his/her own story, is impacted again, in unique ways. The life skills approach takes into consideration the fact that children in similar contexts have different processes and outcomes and conversely, children with the same manifest issues come from different contexts. This approach therefore helps recognizing this 'equation' to effectively construct interventions. Second, given that all children in difficult circumstances require psychosocial assistance and, that resources are scarce, providing individual interventions to each child is not possible. Trained personnel, with the knowledge and skills on how to deal with children's issues, especially with complex and difficult problems, are especially scarce and have resulted in inappropriate and unhelpful responses to children, on the part of caregivers and child care agency staff. As a result, many children



requiring assistance to deal with the difficult psychosocial contexts they are in and come from, do not receive it. Further, most mental child health problems (except for those such as psychosis and those caused by organic factors or physiological problems) may also be viewed as life skill deficits. For instance, violent and abusive behaviours result from children's inability to regulate emotions, negotiate inter-personal relationships and/or resolve conflicts in alternative or creative ways; thus, the objective of any therapeutic work with such children will be to enable them to acquire the life skills to manage anger and aggression—in other words, to manage emotions, develop creative thinking, problem-solving and conflict resolution (life) skills. Children in difficult circumstances (as discussed above), exposed to experiences of deprivation and abuse from early childhood, develop emotional and behaviour problems which may also be viewed as being created by life skill deficits i.e. due to their difficult circumstances, children have not learnt certain life skills, and that results in emotional and behaviour problems.

These life skill deficits, if not addressed, then exacerbate emotional and behaviour problems, increasing the risk for more serious and chronic mental health disorders. The Life Skills approach, only can be used with an individual child but also uses group intervention approaches, therefore ensures that larger numbers of children receive psychosocial assistance to address their emotional and behaviour problems by helping children build the life skills that they may lack.

Severe emotional deprivation and difficult family contexts may have led them to seek out relationships of love and sexuality either with their peers or older adolescents or adults—in such cases, while there is apparent 'consent', they are not always cognizant of the health and psychosocial risks of their sexual behaviours and decisions and are thus vulnerable to abuse and serious health consequences. Many of these children have received little supervision and have not been engaged in discussions on how to make choices about relationships and sexuality.

Finally, it is important to mention here that sex education (as it is called in schools and institutions that pride themselves on conducting such programs) is very different from life skills education and training on sexuality and relationship issues: the former merely imparts information about the body and physiological processes of reproduction, usually in a manner that is didactic (teacher to student or parent to child); the latter may include some discussions of physiology, especially on parts that pertain to health and safety, but the emphasis is on the socio-emotional component of sexuality. This includes an understanding not just issues related to safety but also emotion such as attraction and love, of relationship contexts, for instance, based on which recognition of abuse and coercion take place; and the learning of skills such as assertiveness and refusal ('saying 'no' to sexual overtures if desired), or negotiation (for condom use and safe sex), and problem-solving (coping with peer pressure that compels an adolescent to experiment with sexual acts

Life Skills…

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

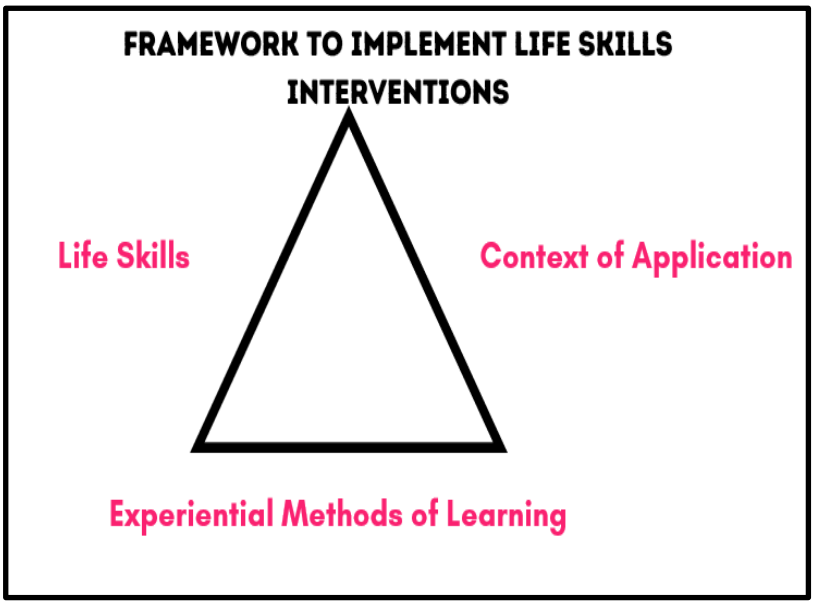
Decision-making and Critical Thinking Skills	Decision making /problem solving	• Information gathering skills
		  ○ Evaluating future consequences of present actions for self and others
		  ○ Determining alternative solutions to problems
		• Analysis skills regarding the influence of values and attitudes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

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

		• Relaxation techniques

The Life Skills Approach

One aspect of psychosocial assistance to such children is curative work with children who have suffered abuse; the other is preventive work, through equipping children with life skills to protect themselves from abuse and other psychosocial problems. While many agencies attempt to impart life skills (and state that they do life skills group activities with children) on issues such as sexuality and relationships, they appear to follow didactic positions, adopted as a result of their personal opinions and viewpoints. This contradicts the essence of life skill promotion work—which entails that all individuals participate equally in the production of knowledge, and that this is a continuous dialogue; and that learners are the subject, not the object, of the process. What this means is that life skill development is not about articulating one's own positions and convincing the adolescent to adopt the same beliefs; it is about adopting an open stance (despite one's own experiences and personal opinions) and creating a space for debate and discussion, so that adolescents can examine and analyse an issue or situation from multiple view points and come to their own conclusions on what might be the best course of actions. In this, the use of creative methods such as stories and narratives, theatre and other art forms, help create the life situations and contexts (such as marriage, sexuality, conflict etc) that form the basis of the discussion. Let us now try some life skills activities, and see how these issues can be discussed using a window approach framework.



The good touch and bad touch debate

We do not advocate the use of 'good touch and bad touch' or 'safe and unsafe touch' approaches to sexual abuse prevention because the so-called 'bad touch' can feel good and right to children or adolescents; in certain situations, especially where abuse entails lure and manipulation or complex grooming processes, children and adolescents can find it exceedingly difficult to distinguish between 'good and bad touch'; promoting sexual touch as 'bad touch' negatively impacts the development of affirmative sexuality i.e. children and adolescents should not associate sexuality as being a 'bad or negative' as this will have other harmful consequences on their relationships, health and happiness in the future.

Activity: Life Skills in Action

Material: Activity Sheets provided under additional materials (for the convenience of the facilitators some activities have been selected for the purpose of demonstration. These are drawn from SAMVAD's Life Skills manuals designed for different age groups. The Life skills manuals have several more activities of this nature, which can be chosen for the demonstration purposes)

- Child Sexual Abuse Prevention & Personal Safety (Pre Schoolers and Children with Developmental Disabilities)

https://nimhanschildprotect.in/wp-content/uploads/2021/03/CSA_Prevention-Preschool__Disability_Kids.pdf

- Child Sexual Abuse Prevention & Personal Safety (7-12 years)

https://nimhanschildprotect.in/wp-content/uploads/2021/04/CSA_Prevention_Module_7_12-yrs_Oct_2017.pdf

- Adolescent Life Skills Series II: Gender, Sexuality and Relationships

https://nimhanschildprotect.in/i-life-skills-gender-sexuality-relationships/

Method: Demonstration

Process and Discussion:

- Divide the participants into groups. Divide the groups based on the number of participants available. Ensure there are at least 3 participants in each group.
- Ask the participants to go through the activity sheets provided. Give about 20 minutes to prepare for demonstration.
- Ask them to use the aids provided with the activity for the demonstration, encourage them to use their own creative ideas to develop aids. (provide them with art material- sketch pens, glue, chart papers, colours, scissors etc. if required)
- Tell the participants that-
    - They are required to facilitate the activity exactly as they would with children.
    - During the demonstration all the other participants will be children.
    - Ask them to introduce the activity, give instructions and follow the discussion points/ questions as set out in each activity.
- Cap the activity with some 'meta-processing' i.e. comments pertaining to the use of a certain type of methodology, or to content (also linking it to concepts discussed thus far in the training program).

Suggested Readings

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- Singla, D. R., Waqas, A., Hamdani, S. U., Suleman, N., Zafar, S. W., Saeed, K., ... & Rahman, A. (2020). Implementation and effectiveness of adolescent life skills programs in low-and middle-income countries: A critical review and meta-analysis. Behaviour research and therapy, 130, 103402.
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Additional Materials

Videos for Activity 'Life Skills in Action'

Adolescent Life Skills Series II: Gender, Sexuality and Relationships
Activity 8.3 – Decisions to Engage in Physical Intimacy
https://nimhanschildprotect.in/wp-content/uploads/2021/03/Activity-8.3-Decision-to-engage-in-physical-intimacy-Hindi.mp4

Adolescent Life Skills Series II: Gender, Sexuality and Relationships
Activity 8.5 – Readiness for Physical Intimacy
https://nimhanschildprotect.in/wp-content/uploads/2021/03/Activity-8.5-Readiness-for-physical-intimacy-Part-1-Hindi_01.mp4

Adolescent Life Skills Series II: Gender, Sexuality and Relationships
Activity 8.8 – Peer Pressure
https://nimhanschildprotect.in/wp-content/uploads/2021/03/Activity-8.8-Peer-pressure-Hindi.mp4

Adolescent Life Skills Series II: Gender, Sexuality and Relationships
Activity 10.3 – Peer Pressure
https://nimhanschildprotect.in/wp-content/uploads/2021/03/Activity-8.8-Peer-pressure-Hindi.mp4

Note: The activities 8.8, 8.5, 8.8, 10.3 from the Gender, Sexuality & Relationships Manual are described below.

Materials for Activity on 'Life Skills in Action'

Each activity first describes the **Methods** and **Materials** it will use; and then lays out the **Process** or the steps to be followed on how to implement the activity; the process is followed by **Discussio**n which provides questions for discussing and processing the activity and summarizing thoughts and learning derived from the activity. While the modules from the life skills manuals are best used in chronological order, they can also be used as stand-alone modules, in case the facilitator urgently requires to address one or another issue first. The activities are accompanied by a set of materials, including film clips.

Child Sexual Abuse Prevention & Personal Safety (Pre Schoolers and Children with Developmental Disabilities)

https://nimhanschildprotect.in/wp-content/uploads/2021/03/CSA_Prevention-Preschool__Disability_Kids.pdf

Activity 2.1. Learning Names of Body Parts

Method: Naming using pictures and children's own bodies or dolls.

Materials: Picture of girl/boy showing body parts or a doll.

Process:

- Ask the children to sit in a circle.
- **Introduction**: Tell the children "Last time, we did fun shapes and actions with our bodies. Now, we will talk a little more about our bodies. We will learn different body parts, what we do with them and how to protect them.
- Show pictures of the human body (of boy or girl) or use a doll and point to body parts on the picture and name them. Ask children to repeat after you.
- Each time you show/point to a part and name it, ask children to point to that part on their bodies: 'where is your nose? Show me where your nose is…'

Note 1: This activity is for children who have not yet (completely) learnt the names of all

their body parts i.e. it is a first level activity for children who do not know their body parts.

Note 2: Ensure that private parts are named too.

Activity 2.2. Naming and Pointing Body Parts

Method: Naming and pointing
Material: None
Process:

- Ask the children to sit in a circle. You (the facilitator) can join in with the children.
- Tell the children that we are going to play a name game: ask them to name different body parts as you point to them, on your own body ('what is this?').
- Next, tell the children that we are going to play a pointing game: as you name different body parts ('where is your…nose?')
- If the children do not name/point to private parts such as the bottom or vagina/ penis and nipple you need to point to them and ask what it is. Acknowledge that boys and girls have different parts there (Boys have a penis and girls have a vagina).
- After doing one round of the naming and pointing more slowly (and establishing the names that children use for private parts), say you are going to play the game more quickly now—and repeat the naming and pointing game (in combination) at a higher speed. But this time name/ point to the private parts more frequently, encouraging children to say them more frequently and loudly.

Note 1: Do NOT use technical terms for private parts—use the term(s) that children use. They need to be comfortable with the term and understand what is being referred to. Allow for some giggling/ laughter as children name their private parts.

Note 2: The frequent repeating of the names of private parts helps children discard their inhibitions and discomfort related to these parts and gradually become more confident about viewing them with the same objectivity and comfort as other body parts. To be able to name private parts comfortably is critical in child sexual abuse reporting—children are often unable to report sexual abuse because they either do not have the words for private parts or because they do not have the comfort to name these parts.

Activity 2.5. How We Use Our Body Parts

Method: Naming/pointing and Description
Materials: Body pictures used or coloured (in previous activities)
Process:

- Explain to the children: "Now that we know different parts of our body let's learn how we use each of our body parts".
- Point to each body part on pictures used or coloured (in previous activities) and on their own bodies, and ask them:
    - Name the body part.
    - What we do with this part [hand], [mouth], [ear], [eyes], [stomach], [buttocks]…?
    - Why we need it?
- Provide information to them on the use of body parts in case they are unsure or do not know. (See box).

Alternative Method: For children who find it difficult to directly explain how each body part is used, you can reverse the above method—state a function and ask which body part does it— for example: which part do we see with? Which part receives our food once we eat it? Which part helps us walk?

How We Use Our Body Parts

- We use our **Mouth, Lips, Tongue** to talk, eat, sing, blow balloons/ bubbles etc.
- We use our **Nose** to breath, smell different things (what is cooking in the kitchen, recognize different flowers such as rose/ jasmine...)
- We use our **Ears** to hear (noises, music, and people calling or talking…), wear earrings.
- We use our **Eyes** to see… (Beautiful things such as…?)
- We use our **Hands/Arms** to dance, to hold things, to eat…
- We use our **Fingers** to write, paint, colour…
- We use our **Thighs/ Knees/Legs/ toes** to walk, run, and climb up and down, dance and play…
- The Food we eat goes into our **stomach**.
- We use our **penis/Vagina** (or whatever words/ terms children use for these parts) to pee.
- We use our **bottom/buttocks** to sit and to do potty.

Activity 3.2. General Safety

Methods: Discussion using picture cards

Materials: Pictures detailing: road safety, fire safety, kitchen safety, Doors/window locks…

Process:

- Make the children sit in a circle. Tell them will show you few pictures of children doing different things; for each picture I show you, tell me whether the person will get hurt doing what he/she is doing...and so, is it safe unsafe?"
- Show them the safety pictures, one by one and ask :
    - What is the person doing here?
    - Will he/she get hurt? (yes/ no)
    - So, is what she is doing safe or unsafe? (if the person gets hurt, it means he is unsafe; if he does not get hurt, it means he is safe).
    - What happens if we...
        - ...touch the fire/stove?
        - ...stick our fingers or any object into an electrical outlet or play with wires?
        - …go very near to the well?
        - …cross the road without looking to see if vehicles are coming?
        - …play on the road?
        - …do not put our toys and things away?
        - …play with sharp objects such as knives, blades, etc.
        - …do not lock the door at night?
        - …open the door without looking to see who is outside first?
        - …do not put the strap on while sitting in the wheelchair?
        - …do not place pillows while lying on the bed?
        - …do not walk down stairs using railing/ we slide down the banisters?
        - …put our hand into a dog's mouth?

Safety Rules: We Should Not…

...Touch fire/ burning stove because we will get hurt and burn our skin

...Stick our fingers or any object into an electrical outlet or light bulb socket- electricity can cause shock, burns

...Go very near a well or peep into them - as we may fall into them and drown

...Cross the road without looking out for vehicles as they may dash into us and we will get hurt.

…Play on the road we may get hit by a vehicle and get injured.

...Leave our toys and things away so that no one slips and falls

...Play with sharp objects like knives, blades as we may cut ourselves

...Leave the home without locking the door because we may get robbed

...Open the door without checking who is outside as they may be thieves and may rob or hurt us

- Provide information on why we should not do certain actions/ why it would not be safe. (See Box).
- Summarize how we follow many safety rules to keep our bodies from getting hurt.

Activity 5.1. Protecting Ourselves from Strangers

Method: Story-telling and discussion
Materials: Story about 'When Somu Forgot the Stranger Safety Rules'

Introduce the Session/ Topic: "We have learnt how to keep our bodies safe from getting hurt because of fire and switches and knives. Now let us talk about safety in a different way—about keeping ourselves safe from some people who may not be very good. There are many good people in this world—and we trust or believe them because they will not do things that will make children/others feel scared or hurt. But is everyone good? Can we trust everyone? [Children likely to say 'no'] So, there are some people who may not be good and whom we cannot trust or believe because they do things that make children/ others feel hurt or worried. Today, we will talk about how we can keep ourselves safe from bad people whom we cannot trust or believe."

Process:

- Tell children: "There are some people we meet everyday—people who look after us, play with us and we know very well. Like who all…? Let us now talk about how to be safe from people we do not know
- Tell the story 'When Somu Forgot the Stranger Safety Rules'—showing the children pictures as you narrate.
- Discuss the following questions:
    - What was a name of the boy (in the story)?
    - Who did Somu live with?
    - Where was his house?
    - Who was Somu's best friend? And what all did they do together?
    - Who came along one day when Somu and Tommy were playing in the park? Did Somu and Tommy know him?
    - What did the man tell Somu?
    - And what did Somu say/ do?
    - What was Tommy thinking at that time?
    - Where did the man take Somu? What happened there?
    - How did Somu feel when the man took him to some unknown place?
    - What happened next?
    - What safety rules about strangers had Somu forgotten?
    - So, what do we now know about keeping safe from strange people?

- Summarize what we have learnt from the story:
    - We must not talk to strangers or accept sweets/ toys from them—no matter how attractive the sweets/ toys may be because we do not know them—so we do not know whether they are good or not, whether we can trust them or not.
    - Similarly, accepting rides from strangers is also not safe—since we do not know them, we are not sure where they will take us.

When Somu Forgot the Stranger Safety Rules

Once upon a time, there was a boy called Somu. He lived with his parents and dog, Tommy, in a house that was on a busy street but also near a park. Tommy was a little brown dog with long silky ears and golden brown eyes; he was a happy, friendly dog and really loved his master, Somu.

Somu and Tommy were best friends. They played ball together and went swimming in the nearby pond; Somu always shared his biscuits and ice-cream with Tommy and Tommy even followed Somu to school and back.

One day, Somu and Tommy were playing in the park. Suddenly, a man came to them and started to talk to Somu.
"Hi, what a nice ball," he said to Somu. "Can I play too?"
Somu smiled and agreed for the man to play with them.
Tommy wondered why Somu was talking to a stranger. Didn't he remember what Somu's mother had told him about talking to strangers? That it was not safe to talk to people you did not know.

A few minutes later, the man had persuaded Somu to go to the toy shop with him and eat some ice-cream after. As Somu walked away with the strange man, Tommy became very worried. He decided to follow them. The man did not notice Tommy walking behind them and Somu was too excited as he was thinking about the toyshop and the ice-cream treat.

After a while, Somu realized that they were not walking towards the market at all. Instead they were in some strange street that he did not recognize. "I don't think that there is any toy shop or ice-cream parlour here," said Somu doubtfully. The stranger said nothing and Somu was starting to feel very nervous and afraid. Where were they going? Where was this man taking him?

At last, they reached a broken-down old building. The man told Somu to sit on the bench outside and wait for him. Suddenly, he did not sound as nice and friendly as he had seemed in the park. Somu sat down upon the bench and started to cry.
"I want to go home, to mummy and daddy," he cried. 'I am scared…and I don't really know this man…I am lost now."

Just then Tommy bounded up. Somu cried out in relief and hugged his dog. "O Tommy, I am so glad you are here…", he said.

Tommy started to pull at Somu's shirt. "O I see…you know the way home and can take us back!" said Somu. "Come on Tommy, let us run…let us go quickly before that strange man comes back."

And so, Somu and Tommy ran all the way back home, where Somu's parents were starting to get

very worried about them. “Where were you?” asked his mother. Somu told his parents what had happened at the
park that morning and where all he had been after, how afraid he had been all alone with a stranger.

“So you forgot the safety rule about not talking to strangers…about never going anywhere with them even if they offer you sweets and toys,” said his father.

“Yes,” said Somu sadly. “But Tommy knew and remembered the rule. That is why he followed me—to protect me from any hurt or harm that may have happened to me.”

So, clever Tommy was given many hugs and an extra special biscuit for helping Somu to be safe.

And from then on, Somu always remembered the 3 safety rules about strangers:

- NEVER talk to strangers!
- NEVER go anywhere with them (or take rides with them)!
- NEVER accept offers of toys or sweets from them!

“Yes,” said Somu sadly. “But Tommy knew and remembered the rule. That is why he followed me—to protect me from any hurt or harm that may have happened to me.”

Activity 5.2. How Known People Can Hurt Us

Method: Story-telling and discussion

Materials: Story about 'Tommy's New Neighbour'

Process:

- Tell the children that we are going to continue talking about people safety and learn what to do in case someone hurts us.
- Tell the story 'Tommy's New Neighbour'—showing the children pictures as you narrate.
    - What exciting news did Somu's father give him one day?
    - Who moved into the house next door to Somu's?
    - Did the two families become friends? How do we know that?
    - Who was not happy? And why?
    - Was Bozo nice to Tommy in the beginning? How do we know that?
    - What happened later to make Tommy unsure of Bozo's friendship?
    - How did Tommy feel when Bozo did not treat him well?
    - What happened next about Tommy's breakfast? Where was it disappearing? And how did that affect Tommy?
    - When Tommy caught Bozo eating up all his food, what did Bozo tell him?
    - How did Tommy manage to tell Somu about Bozo?
    - Was it a good thing that Tommy told Somu about Bozo? What would have happened if he had not?
    - What did Somu's mother say about when we can trust people we know and when we cannot, even though we know them? (How do we know whether some known person is good or not?)
    - So, what have we learnt about trusting people we know?

(**Note**: Given the age of the children, they may require some prompting and repetition—the above questions are a broad guideline on what issues to touch on for learning and discussion).

Summarize:

- Most people we know or our families know/ are friends with are good people and we can trust them.
- A few people, however, may not be good and cannot be trusted.
- When people we know, try to hurt us or threaten us, then we know they are not good people and we must not trust them (like what Bozo did to Tommy).
- In case someone we know does things that are hurtful to us, it is important to tell someone about it (like Tommy told Somu)—so that the hurt can stop and you can be safe.

Note: This part of the module may be appropriate only for children with mild intellectual disability i.e. those who have greater degrees of cognitive impairment may not be able to comprehend these stories.

Tommy's New Neighbour

The house next door to Somu's house had been empty for a long time. "I wish someone nice would move in there, so I could have someone to play with," Somu would keep saying.

One day, Somu's father came home and called out to him: "Hey Somu, I have news for you…a family has moved into the house next door! They have a girl who is your age—her name is Leela--so you have someone to play with…and guess what! They even have a dog…so Tommy can have a new friend too!"

Somu's parents and Leela's parents became good friends. Their fathers would meet and talk about gardening sometimes, their mothers would go shopping together. Somu and Leela also became very good friends: they went to the same school and played hide-and-seek in the park or watched cartoons together at home. So, everyone was happy…except for Tommy.

The next door dog, Bozo was bigger and stronger than Tommy. At first, he seemed very friendly—he would wag his tail when Tommy went over with Somu. He and Tommy would both play ball and hide and seek with Somu and Leela. In fact, Tommy thought Bozo was a kind and friendly dog and liked him very much.

But after a while, Tommy began to wonder whether Bozo was really as friendly and nice as he seemed. Once he ate up Somu's biscuit when he was not looking and Somu scolded Tommy for it, thinking it was his dog who had done it. When they played ball, Bozo who had been gentle and playful before began to push Tommy in a rough and hurtful way, especially when Somu was not looking. Tommy felt sad and confused. "Doesn't Bozo like me? Why does he hurt me like this?" thought Tommy.

One day, Tommy went to eat his breakfast and found his food bowl empty. He was very surprised as he knew he had not yet eaten his porridge and could not imagine how it had disappeared. Somu and his parents would never have forgotten to fill his bowl. This continued to happen—each morning, his porridge would be missing and poor Tommy would be hungry. Since Tommy got little to eat these days, he grew thinner and more tired and Somu could not understand why.

Then, one morning, when Tommy went to eat his breakfast, he was just in time to see Bozo eating up the last of his porridge. "So it is you who has been eating my breakfast everyday! How could you do that? I thought you were my friend!" said Tommy.

"I am no friend of your's…you thought wrong," laughed Bozo, showing his big white teeth. "And if you let Somu know that I eat your breakfast, I will fight you…and you know I am bigger and stronger that you…so, be careful! And Somu will never believe you if you tell him—he likes me!"

Tommy retreated in a hurry and sat under Somu's bed all day, for fear that Bozo would hurt him. Somu could not understand why Tommy no longer came out to play with him or went to the park or followed him to school. He saw that Tommy looked sad and scared these days. "What's the matter, Tommy? Something seems to be wrong…" said Somu.

The next day, Tommy decided that Somu must know the truth. So, knowing when Bozo would come to eat his breakfast, Tommy pulled at Somu's shoelace until Somu got up from the breakfast table and followed him outside. And there was Bozo, eating Tommy's porridge. "Bad dog," said Somu to Bozo. "So, that is why Tommy seems thin and hungry and sad all the time!"

Somu told Leela about Bozo's being mean and nasty to Tommy. Leela was also angry with her dog and punished him—Bozo was not allowed outside to play for several days and all his favorite foods were taken away from him.

"And to think that we thought Bozo was a good, friendly dog!" said Somu. "Sometimes even people we think we know and believe to be nice can be hurtful and unsafe. Am so glad that Tommy told me about Bozo— else, we would never have known how mean he was being to Tommy. But how do we know then who to trust and whom not to trust?"

"When people we know start to do mean or hurtful things…things that make us feel sad or confused or upset, we know then that they are not good people…and cannot be trusted", said Somu's mother. "Sometimes they may seem friendly and nice but do things that are hurtful—just like Bozo did when Tommy thought he was friendly and nice. But most people we know are nice—it's just some people who might be like that."

"Now I have learnt that even people I know can be unsafe," thought Tommy. "But as Somu's mother said, that's not everyone…and I know now how to be safe, so I need not worry. And am glad I told Somu…if I had not told him, he would not have known Bozo was hurting me." And so, safe and happy now, Tommy fell asleep at Somu's feet.

Activity 5.3 Safe and Unsafe Secrets

Method: Story-telling and discussion

Materials: Story about 'Which Secrets to Keep'

Process:

- Tell children: "There are some people we meet everyday—people who look after us, play with us and we know very well. Like who all…? Let us now talk about how to be safe from people we do not know.
- Tell the story 'Which Secrets to Keep'—showing the children pictures as you narrate.
- Discuss the following questions:
    - What is a secret?
    - What plans had Somu made for his mother's birthday?
    - Why did he want it to be a secret?
    - Who were the only two other people who knew about Somu's secret plans for his mother's birthday?
    - Who came along when Tommy was sitting by the gate? What were they talking about?
    - Why did they want Tommy to keep their plans secret?

- What did they tell Tommy he would get if he kept the secret?
- What did they tell Tommy that they would do to him if he did not keep the secret?
- Did Tommy decide to keep their secret or not? Why?
- What did Tommy do that night? How did he make sure that Somu and his parents were safe?
- Somu had a secret plan about his mother's birthday surprise. The thieves had a secret plan to rob Somu's house. So, both had a secret. What was the difference? Which one was a good secret and which one was not?
- What have we learnt about good and bad secrets?

Summarize:

- Secrets can be good and fun (like Somu's plans for his mother's birthday).
- Secrets can also be bad and unsafe (like the thieves' plan to rob Somu's house and hurt his family).
- When people want us to be part of good secrets, there is no problem—because we know that at the end, we as well as others will be happy and no one will get hurt.
- When people want us to be part of bad secrets, there is a problem—because we know that at the end, we as well as others might get hurt and be unhappy.
- When people threaten to hurt us if we refuse to keep the secret, we know surely that they are bad people and we should not trust them (just like the thieves said they would hit Tommy with a stick if he told them their secret plans).
- When people say they will give us something nice, something we like, like sweets or toys to keep 'bad' secrets, we know then also that they are bad people (just like Tommy knew when the thieves said they will give him a box of his favorite biscuits if he kept their 'bad' secret).
- So, if someone tells us a 'bad' secret, it is important to tell someone we trust (just like Tommy always tells Somu, whom he trusts). If we do not tell 'bad' secrets, then we ourselves or others may get hurt or not be safe.

Which Secrets to Keep

Somu's mother's birthday was coming up. He was very excited because he had planned a party and present for her. The best part of this was that it was a secret! He had not told her about it because he wanted it to be a surprise for her. He kept imagining how surprised and happy she would be when she opened the box and saw her new pink saree and when all the guests arrived along with the birthday cake that had been ordered for the evening! Only two others were in on the secret—Dad,
because he was helping with organizing the birthday surprise plans and Tommy because…well, Tommy and Somu were best friends and Somu always told Tommy everything!

The day before Somu's mother's birthday, while Somu was at school, Tommy was sitting outside the house, near the gate, when two strange men came by. They did not notice Tommy as they whispered to each other, pointing to the house.

"Yes, so we will come tonight…at around midnight so that the family is fast asleep…" said one.

"We can break in through the side door—it looks a little old so it should be easy to get in that way," said the other. "And if the family and the kid give us any trouble as we steal all the stuff in the house, we will just hit

them on the head."

Tommy pricked up his ears when he heard their conversation, especially the last part about the stealing and the family being hurt…someone was going to hit his beloved Somu??

Suddenly they noticed Tommy but did not realize that he belonged to the house they were going to rob and the family they were planning to hurt. The first man laughed and said "aha, you silly dog…so you heard our secret! You better not tell…it is a secret…if you don't tell, I will give you a large box of your favourite biscuits."

"And if you tell, we will smack you on the head with a heavy stick", said the other one.
Tommy felt afraid…and confused. What did they mean that it was a secret? Weren't secrets supposed to be good things? Just like Somu's secret about his mother's birthday surprise? What kind of secret was this then—these strange people were planning to steal stuff and hurt people? Was he supposed to really keep it a secret when he knew that Somu's house was going to be robbed and Somu and his family were going to be hurt??

Of course not!! This was not the kind of secret he was going to keep—not for a bag of his favorite biscuits and not even if anyone threatened to hurt him! In fact, if these strange men were going to do bad things like stealing and hurting people, Tommy thought, he must certainly not keep their secret!

And so, that night, Tommy did not go to sleep as usual on Somu's bed. He sat by the window and kept watch—long after Somu was asleep, and his parents had gone to bed. At about midnight, Tommy heard a noise and saw two men come down the road—the thieves he had seen yesterday, the ones who had told him to keep a bad secret. He started to bark loudly until Somu and his parents woke up and came running to see what the matter was. Standing by Tommy, Somu's father saw the two thieves approach the house. He immediately called the police—and within minutes, the police car was at their house and the two thieves, who had been hiding in the bushes near the gate, were caught.

Tommy was petted by the family and given his favourite food the next day. "Clever dog," said Somu's mother.

"I wonder how he knew the thieves were going to come," said Somu. And Tommy thought to himself: "I heard them plan…and knew their secret. But their secret was not a safe or good secret and so I did not keep it."

That evening, Tommy watched Somu and his father give his mother the surprise birthday present, and the guests and cake arrive for the surprise party. Somu's mother was excited and happy… "I never knew you had planned all this!" she said. "It was a secret," said Somu.

"A very good secret", thought Tommy. "Because no one got hurt and everyone was happy!"

Activity 4.1. The Concept of Privacy

Method: Pictures and narrative

Materials: 2 sets of picture cards: i) Picture cards detailing daily activities that children usually engage in: eating, sleeping, brushing teeth, bathing, combing hair, dressing, undressing, going to toilet, singing, dancing, studying, playing;

ii) Picture cards showing people children know and encounter in their daily lives, namely mother/ father/ aunt/ uncle/ sister/ brother/ teacher/school cleaner/doctor/ male &; female caretakers in an institution...

Process:

- Explain to children: "We do several activities everyday such as eating, sleeping,
- bathing, playing etc. Some of these activities are done along with others or in front of others…for example? [children may suggest playing/ studying] Some activities are done either alone or with particular people but not everyone. We are now going to look at various activities and understand whether it is appropriate to do them with everyone or it is appropriate only to do them with particular people. Knowing what to do and how to be with whom is another way of keeping ourselves safe."
- Lay out the people picture cards, on the floor, in such a way that children can clearly see them.
- Ask children to identify each person (i.e. in terms of their family/ social relationship) on the card; if anyone is missing you may ask the children to draw in and add a card.
- Present the daily activities cards one by one, and discuss the following questions:
    - What do you see here? (What action is being performed?)
    - With which people or in front of whom (indicating the people cards) can we do this action? i.e. with everyone or particular people?
    - Why is it appropriate (or inappropriate) as the case may be? (For example, if children say they cannot bathe in front of their uncle…why would it be inappropriate to do so?)

Summarize the discussion thus:

- There are some daily activities, like brushing your teeth, which one may not feel entirely comfortable carrying out in the presence of a stranger.
- You may know some people very well, very closely but there are some daily activities such as bathing/ undressing that you may not do in their presence.
- This is because we do certain things privately—either by ourselves/ alone or with the help of our mothers/ grandmothers/ special care-takers only. If we are asked to do them in front of others, we feel shy or uncomfortable.
- So, if anyone other than mothers/ grandmothers/ special care-takers suggest that they want to do certain activities with us such as bathing/ dressing/undressing, we must do two things: i) say 'no, I don't want to'; ii) tell mother or grandmother or someone else you trust about it.

Child Sexual Abuse Prevention & Personal Safety (7-12 years)

https://nimhanschildprotect.in/wp-content/uploads/2021/04/CSA_Prevention_Module_7_12-yrs_Oct_2017.pdf

Activity 2.1. Body Maps

Methods: Body mapping

Materials: Large sheets of paper taped together to create a single surface (large enough to fit a child's body on it); crayons/colour pens

Process:

- Introduction to Session: "Last time, we did fun shapes and actions with our bodies. Now, we will talk a little more about our bodies. We will learn different parts, what we do with them and how to protect them".
- Introduce the idea of maps and outlines to children—telling them what they are. Tell them that we are now going to do an outline of our body.
- Ask a child volunteer to lie down on the large piece of paper on the floor: another outlines the shape of the body.
- Name/label all the visible body parts—as many as the children can name (according to age).
- When they are done, ask the children to look
- Make sure to name the private parts—whatever name the children give them.

Note: *Do NOT use technical terms for private parts—use the term(s) that children use. They need to be comfortable with the term and understand what is being referred to. Allow for some giggling/ laughter as children name their private parts and acknowledge that people find it funny or embarrassing to mention these parts.*

Activity 2.2. Speed Name Game

Method: Naming and pointing game

Material: None

Process:

- Tell the children: "Now that we have identified all our visible body parts and know their names, we are going to do a quick revision of the same by playing a speed name game. I will point to a body part and you have to name it…really quickly."
- Stand where all group members can see you clearly.
- Point to various body parts, one at a time, allowing them to name each part.
- Frequently point to private parts such as vagina/penis/breast/buttocks so that the names of these parts are clear and children know them. (But ensure that you do not point to them continuously i.e. the naming/pointing of these parts must be interspersed with other body parts).

Note: *The frequent repeating of the names of private parts helps children discard their inhibitions and discomfort related to these parts and gradually become more confident about viewing them with the same objectivity and comfort as other body parts. To be able to name private parts comfortably is critical in child sexual abuse reporting—children are often unable to report sexual abuse because they either do not have the words for private parts or because they do not have the comfort to name these parts.*

Activity 3.1. Learning about General Safety

Methods: Board game

Materials: Board game, dice, pawns (as many pawns as children or teams in case of many children)

Process:

- Tell the children: "We have been talking about how to protect our bodies in certain ways, such as personal hygiene and eating nutritious food. By doing these things, we protect our bodies from dirt and diseases. In addition to this, there are other ways in which we protect our bodies—some basic safety rules we follow. Let us play a game to know more about general safety rules."
- Place board game on the floor/ table and have the children sit around it. (If there are many children, they could be divided into teams of 3 to 4 per team).
- Ask each child/ team to select a pawn.
- Ask each child/ team to take turns to throw the dice and move along the boxes.
- When a box with a safety message/ instruction is reached, discuss the safety rule with the children, asking them what they think about it/ why the rule is important/ what will happen if they do not follow that rule.

Activity 4.1. Protecting Ourselves from Strangers
Method: Story-telling
Materials: Story about stranger safety (See box)
Process:

- Tell the children: *"We have talked about general safety and the rules we need to follow at home and outside (about traffic rules, fire safety, electricity etc). Now let us talk about safety in relation to people. There are many good people in this world. But is everyone good? Can we trust everyone? [children likely to say 'no'] So,*

there are some people who may not be good or trustworthy. Today, we will talk about how we can keep ourselves safe from bad and untrustworthy people."

- Tell the story about Chintu and Pinky.
- Discuss the following questions:
    - What were the names of the children/ rabbits?
    - What was the relationship between them?
    - They played together and had many similar interests. But what was one difference between them?
    - What did Chintu tell Pinky about her talking to strangers?
    - What did their father show Pinky and tell her?
    - After what her father told her, how did Pinky feel at night? Why?
    - What was her response to Chintu's invitation the following morning, to play in the park?
    - How did Pinky finally decide to go to play in the park?
    - Chintu and Pinky did something very important before going to the park. What was that?
    - When they came home that afternoon, Pinky was helping her mother make some apple juice. As they cut the apples, what did Pinky say about some of the apples?
    - What was her mother's response to this?
    - So people are also like apples…some may look not-so-nice from the outside but on the inside, they may be……..? Some may look very nice on the outside but inside, they may be……..?
    - So, based on this, what can we learn about judging people? (Can we know whether people are good/ we can trust them just by looking at them/ from their appearance?)
    - Later that afternoon, when Pinky and Chintu went to the park, who did they see? And what did Chintu do?
    - What did Pinky tell Chintu at the time?
    - What people safety rules had Pinky learnt?

Summarize what we have learnt from the story:

- We must not talk to strangers or accept sweets/ toys from them—no matter how attractive the sweets/ toys may be because we do not know them—so we do not know whether they are good or not, whether we can trust them or not.
- Similarly, accepting rides from strangers is also dangerous—since we do not know them, we are not sure where they will take us.
- Telling someone at home where we are going and with whom, before we go out somewhere, is very important—because in case something happens to us, they will know where to try to find us.
- Judging whether a person is good or bad from his/her appearance may be problematic— because good people sometimes may not be beautiful and bad people may be beautiful. So knowing a person means spending time with them, watching and understanding how they behave, ensuring that they are known to our parents/ caregivers…before we start playing with them or trusting them.

Pinky and Chintu Learn to Keep Safe from Strangers

Pinky and Chintu were brother and sister. They lived with their mother and father in a nice house which was near an apple orchard. Except for the fact that Pinky was a girl and Chintu was a boy, and that each had hobbies of their own (Chintu loved to build and fly model airplanes and Pinky liked to play with dolls), they enjoyed many of the same things too – bike

riding, football, hide and seek and just going to the park. There was one other important difference between them:

Chintu was cautious and careful and a little weary of strangers. Pinky, on the other hand, wasn't the least bit weary. She was friendly to a fault. Just about everybody that came her way got a big "Hello!" "Hello Butterfly!"

"Hello Frog!"
"Hello Mr. Truck driver!"
"Hello Mr. Postman!"

Chintu worried about Pinky's free and easy way with strangers. Strangers weren't the problem for him. Not talking to strangers suited cautious and careful Chintu just fine. But friendly-to-a-fault Pinky was different. She talked to everybody.

"Pinky" said Chintu. "You're going to have to stop that!!"
"Stop what?" she asked.
"Talking to strangers. It's just not a good idea!"
"Why?" She wanted to know. "Why shouldn't I talk to strangers? What harm is there in it? Is there something wrong with strangers?"
"Hmm" said Chintu thinking about it for a moment. "Those aren't questions for me. Those are for Mama and Papa…"

"Pinky, I'm glad you asked these questions" said Papa in his deepest and most serious voice. "The reason you should never talk to a stranger and never ever take presents or sweets from a stranger and Never Ever go anywhere with a stranger is that it's dangerous ! "

"What's dangerous about it?" she asked wide-eyed. "What can happen?"
"All sorts of things!" Papa said. "Here! Look at the newspaper."
As she looked at it her eyes grew wider and wider. This is what she saw:

STRANGERS TROUBLES CHILD
MISSING CHILD FOUND
POLICE QUESTIONS STRANGER
CHILD SAFETY MEETING

"I hope you're paying attention to all this" called Papa to Chintu and Pinky.

Pinky had a hard time falling asleep that night. Her mind was filled with those headlines. The next day dawned bright and friendly to everybody but Pinky. She had spent a restless night and when she looked out the window everything seemed a little scary. The trees seemed bigger and like their branches were going to reach out to catch her; the owls and crows seemed to look at her in a frightening way.

"Let's go out and ride our bikes" said Chintu after breakfast. But Pinky didn't want to. Chintu

was puzzled. Their neighborhood was a busy and friendly place where she loved to play.
"Well, how about some football?" But she didn't want to do that either. It wasn't until he suggested hide and seek, her favorite game that she agreed to go along.
Before they left, they told Mama where they would be – It was a family rule that they never went anywhere without telling Mama or Papa.
"That's fine" said Mama. "I'm on my way to pick some apples at the orchard. I'll stop by for you on the way home."
Everything continued to look a little scary to Pinky…the neighbors, other people, the dogs, even the frogs.
Later, when one someone tapped her on the shoulder, she jumped a mile - even though it was just Mama.
"How was the morning?" asked Mama on the way home in the car.
"It was ok", said Pinky "But there were so many strangers!"

Later at home when Mama and Pinky were getting ready to make apple juice, Mama said "You know what Papa told you were quite right. It's not a good idea to talk to strangers, accept presents or rides from them." "But" she continued. "That doesn't mean that all strangers are bad. Let me explain… it's like this barrel of apples. There is an old saying that goes there'll always be a bad apple in every barrel. That's the way it is with strangers. Children have to be careful because of the few bad apples." "Look!" said Pinky. "I found one! It's all bumpy and has a funny shape!"
"Well, it's certainly strange looking, but that doesn't necessarily mean it's bad. You can't always tell from the outside which are the bad apples."
She cut it in half. "See." She said. "It's fine inside."
"Now, here's one that looks fine on the outside…"
"… but inside it's all wormy."
"Ugh!" said Pinky.
"What's up?" asked Chintu.
"A bad apple!" said Pinky.
"See, that's what I mean," said Mama. "It looked good from the outside but was bad on the inside. People are also like that sometimes…some don't look very nice on the outside but may actually be good on the inside, so they are good people. Some look beautiful outside but may not be very nice on the inside—that is, they are not to be trusted. Just like apples, it is hard to tell what people are like on the inside by just looking at their outsides. And that's why we cannot tell with strangers—we don't know who they are or what they are like inside.

"Hey, I'm going to the field outside to fly my new airplane. Want to come?" asked Chintu.
"Sure" said Pinky. She felt much better now… more like her old friendly self.
The airplane was a great success and the children were about to head home when someone came to the field with a big beautiful orange and green model airplane.
"Wait!" said Chintu. "I want to watch! It's an automatic remote control plane!"
Chintu ran up to the stranger and started talking to him! For that's what he was-- a stranger -- no matter how big and beautiful his airplane was!
"I'm going to send it up and follow in the car," the stranger was saying. "Want to come along?"

"Wow!" said Chintu. And he would have – if Pinky hadn't grabbed his arm and said "Don't you dare!" The stranger drove off following his airplane.
And Pinky ran home shouting, "Chintu talked to a Stranger! Chintu talked to a stranger!" "But it was a big orange and green radio-controlled airplane!" said Chintu.
"That doesn't matter", said Papa. "We have rules about strangers – and they're important!"
"We have rules about tattletales too" said Chintu, glaring at Pinky.
"Pinky wasn't tattling. Tattling is telling just to be mean' explained Mama. "And Pinky was telling because she loves you and she was worried."
"Do you think that fellow was like a bad apple?" asked Chintu.
"Probably not" said Mama.
"That's right" said Pinky, "Most folks are friendly and nice and wouldn't hurt a fly. But you have to be careful, just in case."
"Speaking of apples," said Mama. "How about some of this apple juice I just made?"
As they drank Mama's delicious apple sauce, Chintu and Pinky thought about what they had learned that day. There was quite a lot to think about.

Activity 4.2. How Known People Can Hurt Us

Method: Story-telling

Materials: Story about how known people can hurt us (See box)

Process and Discusison:

- Tell the children: "We have talked about how to keep ourselves safe from unknown people or strangers. But sometimes, as we said before, even known people (not all, but some) can make us feel unsafe or hurt us. Let us first see how…"
- Tell the children the story.
- Discuss the following questions:
    - Who was Pinky's special friend?
    - What happened one day when they were both in the playground?
    - Did Pinky want to keep the pencil box? Why not?
    - But why did she finally agree to keep it?
    - What happened in class that afternoon?
    - When Pinky tried to explain to teacher as to how she had the pencil box, what did Meena say?
    - What can we learn from this story about known people and safety?
    - In case you have the kind of experience Pinky did, who would you trust and go to for help?

Summarize:

- All known people are not bad—we do have family members and friends who are good and trustworthy. However, some of them may not be.
- One way to identify whether they are good/ trustworthy is by judging what they tell us to do—is what they are telling us to do good/ comfortable or not? i.e. will it be harmful to us or others? If it is harmful or hurtful to us or others, what they are telling us to do is not good— and so we know that they are not good people either. (Recall what Meena told Pinky to do— to take someone else's pencil box without their permission/ without them knowing it).
- The second way to identify whether they are good/ trustworthy is by understanding HOW they tell us to do certain things—are they forcing us to do it? Are they threatening to hurt us/not love us/ not be our friend? Anyone who forces or threatens us cannot be telling us to do something good— and so they are not likely to be good or trustworthy people. (Recall Meena's threat to Pinky if she did not keep the pencil box).
- The third way to identify whether they are good/trustworthy is by listening to see whether they make us promises to give us something nice or something we like in return for doing as they ask i.e. 'if you do what I say, I will give you/buy you..' which also means that 'if you don't do as I say I will not give you/buy you..' If people are good and trustworthy, they would give us or buy us something nice because they love us-not because we do as they say.

Pinky Learns that Sometimes Even Known People Can hurt Us

Pinky had a special friend in school. She was called Meena. They were very good friends and sat next to each other in class, did homework together and played all their favourite games together—like hide and seek and hopscotch. One day, while they were in the school playground, they found a shiny red pencil

box on the bench.

"I wonder whose pencil box it is...someone has forgotten it and left it here," said Pinky.

"If it has been left here, it belongs to us now...we can take it," said Meena.

Pinky was worried. "I don't think so...it does not belong to us...we can't just take what belongs to someone else...and they will be sad without it, no?" she said.

"Don't be silly," said Meena. "You worry too much about everything. Just take the box and put it into your bag...and we will see what we can do with it later. If you don't take it, I will not be your friend anymore...if you do what I say, you can ride my new bicycle." And so, although Pinky did not want to keep the pencil box, she was forced to do so by Meena. Pinky was scared that if she did not obey Meena, then Meena would not be friends with her—and Pinky really wanted Meena to like her and be friends with her. That afternoon, when they went back to class, Tinku was sitting at his desk and crying. When the teacher asked why, he said that he had lost his new red pencil box—the one that his uncle just gifted him on his birthday—and his mother was going to be very annoyed with his carelessness too.

"Don't cry", said teacher. "Let us look for it—we are sure to find it." The teacher got everyone to search their desks and the classroom. Pinky, who by then was very scared, took the pencil box out of her bag and handed it to the teacher.

When teacher asked Pinky why she had taken Tinku's box, Pinky tried to explain that she had not wanted to, that Meena had forced her to...but when teacher asked Meena, she said "I don't know anything about the pencil box—I have never even seen it before. Pinky is lying."

Pinky was very sad when she went home that day. "I can't believe that Meena got me into trouble," she cried to her mother. "Meena is supposed to be my friend. Doesn't she care about me? Why did she make me do bad things and tell lies?"

"Most people whom we know, especially those who are our friends are good and trustworthy people. But sometimes even people we have known for a long time, and think are our friends may not be good or trustworthy—just like Meena turned out to be," said her mother.

"But how do we know when not to trust someone?" asked Pinky.

"Anyone who tells you to steal something or do anything that will hurt either you or someone else could not possibly be telling you something good...and so you know that person is not good and trustworthy," answered her mother.

"And if someone tells me to do bad things, like Meena did, what should I do?" asked Pinky.
"You can just come and tell me or Appa first...or your teacher or some grown-up you can really trust. And we will help you to deal with the bad person. Now, don't cry any more...I am sure you have other friends to play with whom you can trust—remember not all our friends are bad and untrustworthy. I will talk to your teacher tomorrow to explain what happened with Meena, I am sure she will understand."

"Ok Amma, I am glad you are there to help me," said Pinky wiping her eyes.
"Of course I am...and I always will be," said her mother.

Activity 4.3. Good and Bad Secrets

Method: Story-telling

Materials: Story on 'To Tell or Not to Tell?'

Process and Discussion:

- Tell children: "There are some people we meet everyday—people who look after us, play with us and we know very well. Like who all…? Now we are going to learn some more about being safe from people we know…we are going to talk about what to do when people tell us secrets.
- Tell the story 'To Tell or Not to Tell—showing the children pictures as you narrate.
- Discuss the following questions:
    - Why did Pinky and Chintu's parents have to go away?
    - Who came to look after them in their parents' absence?
    - Did they like Vanitha aunty at first? Why?
    - When they came home from school one day, what did they find Vanitha aunty wearing? And what did she say about it?
    - How did Vanitha aunty convince Pinky and Chintu to keep the pink sari a secret?
    - What did Vanitha aunty do when Pinky and Chintu asked to help with washing up later?
    - How did Pinky and Chintu feel that night?
    - What did Vanitha aunty want Pinky and Chintu to keep secret from their parents? Why?
    - What were all the ways she used to make them keep it a secret?
    - Why did Pinky and Chintu hesitate to tell their parents all about Vanitha aunty's visit?
    - What was Amma's response to their fears about telling Vanitha aunty's secrets?
    - What did Appa say about secrets?
    - Vanitha aunty had tried to keep various things a secret like her wearing Pinky's mother's sari/ her not feeding the children/ her making them wash clothes/ her ruining the furniture. In the end, Pinky and Chintu's parents had also kept their beach plans a secret. What was the difference between Vanitha aunty's secret and Pinky/Chintu's parents' secret? Which one was a good secret and which one was not?
    - What have we learnt about good and bad secrets?

Summarize:

- Secrets can be good and fun (like the beach plan Pinky and Chintu's parents had).
- Secrets can also be bad and unsafe (like Vanitha aunty's secrets about the saree, or hurting Pinky and Chintu).
- When people want us to be part of good secrets, there is no problem—because we know that at the end, we as well as others will be happy and no one will get hurt.

- When people want us to be part of bad secrets, there is a problem—because we know that at the end, we as well as others might get hurt and be unhappy.
- When people threaten to hurt us if we refuse to keep the secret, we know surely that they are bad people and we should not trust them (just like the thieves said they would hit Tommy with a stick if he told their secret plans).
- When people say they will give us something nice, something we like, like sweets or toys to keep 'bad' secrets, we know then also that they are bad people (just like Vanitha aunty gave Pinky and Chintu chocolate ice-cream to keep her 'bad' secret).
- So, if someone tells us a 'bad' secret, it is important to tell someone we trust (just like Pinky and Chintu told their parents). If we do not tell 'bad' secrets, then we ourselves or others may get hurt or not be safe (as happened to Pinky and Chintu when they did not tell Vanitha aunty's secrets to their parents sooner/ on the phone).

To Tell or Not to Tell?

Pinky and Chintu were playing in the garden when their mother called them to say that she had just had some bad news. Their ajji, who lived in the next town, was very ill and so she and their father had to go away for a few days to take care of her. "But don't worry, you will not be alone at home—I have made arrangements for Vanitha aunty to stay with you and take care of you while I am gone."

Vanitha aunty was an old family friend of their mother's and the children had met her only once—so they did not know her too well although their parents had been friends with her for a long time. She arrived the day before Pinky and Chintu's parents left town so that she could get settled in and learn how everything in the house worked. She was a tall lady and Pinky was a little afraid of her tall bun and thick black glasses. But she greeted the children warmly: "So, no problem with your parents being away...I am here and we are going to have a whole of fun together," she said. Pinky and Chintu certainly hoped so.

At first, Vanitha aunty seemed nice. She made the children their favourite foods for dinner and played board games with them when they got home from school. But slowly, the children did not feel so sure about her. They returned from school one day to find her wearing their mother's saree. "Oh Amma's favourite pink saree," said Pinky, very surprised. "She usually does not let anyone touch it as she doesn't want it spoilt...how come she let you wear it?"

"O she need not know I wore it," said Vanitha aunty, laughing, and wiping off some sambhar that had dripped onto the delicate sari. "What she does not know, will not hurt her." Pinky and Chintu were puzzled— borrow Amma's favourite sari? Drop food on it and ruin it? Not tell Amma about it?

"And just so you keep our little secret, I have bought you some chocolate ice-cream...which your mother said not to give you in cold weather because you might get a sore throat...but it's ok yaar...you eat some ice-cream and I won't tell Amma that you ate it...just like you won't tell her that I wore her pink saree," said Vanitha aunty, winking.

After eating their ice-cream, the children wanted to go outside to play. "No, no, I want you to wash up everything in the kitchen, not go out and play now," said Vanitha aunty. "After all, I have worked hard to make you dinner."

When Pinky and Chintu pleaded to help with washing up later in the evening, after play time, she got angry and slapped them hard. "Bad children," she said, "you need to learn to obey your elders properly—and just so you remember to do so next time, you are not getting any dinner tonight," she shouted. "And don't you dare tell your parents about any of this—if you do, I will tell them about the ice-cream and they will know how disobedient you have been."

Pinky and Chintu were too afraid to argue. So, they silently washed up in the kitchen and went to bed without any dinner.

"I am hungry," said Pinky.

"Me too," said Chintu. "Amma has been angry with us sometimes but she has never denied us our food. I am going to tell her what Vanitha aunty did."

"But Vanitha aunty is a really good friend of Amma's—they have known each other for so long...do you think Amma will believe us? And what about us eating the chocolate ice-cream? Won't Amma get angry if she knows that we ate some in this weather?"

"Perhaps...I don't know," said Chintu. Sad and confused, they fell asleep.

And so, the week went by, with Vanitha aunty often getting angry and making Pinky and Chintu do things that were difficult and unnecessary—like forcing them to wash her clothes, refusing to feed them if they did not clean up the kitchen, stay home with her instead of playing outside. Sometimes she was angry and threatening and other times she was sugar-sweet and promised to buy them treats (like clothes and toys) if they obeyed her. The latter, they noticed, was mostly when she had ruined Appa's furniture or stained
Amma's new carpet-- and she told them to keep these things secret from their parents.

Pinky and Chintu were delighted when finally their parents came home and Vanitha aunty left.
"So, I hear that you were very good children," said their father.
"Yes, Vanitha aunty said she loved being with you...so much so that in case Ajji falls ill again, she said she would be happy to come back and look after you," said Amma.
Pinky and Chintu were silent, unsure of whether to tell Amma and Appa about Vanitha aunty and her secrets. But when they said nothing, Amma and Appa noticed that they looked afraid, and Amma said, "Is there something you want to tell me? Why do you look so scared?"
And then, Pinky and Chintu could not keep the secrets any more—they told their parents everything...about Amma's pink saree and the chocolate ice-cream, Vanitha aunty slapping them and not giving them dinner, her spoiling the furniture and her threats...her promises to buy them treats for keeping her secrets.

Amma and Appa listened in amazement.

"Why did you not tell us all this when we called everyday to check how you were doing?" asked Appa.

"Because we were scared you would be angry about us eating the chocolate ice-cream...and we were scared Vanitha aunty would be angry if we told you," said Pinky.

"And we thought you might not believe us since Amma and Vanitha aunty are such good friends," said Chintu.

"We would always believe you, no matter what, so you can tell us anything you like—especially if someone hurts you or does cruel things," said Amma. "We are so glad you told us now...I will deal with Vanitha aunty."

"We thought that Vanitha aunty was a good person, especially since we have known her so long...but we were wrong...we did not know," said Appa. "Anyone who tells you to do bad, dishonest things like Vanitha aunty did is a bad person...only a bad person would ask you to keep secrets about bad things done...and either threaten you if you don't keep the secret or bribe you with sweets and toys."

Chintu and Pinky, who had always thought that secrets were good and fun things now understood that bad and untrustworthy people can sometimes make you keep secrets that are bad—because they are hurtful to us or to others.

The next day, Amma said: "Hey Chintu and Pinky...Appa and I have a surprise for you...pack your bags, we are going to the beach for the week end!"

Pinky and Chintu shouted with joy...they loved the beach! "Wow, how come you didn't tell us that before?" asked Pinky, her eyes shining with excitement.

"Because it was a secret...Appa and I wanted to surprise you and reward you for being so good while we were away to take care of Ajji," said Amma smiling.

"A secret-surprise," sang Chintu running to pack his swimsuit.
"A good secret," Appa reminded them, "because no one was angry, no one shouted and threatened or told others to do bad or hurtful things...a happy secret and surprise."

Activity 5.4. Learning Boundaries

Method: Game

Material: Chalk, list of safe/ unsafe situation statements (see box below)

Process and Discussion:

- Tell the children: "Just like hopscotch, this is another game about following boundary lines. This game is a little more complex than hopscotch because it involves decisions around safety boundaries".
- Ask each child to draw a triangle (about the size of a hopscotch box) and stand inside the triangle.
- Explain to children how the game is played:
    - "This is your individual/ personal safety triangle."
    - "I will read out a bunch of statements, one by one—each statement will give you a scenario.
    - "You have to listen carefully to each statement and decide whether the statement describes a situation that is safe or unsafe for you".
    - If you decide you are safe i.e. that the person concerned is not crossing your boundaries and making you feel unsafe, then you remain within your personal safety triangle.
    - If you decide you are unsafe i.e. that the person concerned is crossing your boundaries and making you feel unsafe, then you step outside your personal safety triangle.
- Proceed to read the statements one by one—for each decision that the children make about being safe/ unsafe, ask them why it is so.

Statements for Safety Boundaries: In or Out of the Safety Triangle

- Your grandfather pats you on the back when you do well in school.
- Your uncle asks you to sit on his lap.
- Your cousin brother takes his trousers off in front of you.
- Your brother takes you out shopping to buy you clothes for your birthday.
- The doctor puts ointment on your thigh when you get hurt.
- Your father sleeps next to you and touches your body all over, saying that he loves you/ that you are his special child.
- The PT master picks you up and carries you to the sick room when you hurt yourself during games.
- The next-door aunty asks you to touch various body parts of her and says she will give you a chocolate for doing so.
- The priest (in temple/ church/ mosque) puts his hand on your head to give you his blessings.
- Your father's friend touches you in your private parts and tells you that if you tell anyone, he will hurt or kill your family.
- Your father's friend touches you in your private parts and tells you that no one is more special than you/ that he loves you.
- An unknown man flicks the insect off your bag while you are riding the bus.
- Your elder brother says he likes to watch you having a bath.

Activity 6.2. Whom to Tell

Materials: Paper, colouring materials (crayons or pencils)

Process:

- Tell the children: "We have seen the video about Komal and saw how despite our best efforts, sometimes we may still be in unsafe situations. You also saw how when Komal felt uncomfortable and unsafe, she told her mother…so we learnt that we need to tell someone. Why is it important to tell someone? [Re-cap how if we do not tell, the difficulties and hurt will continue, and will not stop]. I hope that something like what happened to Komal will not happen to you—and especially as now you have learnt to keep yourselves safe, I believe you will be. But in the event something like that does happen to you, it would be good to be prepared and just plan who you would tell. So let us plan who each of you would tell…and understand why you are selecting this person."
- Ask the children to close their eyes and think of one person they would go to and tell about difficulties, if a situation of hurt and lack of safety were to occur.
- When they have thought and are ready, ask each child to quickly name the person they would approach (example mother, sister, father, teacher…)
- Ask them to now draw a picture of a person they thought of.
- Discuss the following questions:
    - Why would you tell this person?
    - What special powers or qualities does this person have to help you?
- **Summarize:**
    - It is good to have thought of someone just in case something happens—you will easily be able to tell your troubles to this person and so you can get help more quickly than you would otherwise if you were not sure who to tell.
    - People we tell are usually people we trust very much—we trust them to listen to us, to believe us and then to do something about it (whether to get help from others or from the police).

Adolescent Life Skills Series II: Gender, Sexuality and Relationships

https://nimhanschildprotect.in/i-life-skills-gender-sexuality-relationships/

Activity 7.2: Acknowledging Needs and Pleasures

Method: Listing and categorization

Materials: Flip chart/ white board and markers

Process:

- Introduction: "In the last few sessions we discussed about our body, its functions, and also how we protect it. This session we will be talking about what our life needs are in order to maintain good health.
- Ask children to list all the various needs that need to be met for our daily functioning and for our bodies to work well/ for us to be healthy.

- Allow for children to express needs that relate to physical needs such as food/shelter/clothing…as well as social and psychological needs, such as family, relationships etc.
- Next, ask children to categorize the items on this list into two: i) Basic Needs- those that sustain life; ii) Other essential needs. Tell children that they need to be able to explain this categorization/ how they made the decision about each item.

Discussion:

- What are the ways in which we can get these (listed) needs?
- How do we feel when these needs are met? (Joy/ pleasure…)
- If children do not mention it, ask about where sexual desire/ need for romantic relationships and physical intimacy may be placed.
- When needs are met, at some point there may also be negative effects felt. When does this happen? What might be some negative effects? *
- Validate needs and pleasures…discuss the amount consumed/ time spent…introduce concepts of balanced approach and time management.*

*Apply these last two discussions to need for romantic relationships and physical intimacy— while the need is perfectly legitimate, at what point might there be negative effects (for example, if we spend all our time thinking only about our romantic relationship, ignoring other things we have to do in life…or make decisions focussing only on these needs without considering other life issues…)

Activity 7.3. How We Use Our Senses

Method: Listing and discussion

Material: Flip chart/ white board and markers

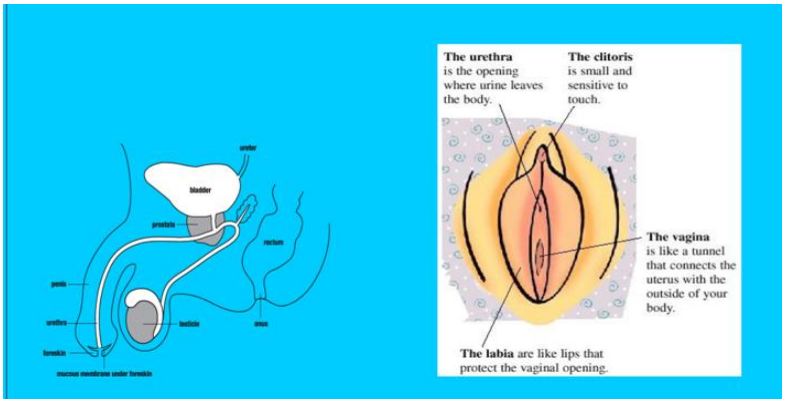
Process:

- Introduce the 5 sensory organs—eyes, ears, nose, mouth, skin. Explain how we feel or experience the environment around us through these five organs—namely through sight, sound, smell, taste, touch.
- Taking each sensory organ or sense, ask participants to list various experiences we can have through it. For instance, 'what are all the things we can do with our eyes? What experiences can we have using the sense of sight/ vision?' Remember that these experiences may be pleasant or unpleasant'. (Similarly, 'what are all the things we can do with our ears? What pleasant/ unpleasant experiences can we have using the sense of hearing? 'What are all the things we can do with our skin? What pleasant/ unpleasant experiences can we have using the sense of touch?'
- List the experiences (on paper or white board) as the participants speak. Either during or after the listing categorize the experiences into pleasant or unpleasant experiences—also described as pleasurable or painful experiences.
- At the end of the listing (and if the participants have not already done so), introduce the concept of sexual pleasure: 'As we discussed, we get pleasure sensations from experiences of various kinds of physical touch. Sexual touch is one type of physical touch from which we get pleasure—that is if we are touched in certain ways, in certain places in the body by a boy or girl that we like or feel attracted to. Just like when we eat good food, we feel happy because of yummy taste…or when we hear good music, we feel soothed or happy, sexual touch by certain people we like or desire can make us feel good.'
- Return to the body map drawn and explain: 'Sexual pleasure, like other pleasure sensations and experiences also has a physical basis. Let me show you where and how…'

- For girls' groups, draw into the body map (where the vagina is/ at the top of the vaginal opening, roughly) a leaf-like structure, as the clitoris and explain: 'There is a tiny and very sensitive organ just above the vaginal opening. It is called the 'clitoris' (in English). This tiny little body part is how and where girls feel sexual pleasure…when it is touched directly or if other parts of her body receive sexual touch—then also this part helps her to feel pleasure.'
- For boys' groups, point to the penis on the body map and explain: when touched directly or if a boy receives sexual touch in parts of his body, the sexual pleasure is felt primarily here, in the penis.'

Discussion:

- Ask the children to summarize their learning and understanding from the session/ activities.
- Conclude by reiterating: 'how pleasure (and pain) experiences come from sensations that we feel through our five sensory organs…and that sexual pleasure sensation and experience is a part of this. However, while sexual pleasure has a physical or bodily basis, this is NOT the only way in which we experience it. There is a big emotional component to sexual pleasure—what we think and feel not just in our bodies, but in our minds and hearts…what we then experience as feelings of love and attraction—issues we will discuss in the coming sessions.



Some Body Basics…

As the children already know about different body parts, the facilitator needs only to emphasise about the reproductive parts/organs in the body by also discuss about their role in the course of sexual act. The facilitator can use a picture to explain.

The female genital organ consists of 3 major parts namely clitoris, the urethra and vagina. These parts are covered and protected by two soft tissues. The clitoris is located at the front of the vulva. Typically, the clitoral is roughly the size and shape of a pea. The clitoral is highly sensitive, containing many nerve endings. Clitoris is the part which is Urethra is the external opening, from which urine is ejected during urination. Vagina is an elastic and muscular canal which connects the uterus to the outside world. The vagina receives the penis during sexual intercourse and also serves as a canal for menstrual flow from the uterus. During childbirth, the baby passes through the vagina (birth canal).

The male reproductive system consists of a number of sex organs that play a role in the process of human reproduction. These organs are located on the outside of the body and within the pelvis. The main male sex organs are the penis and the scrotum. The scrotum is a pouch-like structure that hangs behind the penis. It holds and protects the testicles. Testicles are the organs which produce sperms. Penis is the external genital organ which has an opening through both urine and the semen/sperms is ejaculated. Penis is the organ which enters the female genital tract vagina during intercourse

Activity 8.3. Readiness to engage in physical intimacy

Method: Film clip viewing and perspective-taking
Materials: Film clip 'Decision to Engage in Physical Intimacy'
Process:

- Screen the film clip.

Discussion:

- What do you see here?
  - What does the boy say to the girl; what does he ask her (What does he want)?
  - What was her reaction? Was she allowed to refuse? Why do you think she refused?
  - How did he react to her refusal? What is your opinion of his reaction?

- Why do you think he reacted that way? What were his feelings?
- After she said 'no' what else could he have done instead of threatening her?
- How do we make decisions about getting into physical relationships?
- What have we learnt about consent and permission in sexual relationships?
- Perpetrator- While asking somebody if they are interested in physical relationship. What are some issues we need to consider? (before asking them)
- Later, ask the children to divide into groups of 4-5 and ask them to role play a similar situation and tell them that they need to show how they would respond to the same situation.

Activity 8.8. Peer Pressure

Method: Film clip viewing and perspective-taking

Materials: Film clip 'Peer Pressure'

Process:

- Screen the film clip.

Discussion:

- What is happening in this clip?
- What is the relationship between these three people?
- What are they discussing about? What is your opinion about such discussions? (is it normal/does it happen…)
- One person/boy is not participating in the conversation. What do the others think of him? What is your opinion about lack of sexual experience in someone? Is it necessary..?
- "If you're a man, you should try… if you don't try then you are a disgrace to the 'male' community…." Do you agree with this statement? – Why/Why not?
- "If you haven't seen anything yet, then when are you going to do"… What do you think of this?
- What do you think was the reason for his hesitation? Was he interested?
- Who do you think passed by and how old might this person have been?
- What do you think he had in mind for this child?
- Can we engage in sexual acts with children (let's say below 13 years of age)? Why/Why not?
- Does this mean that we can engage in sexual acts with those who are 13yrs and above? Why/Why not?

OR

  - Under what circumstances could you even consider engaging in a sexual act? (On issues of consent / protection / using condom/ Risk of pregnancy and STD)
- What does the law say about engaging in sexual acts with children? (Provide information about POSCO)
- How could he have responded to these friends who believed that engaging in sexual act is important and shows that you are a "real man"? What, according to you, are the qualities of a 'real man'? (Facilitator to discuss qualities that are human—to do with compassion, equality, sensitivity…)

Activity 8.5. Readiness for Physical Intimacy

Method: Film clip viewing and perspective-taking

Materials: Film clip 'Readiness for Physical Intimacy'

Process:

- Screen the film clip.

Discussion:
- What do you see here?
- What type of relationship did they have?
- Where does he suggest taking their relationship?
- Is it ok for 2 people who know each other for long time(friends/lovers) to want to take the relationship to the next level/
- What level of physical intimacy was she comfortable with? Is it different from what he wants/is suggestion, how so?

Scene1:
- Is (i) Experimentation (ii) Knowing someone for long time; is this enough to engage in physical/sexual relationship?
- What is she feeling w hile he was trying to persuade her?
- When she absolutely refuses to get into a physical relationship what does he say initially? Why does he say this? What are his feelings?

Scene 2:
- What reasons does she give for not wanting to engage in physical intimacy, are they valid?
- What is his response to her refusal this time?
- What is the difference between his response in scene 1 and 2, which do you think is better response and why?

Activity 10.1: Safety in Practice

Methods: Art, simulation games

Materials: Sheets of white paper, pens, colours

Process:

- Introduction to session: We are going to talk about safety issues, especially pertaining to personal safety and abuse. This is the next criteria in making decisions about love and sexuality issues.

- Explain to the group: "Everybody deserves to feel safe and protected. Trusting a person means knowing or believing that this person will not hurt you in any way or do anything that makes you feel confused or uncomfortable. Children who have been hurt by someone have had their trust broken. It can be hard to trust others again when you have been hurt or been unsafe and unprotected. Sometimes you may not even trust yourself—and you may even believe that it was your fault that you were hurt. But you need to know that what happened was NOT YOUR FAULT!"
- Give them sheets of white paper and pens/ colours.
- First, ask them to draw a picture of a person they can trust.

- Then, ask them to draw a picture of a person they cannot trust.
- Now, ask them to draw a picture of a space they feel safe in.
- Then ask them to draw a picture of a space they feel unsafe in.

Discussion (Part 1—about Safe/ Unsafe People):

- What does trust mean to you?
- The person you trust—what are some of the things that this person does (or does not do) that makes you feel he/she is trustworthy?
- Can you share secrets with this person? Even secrets that are hard to tell?
- The person you do not trust-- what are some of the things that this person does (or does not do) that makes you feel he/she is NOT trustworthy?
- What are some ways you feel that trust can be broken?

Discussion (Part 2—about Safe/ Unsafe Spaces):

- Why do you feel safe/ unsafe in these places?
- About unsafe spaces--has anything ever happened to you or other children in these places to make you feel the way you do?

Summarize the discussion with some safety rules such as:

- It is ok to say 'no' to someone who wants to get in your personal space.
- It is ok to express any feeling as long as you don't hurt anyone or anything.
- Keep a safe distance from strangers or people who make you feel uncomfortable.
- It is advisable to avoid places that seem unsafe to you.
- If anyone/ any incident makes you feel unsafe or uncomfortable in any way, it is important to tell an adult that you trust (discuss who that might be for individuals in this group).
- Encourage the group to add to this list of rules (as applicable to their context).

Note: Children who feel reluctant to share need not do so. Let them know that there is no pressure to do so and that it is fine if they are able to participate and think through some issues and learn about them along with others. (They may also choose to talk to you/ facilitator later on if they wish to share *anything in particular)*.

Activity10.3. Sexual Abuse

Method: Film clip viewing and perspective-taking

Materials: Film clip 'Sexual Abuse'

Process:
- Screen the film clip.

Discussion:
- What do you see here?
- Did Shiva know his new neighbour? How did the N. uncle gradually get to know Shiva?
- If the first conversation that they had (playing with friends, watching Jungle Book), there was something that the uncle said (a particular sentence) that should have warned Shiva that this uncle may not be a good person. What was that?
- Why is this a problem if someone says "don't tell your parents"?
- What is the difference between the kind of secrecy that is expressed here vs. the secrecy regarding a surprise birthday party/Gift for someone?
- What kind of pictures do you think the uncle is showing Shiva?
- What do you think of the statement – If you see all these things you grow up…. Does anyone at home/at school teach you stuff like this…?
- Is Knowledge/Experience of sex the only way to be grown up? Are there other ways of growing up such as …?
- Did uncle force Shiva to come home and see these pictures and taking photos at any point of time? So, does this mean Shiva is a bad guy? Who is the bad guy here?
- When Shiva said it's bad, what did the uncle suggest? What is your opinion? Why/Why not?
- At what point did Shiva feel uncomfortable and why?
- Do you think that he felt uncomfortable only when his uncle touched him Or even before?
- One danger sign is "Do not tell anybody. This is our secret!!"
- What is another sign to recognize danger?

(Hint: It is to do with how we feel) – Ans: Discomfort/confusion
- When Shiva says he wants to go home, what does his uncle threaten to do?
- What should Shiva do now? How should he respond?

Activity 11.1. Family Relationships

Methods: Listing and Discussion; Role Play

Materials: White board/ paper

Process:
- Introduction to session: "Today we will discuss relationships. There are many different types of relationships—those within families and those in social spaces. Relationships have feelings and experiences within them. There are also differences in levels of closeness…and relationships can be easy or difficult. We will now try to understand different types of relationships and what respect and security mean within these relationships, how to make decisions on which relationships we wish to engage in and how/ with whom".

- In plenary, ask children to list various types of relationships within families.
- Ask them to describe the nature and characteristics of these relationships: o Feelings involved

- Activities done within them
- Expectations of each person involved

Discussion:

- What are the differences even within the family, between various relationships?
- Introduce the concept of rules and boundaries—that each relationship has certain boundaries/ people in it have certain roles to play…if they fail to play these roles/ do them differently, there might be a problem/ a violation.
- Ask children to give examples of when/ how these relationship boundaries get violated. In doing so, ask them to go back to the concepts of safety and permissions…how would they use these now to understand boundaries in relationships.
- In case the children do not provide examples of incest/ sexual abuse within the family, ask them about whether/how relationship boundaries would be violated if fathers/ uncles/ male cousins engaged in sexual relationships with children and adolescents (what parameters of relationships have been violated here?)

13. Navigating the Dilemmas of Mandatory Reporting in Child Sexual Abuse: Practice Guidelines for Implementation under POCSO Act

Learning Objectives

- To provide a comparative understanding of the chronological development of mandatory reporting provisions and their significance.
- To briefly explore the challenges in implementation of mandatory reporting provisions in India.
- To learn about a conceptual framework for balancing children rights to participation & decision-making with the mandatory reporting law.
- To develop skills in mandatory reporting through adoption of practice guidelines with children (and families).

Time

3.5 Hours

Concept

Mandatory Reporting Provisions under POCSO Act 2012

Mandatory reporting is a vital component of the law against child sexual abuse in India. Section 19 of the POCSO Act, 2012 (hereafter referred to as 'the Act') states:

"Section 19. Reporting of offences.

(1) Notwithstanding anything contained in the Code of Criminal Procedure, 1973 (2 of 1974) any person (including the child), who has apprehension that an offence under this Act is likely to be committed or has knowledge that such an offence has been committed, he shall provide such information to --

(a) the Special Juvenile Police Unit; or

(b) the local police.

(2) Every report given under sub-section *(1)* shall be--

(a) ascribed an entry number and recorded in writing;

(b) be read over to the informant;

(c) shall be entered in a book to be kept by the Police Unit.

(3) Where the report under sub-section *(1)* is given by a child, the same shall be recorded under subsection *(2)* in a simple language so that the child understands contents being recorded.

(4) In case contents are being recorded in the language not understood by the child or wherever it is deemed necessary, a translator or an interpreter, having such qualifications, experience and on payment of such fees as may be prescribed, shall be provided to the child if he fails to understand the same.

(5) Where the Special Juvenile Police Unit or local police is satisfied that the child against whom an offence has been committed is in need of care and protection, then, it shall, after recording the reasons in writing, make immediate arrangement to give him such care and protection including admitting the child into shelter home or to the nearest hospital within twenty-four hours of the report, as may be prescribed.

(6) The Special Juvenile Police Unit or local police shall, without unnecessary delay but within a period of twenty-four hours, report the matter to the Child Welfare Committee and the Special Court or where no Special Court has been designated, to the Court of Session, including need of the child for care and protection and steps taken in this regard.

(7) No person shall incur any liability, whether civil or criminal, for giving the information in good faith for the purpose of sub-section *(1)*."

While section 19 of the Act creates an obligation to report for individuals, section 20 of the Act, creates such an obligation for certain institutions. Section 20 states:

"Section 20. Obligation of media, studio and photographic facilities to report cases.

Any personnel of the media or hotel or lodge or hospital or club or studio or photographic facilities, by whatever name called, irrespective of the number of persons employed therein, shall, on coming across any material or object which is sexually exploitative of the child (including pornographic, sexually-related or making obscene representation of a child or children) through the use of any medium, shall provide such information to the Special Juvenile Police Unit, or to the local police, as the case may be."

Section 21 of the Act prescribes punishment for the failure to report. It states:

"Section 21: Punishment for the failure to report a case.

(1) Any person, who fails to report the commission of an offence under sub-section *(1)* of section 19 or section 20 or who fails to record such offence under sub-section *(2)* of section 19 shall be punished with imprisonment of either description which may extend to six months or with fine or with both.

(2) Any person, being in-charge of any company or an institution (by whatever name called) who fails to report the commission of an offence under sub-section *(1)* of section 19 in respect of a subordinate under his control, shall be punished with imprisonment for a term which may extend to one year and with fine.

(3) The provisions of sub-section *(1)* shall not apply to a child under this Act."

By the use of the operative word *shall* in section 19(1), and section 20, the POCSO Act casts an obligation upon every adult in the country and certain institutions respectively, who knows or suspects that a child is being sexually abused to report the case to the authorities. To report a case, one must provide the information they know about the incident of child sexual abuse to the Special Juvenile Police Unit (SPJU), or to the local police, which sets in motion the chain of the criminal justice process. *Knowledge* in section 19(1) has been interpreted by the Supreme Court to mean some information received by such a person gives him/her knowledge about the commission of the crime. There is no obligation on this person to investigate and gather knowledge. Thus, there is no requirement for this person to deduct from circumstances that an offence has been committed. Failure to report is a punishable offence, as stated in section 21(1) of the Act, with imprisonment of up to six months, or a fine, or both. In instances when the person is in charge of a company or institution (such as a School Principal, the Superintendent of a Child care institution, etc) fails to report a crime of child sexual abuse which their subordinate committed, the punishment is imprisonment of one year and a fine, as stated in section 21(2).

Referred to as "Mandatory Reporting", this obligation to report is crucial – the legal process and the punishment is dependent upon crimes being reported. It is intended to protect the child, protect their best interests, and to safeguard other children who may potentially face abuse from the perpetrator. Further, it can also serve to act as a deterrent to potential abusers and rightfully seeks to make perpetrators accountable for their crimes.

As beneficial as the legislation is, mandatory reporting brings along with it a number of challenges.

In the light of these difficulties, how best can mental health professionals, child protection workers and other child service providers help children and families to work through their many concerns in order to ensure, as far as

possible, adherence to the mandatory reporting provisions of the POCSO Act? This module discusses the challenges and provides frameworks and methodologies for working with children (and families) on mandatory reporting issues in the context of CSA.

Practical Challenges in Implementation of the Law

Mandatory reporting is the most crucial aspect of implementing the CSA law because the legal response to a sexual offense, i.e., the investigation, framing of charges, trial, sentencing of the offender and prevention of further abuse, relies almost entirely on this provision being triggered in the first place. The law seems to imply that irrespective of what child victims' opinion on the matter is, the incident(s) must be reported. But what if a child (or her family) do not wish to report? What are barriers to reporting?

Barriers to reporting refer to issues similar to what we learnt in disclosure of CSA. They pertain to a range of reasons in children, such as fears of not being believed, of being blamed ('it was your fault') and of the police and law enforcement agencies, that the perpetrator may harm them or their families for reporting, that 'everyone/ all my friends will know what happened to me'…and family-related fears may similarly include social stigma, fears of the perpetrator, the discomfort of reporting on the perpetrator if he/she is a family member, reluctance to engage with the relatively unknown or unchartered territories of legal processes. Therefore, supposing we were to implement the law as is, without consulting and communicating with children and families i.e. without understanding and addressing their fears and anxieties regarding reporting, what might happen? We, as citizens and/or child care professionals may have done our duty as per the law and reported the incident. But if the child (and family) were reluctant to report in the first place, they are unlikely to follow through with the legal processes thereafter…in other words, when the police contact them for the filing of the FIR and the recording of the 161 statements, the child (or family) may refuse to cooperate, in which the case is unlikely to move forward.

While even the Supreme Court has routinely acknowledged the aforementioned barriers to reporting, it has tended to hold the view that the best interests of the child (a legally recognised principle of child rights) can only be ensured if despite these barriers, reporting is ensured through the provision of mandatory reporting, due to the threat of continued perpetuation of CSA against the child. Thus, in order to ensure the best interest of the child, it is important to adopt a framework which balances the legal obligation to report with the child's fears and apprehensions about initiating and participating in legal proceedings.

Activity: Barriers to Reporting

Method:
Listing and discussion

Materials:
None

Process and Discussion:

- Provide the following scenario: A child discloses CSA to you…and begs you not to report. She/he says… *'please don't report! I don't want anyone to know…if my parents get to know this, they will blame me…I don't want bad things to happen to my family…'*

- Take a range of responses on: *"What would you do? i.e. would you report or not? And what basis would you make this decision on?"*

- Next, engage in an exercise of listing and categorizing:

-Go around the room and ask each participant to state one barrier to mandatory reporting…it could be child or family-related, or it might be socio-cultural or systems related…

-Categorize the barriers accordingly…add any other categories that may emerge.

Listing and Categorization of Barriers…

Child & Family Related including socio-cultural

Fear of future…marriage/relationship
When perpetrator is a family member
Fear of breaking the family
Lack of awareness of law and uncertainties of legal processes
Child being re-traumatized…adverse mental health impacts on child
When child is groomed (will not report)
Child does not want to disclose/ report
Child's fear of being blamed
Threats from perpetrator
Child's fear of losing physical mobility/ education
Status of family…more marginalized community groups less likely to report
Social stigma (Family)
Family's fear of loss of income, social exclusion
Age and disability…young/disabled children have difficulty reporting
Position of (powerful) perpetrator in community
Normalization of abuse /violence…fatalism
Religion, personal beliefs of child/ family…of forgiveness
Institutionalized children…afraid of reporting (nowhere to to)

Systemic (from mental health service providers' perspective)

Lack of specificity of law
Lack of understanding of methods to proceed with reporting
Confusions about roles & responsibilities
Mental health professionals' lack of knowledge on CSA law
Family pressuring professionals not to report
Fear of losing a client
Fear of one's own safety
Reluctance to report—to get involved in tedious court processes
Lack of time (mental health professionals)—to get into legal processes
Difficulty in balancing child protection system agenda and family's needs
Inconsistencies in narratives provided by child and family (MH professional reluctant to report)
Inadequate assessment and inquiry (we often do not know or have adequate information to report)

A Framework for Balancing the Mandatory Reporting Law with Children's Rights to Participation & Decision-making

The implications of the (above-discussed) barriers to CSA disclosure and reporting are that while the law is important, its effective implementation needs to take into consideration the rights of children (and families), to make decisions and provide consent on reporting issues. Without the consent of children (and the assent of parents/families), in the mandatory reporting process, further legal processes are unlikely to proceed smoothly i.e. children and families may simply turn hostile, causing the case will fall through.

In essence, what we are dealing with is the tensions between the law and child rights, participation, and consent—as represented in figure 1 below. The 'see-saw' comprises of legal and systemic perspectives on the one side, and children's perspectives on the other. Effective implementation of mandatory reporting would require the integration of these two perspectives—each of which comprise of the elements subsequently discussed in Table A below.

Figure 1: A Framework for Balancing the Mandatory Reporting Law with Children's Rights to Participation & Decision-making

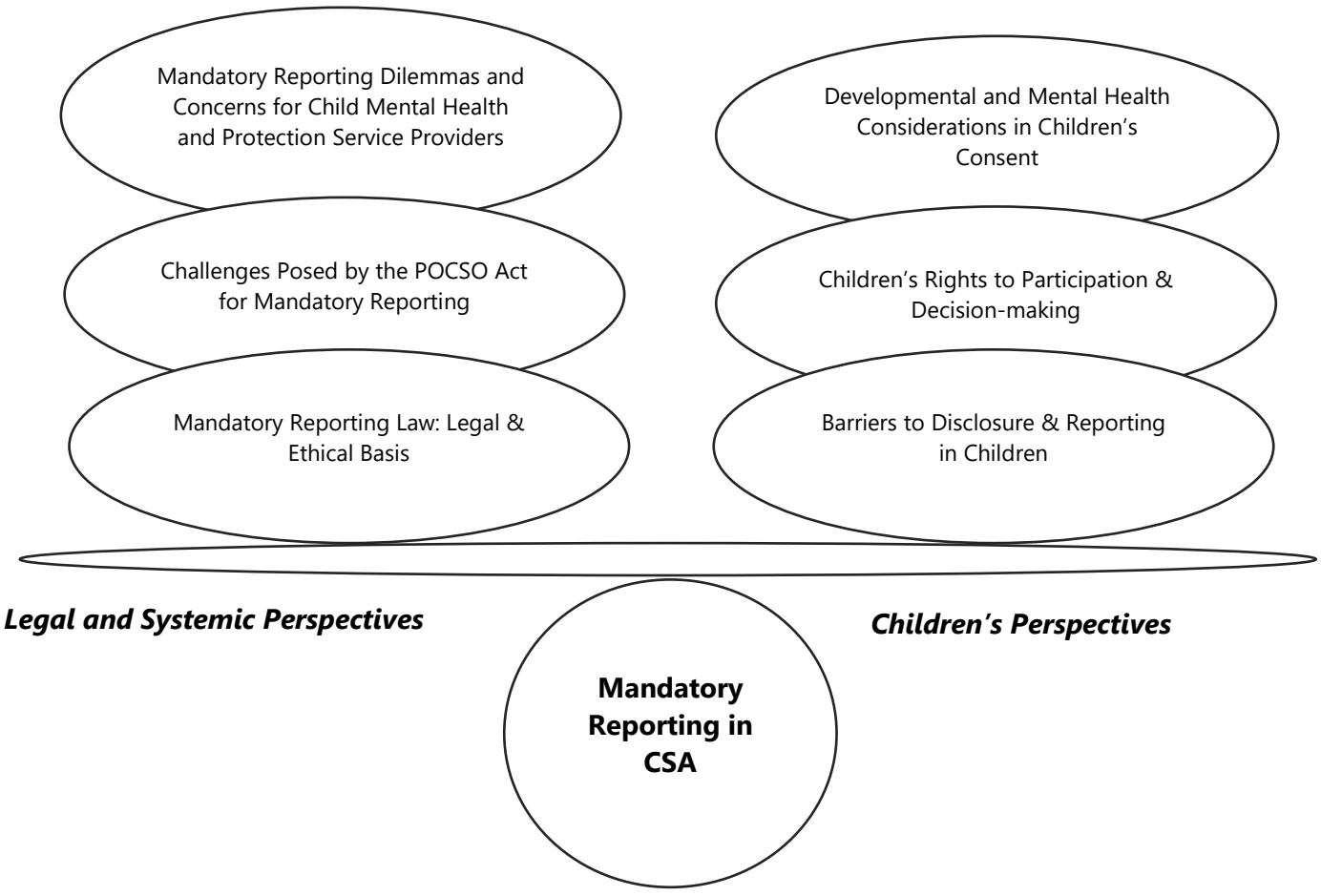


Table A: Elements of Framework for Balancing the Mandatory Reporting Law with Children's Rights to Participation & Decision-making

Legal & Systemic Perspectives	Children's Perspectives
Legal & Ethical Basis for Mandatory Reporting • Every society has an obligation to protect its citizens, especially the most vulnerable. • The need to break the silence about sexual crimes against children. • Imperatives for early detection of abuse, prevention of child abuse, ensuring appropriate institutional responses.	**Barriers to Disclosure & Reporting in Children** • Patriarchal attitudes, gender stereotypes and consequent stigmatization, • Fear of not being believed or rejected • Upsetting the parents/caregivers, • Disruption of the family dynamics • Having a close relationship with the perpetrator.
Challenges Posed by the POCSO Act for Mandatory Reporting • Lack of awareness of the law amongst child service providers. • Lack of adequate training of the stakeholders (i.e., police, prosecutors, judges, doctors, mental health professionals). • No specification of categories of persons or professionals who should report, or provisions for protection for them.	**Children's Rights to Participation & Decision-making** • UN Child Rights Convention (CRC) states: children's *'empowerment and participation should be central to child caregiving and protection strategies and programmes'*. • UNCRC defines child participation as: *'ongoing processes, which include information-sharing and dialogue between children and adults…in which children can learn how their views and those of adults are taken into account and shape the outcome of such processes.'* • Child's right to protection cannot be implemented in isolation from other rights.
Dilemmas and Concerns for Child Mental Health and Protection Service Providers • Lack of knowledge and recognition of child abuse. • Concerns about the negative effect of the reporting on the child's family. • Lack of training for professionals working with children on how to appropriately respond to or deal with disclosure of sexual trauma. • Adverse effect on therapeutic alliance between the therapist thus disrupting the child's healing process.	**Developmental and Mental Health Considerations in Children's Consent** • Children's abilities to provide consent are dependent on their age and developmental abilities as well as their mental health status (in terms of trauma and other psychiatric disorders)—for these factors impact their capacities to engage in participatory processes relating to consent, in the context of mandatory reporting.

In the light of the tensions and the complexities of the mandatory reporting context in India the questions we need to consider are:

- **How do we navigate the dilemmas and challenges for reporting from the perspectives of service providers and child protection and mental health systems, by considering: a) the requirements of the POCSO law, and b) child rights and consent in the process of mandatory reporting?**
- **How to implement the mandatory reporting clause of the law by balancing the law with child rights and consent—or in other words, how to negotiate with children (and families) in ways the enable them to move towards the law and participate in reporting processes?**
- **In sum, how do we balance the law with child rights, participation and consent in the context of mandatory reporting.**

Further Considerations relating in Participating in Mandatory Reporting Processes… Child's Age and Developmental Stage

- Informed consent' or 'valid consent', means agreeing (to treatment or intervention), based on: (i) capacity—an adequate understanding of the situation; (ii) voluntariness—ability to use free will and be free of pressure and coercion; (iii) sufficient information.
- In order to provide informed consent, child needs to be able to understand:
  - what happened by way of the abuse (what the perpetrator did to him/her)
  - what perpetrator did was wrong, including why it was wrong
  - there are laws/ rules that do not allow children to be hurt.
- Piaget's Cognitive Development Theory for Children, and its implications for consent:
  - Children of 7 years of age: i) are more logical and organized in their thinking (though still very concrete); ii) begin using inductive logic, or reasoning from specific information to a general principle; (iii) develop the ability to think more from other people's perspectives.
  - Therefore, minimum age to engage child in mandatory reporting processes is 7 years.

Assent or parental consent to be obtained for very young children (below the age of 7 years) and/or children with intellectual disabilities as these children do not have the cognitive capacities to engage in consent and mandatory reporting processes.

SAMVAD's 8-Step Process Guidance on Engaging Children in Mandatory Reporting

Given that one of the key lacunae in the implementation of mandatory reporting processes by child mental health and protection personnel pertains to a paucity of systematic guidelines or protocols on navigating the challenges of mandatory reporting, this session focuses on methods and skills to work with children (and families) on mandatory reporting issues. SAMVAD has, based on its experience in CSA work, developed an 8-step guidance on engaging children in mandatory reporting.

Activity 2: Communicating with children on mandatory reporting issues

Method: Viewing and discussion of video clips in plenary

Materials: Video clips developed by SAMVAD on mandatory reporting, available on YouTube at:

https://www.youtube.com/watch?v=Aw-VTsYZ44c&list=PL6M-G4mGr43pxE7VQ0Gs5_MA1br6BkDmy&pp=iAQB

(QR codes for these videos are also available at the end of this module--refer to 'Additional Materials').

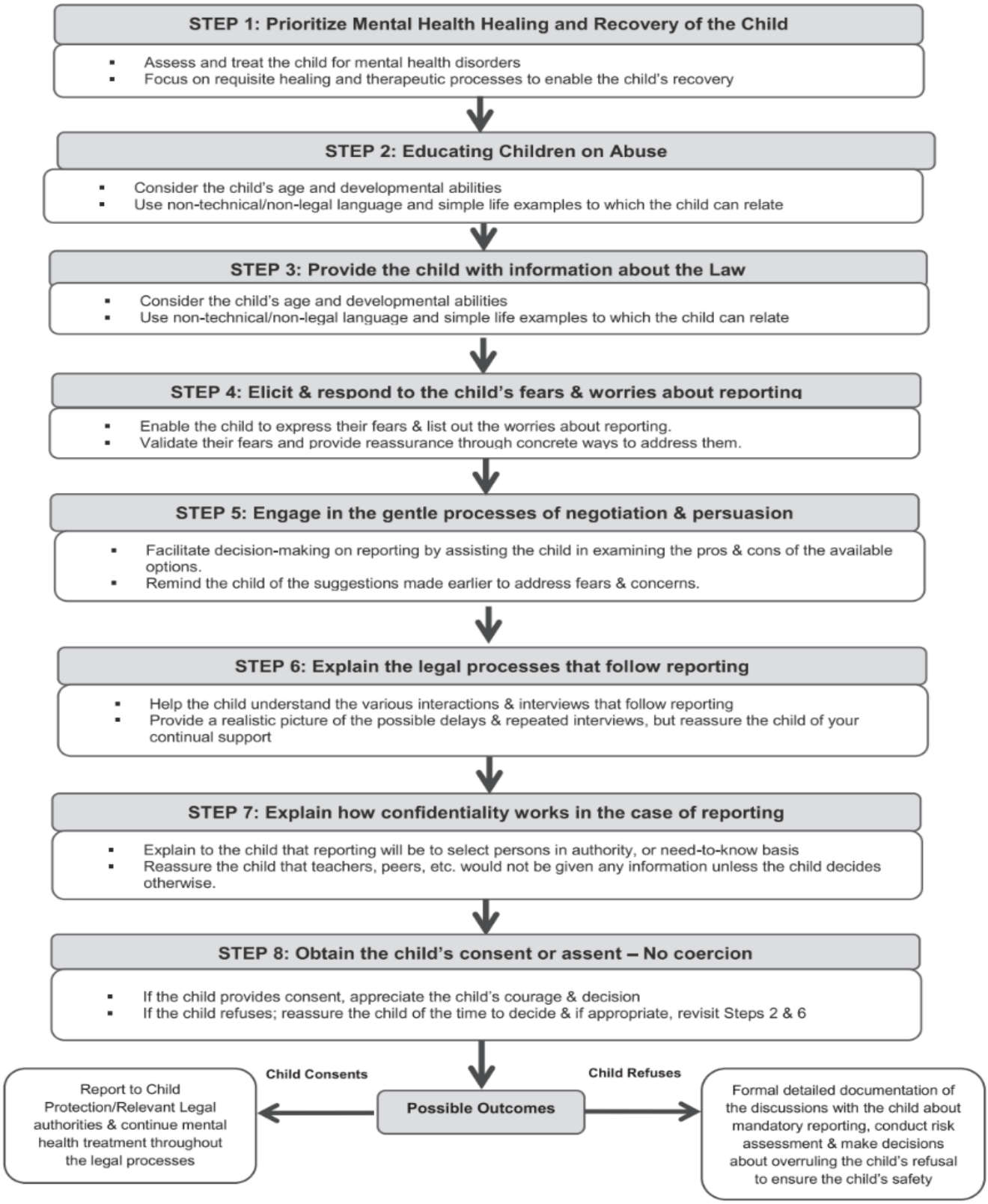
Process:

- Explain to the participants that:
  - SAMVAD has developed a bunch of demo videos to show how discussion on mandatory reporting can be had with children, based on the mandatory guideline (also developed by SAMVAD).
  - The clips reflect excerpts of conversations that mental health service providers/ health worker may have with children—thus also providing service providers with possible scripts and ways to approach the mandatory reporting discussions with children and parents.
  - We will view the clips one by one—with each viewing followed by a discussion on the approach and script used by the child worker/therapist, with the child.
- Play the clips one by one—there are six clips in all, to be played in order, as follows:
  - Providing Information to Children about the POCSO Law
  - Eliciting and Responding to Child's Fears and Worries about Reporting
  - Engaging Children in Gentle Processes of Negotiation and Persuasion
  - Explaining Legal Processes that Follow Reporting
  - Obtaining Consent without Pressure or Coercion (including responding to situations where children ultimately consent to reporting versus when they still express reluctance to report).

Discussion:

- What were some of the concerns and hesitancies you observed in the child?
- How did the therapist/ child worker respond to them?
- What were some of the things that struck you about the therapist/ child worker's scripts and responses?
- Emphasize that similar approaches can be used with parents and family members also, to enable them to follow through with mandatory reporting processes.

Figure 2: An 8-Step process guidance on engaging children in Mandatory Reporting



What if a Child Does Not Agree to Reporting CSA?

One may follow all the necessary guidelines to engage children in the mandatory reporting, embedding the requisite processes in children's developmental abilities, mental health issues, child rights and participation, some children might still refuse to acquiesce reporting. How then do we respond to children's refusal to reporting? One possibility is to conduct a risk assessment as outlined in the table below, and make reporting decisions accordingly.

Responding to Children's Refusal to Mandatory Reporting

Risk Assessment of Child (Re)Abuse		Service Provider Decisions & Responses
High Risk	• Child is at high risk of continued abuse. • Perpetrator is a family member who lives with the child. • Perpetrator has regular and easy access to the child.	• Negotiate with (non-abusive members of) the child's family and make alternative living arrangements for the child, perhaps even temporarily. • Prioritize the child's (physical) safety over adverse mental health consequences that might result from going against the child's wishes. • Over-ride family/child's decision and refusal to report—and proceed with mandatory reporting to law enforcement authorities.
Low Risk	• Perpetrator is no longer present in the child's life. • Abuse was a one-off incident either by a person relatively unknown to the child or by one who does not have easy or regular access to the child.	• Comply with the child's wishes and not proceed immediately with mandatory reporting but ensure necessary documentation to this effect.

A child who lives with the perpetrator (within the same house or family), or wherein the perpetrator, for whatever reason, has regular access to the child, would be at high risk as the abuse is likely to continue—in this situation, service providers would need to override the child's decisions and refusal, and proceed to report. However, if the perpetrator is no longer present in the child's life, and/or the abuse was a one-off incident either by a person relatively unknown to the child or by one who does not have easy or regular access to the child, the service provider may comply with the child's wishes and not proceed immediately with mandatory reporting.

Document, Document, Document!

Finally, it is critical for service providers to document every discussion that is had with the child (and family) on mandatory reporting—so that there is always evidence that attempts have been made to follow the mandatory reporting clause of the law. In case of any questions raised by child protection and legal authorities at a later stage, appropriate documentation may serve to protect service providers as the authorities are made aware of due attempts at mandatory reporting. This documentation (preferably in the child's file) must include the following:

- Information that was provided to the child/ family regarding the law.
- Reasons and reservations expressed by the child (and family) for not reporting.
- Attempts made by the service providers to persuade the child (and family) to report (Thus, having a protocol or guideline for discussion of mandatory reporting processes with children and families also enables service providers to engage methodically in discussion processes and consequently, and allow for systematic documentation).
- Outcomes of discussions and negotiations, at each stage i.e. child and family responses.

Activity 3: Let's try it out!

Method:
Role play

Material:
A hand-out with the 8-step mandatory reporting guideline (developed by SAMVAD);
Additional Materials (2) on frequently asked questions in mandatory reporting—for use by the facilitator but may, at the end of the session also be shared with the participants.

Process:

- Ask participants to divide into pairs—wherein one person assumes the role of the child, and the other, that of a counsellor.
- Provide each pair with a hand-out with the 7-step mandatory reporting guideline.
- Request them to use the guideline, particularly the script, to try out some ways of engaging a child in the mandatory reporting process.
- If time permits, ask one to two participant pairs to to volunteer to do the role play in plenary.

Discussion:

- Request participants to share their experiences—particularly parts of the discussion that may have been challenging (i.e. where they struggled to respond to children).
- Explain that the steps and scripts presented in the guideline are approaches and ideas to make the interactions and discussions on mandatory reporting more systematic—but that participants/service providers may feel free to try out various analogies or methods that are

Final Thoughts on Mandatory Reporting

How child mental health and protection service providers balance issues of law with child rights and participation, child development and mental health, to make decisions on mandatory reporting ultimately depends on quintessentially on their orientations to children and childhood and views on children's rights; whether they believe that children's rights to safety and protection must always supersede their rights to participation and decision-making; the circumstances under which compliance with rules and laws are absolute vis-à-vis situations in which children may be provided space to be heard, and to participate in decisions that affect their lives. All responses to mandatory reporting are a result of the permutations and combinations of such individual knowledge and beliefs factors, in ever varying proportions. This might explain why one service provider's position might be to always report CSA, because children's safety and protection interests must always be paramount (and take precedence over child rights and resulting mental health issues); and another service provider's position may be to never report without the consent of the child, even if it means going to prison for six months, because children's rights and consent are paramount. These responses, at the two extreme ends of the spectrum of responses, can neither be intensely condemned, nor strongly supported, because they are predicated on individual belief systems and professional ideologies.

In order to straddle these varied personal and professional beliefs and ideologies, and the challenges of varying contextual realities in which CSA plays out and mandatory reporting is required to be implemented, that the 8-step guidance has been developed…in the hope of empowering service providers with a framework for systematic engagement and response so that, no matter what the final outcomes are for mandatory reporting, appropriate attempts were made, to push for the implementation of mandatory reporting, in ways that attempt to balance the existing law with children's rights to participation and decision-making.

Suggested Readings

- Ramaswamy, S., Devgun, M., Seshadri, S., & Bunders, J. (2023). Balancing the law with children's rights to participation and decision-making: Practice guidelines for mandatory reporting processes in child sexual abuse. *Asian Journal of Psychiatry*, *81*, 103464.
- Mathews, B. (2015). Mandatory reporting laws: Their origin, nature, and development over time. In *Mandatory reporting laws and the identification of severe child abuse and neglect* (pp. 3-25). Springer, Dordrecht.
- Pietrantonio, A. M., Wright, E., Gibson, K. N., Alldred, T., Jacobson, D., & Niec, A. (2013). Mandatory reporting of child abuse and neglect: Crafting a positive process for health professionals and caregivers. *Child abuse & neglect*, *37*(2-3), 102-109.
- McQuoid-Mason, D. (2011). Mandatory reporting of sexual abuse under the Sexual Offences Act and the 'best interests of the child'. *South African Journal of Bioethics and Law*, *4*(2), 74-78.
- Kuruppu, J., Forsdike, K., & Hegarty, K. (2018). 'It's a necessary evil': experiences and perceptions of mandatory reporting of child abuse in Victorian general practice. *Australian journal of general practice*, *47*(10), 729-733.
- Hepworth, I., & McGOWAN, L. (2013). Do mental health professionals enquire about childhood sexual abuse during routine mental health assessment in acute mental health settings? A substantive literature review. *Journal of Psychiatric and Mental Health Nursing*, *20*(6), 473-483.
- Wekerle, C. (2013). Resilience in the context of child maltreatment: Connections to the practice of mandatory reporting. Child abuse & neglect, 37(2-3), 93-101.
- Falkiner, M., Thomson, D., & Day, A. (2017). Teachers' understanding and practice of mandatory reporting of child maltreatment. Children Australia, 42(1), 38-48.
- Shankar Kisanrao Khade v. State of Maharashtra, (2013) 5 SCC 546.
- Sr. Tessy Jose and Others vs. State of Kerala, (2019) 3 SCC (Cri) 164.
- Lalita Kumari vs. Govt. of UP and Ors. (2014) 2 SCC 1

Additional Materials

Videos for the Activity on 'Communicating with Children on Mandatory Reporting Issues'

Video Title	Mandatory Reporting Processes in POCSO (English)	Mandatory Reporting Processes in POCSO (Hindi)
Providing Information About the Law	https://www.youtube.com/watch?v=2ZNg10zbZ0s&list=PL6M-G4mGr43pxE7VQ0Gs5_MA1br6BkDmy&index=2	https://www.youtube.com/watch?v=iYANFvUPFVM&list=PL6M-G4mGr43omsdhfnuyonlccL9big1cG&index=7
Eliciting Fears and Worries about Reporting	https://www.youtube.com/watch?v=Aw-VTsYZ44c&list=PL6M-G4mGr43pxE7VQ0Gs5_MA1br6BkDmy&index=1	https://www.youtube.com/watch?v=cx05mZcw4a4&list=PL6M-G4mGr43omsdhfnuyonlccL9big1cG&index=6
Negotiation and Persuasion	https://www.youtube.com/watch?v=JC9bXKFVILY&list=PL6M-G4mGr43pxE7VQ0Gs5_MA1br6BkDmy&index=3	https://www.youtube.com/watch?v=9IE6jZtipEY&list=PL6M-G4mGr43omsdhfnuyonlccL9big1cG&index=5
Legal Processes Following Reporting	https://www.youtube.com/watch?v=uXk3mol7OF8&list=PL6M-G4mGr43pxE7VQ0Gs5_MA1br6BkDmy&index=5	https://www.youtube.com/watch?v=oAIrHd7H1uA&list=PL6M-G4mGr43omsdhfnuyonlccL9big1cG&index=4
Explaining Confidentiality to the child	https://www.youtube.com/watch?v=nR5fjm3ygiw&list=PL6M-G4mGr43pxE7VQ0Gs5_MA1br6BkDmy&index=7	https://www.youtube.com/watch?v=oaztX6cw4Nc&list=PL6M-G4mGr43omsdhfnuyonlccL9big1cG&index=3
Obtaining Consent (A) If Child Is Decides to Report	https://www.youtube.com/watch?v=wnj0Lkp3vog&list=PL6M-G4mGr43pxE7VQ0Gs5_MA1br6BkDmy&index=4	https://www.youtube.com/watch?v=WG6M_0otAVg&list=PL6M-G4mGr43omsdhfnuyonlccL9big1cG&index=2
Obtaining Consent (B) If Child Is Decides to Not Report	https://www.youtube.com/watch?v=ioLPD7tRd9c&list=PL6M-G4mGr43pxE7VQ0Gs5_MA1br6BkDmy&index=6	https://www.youtube.com/watch?v=59r4-llOxfA&list=PL6M-G4mGr43omsdhfnuyonlccL9big1cG&index=1

Suggested Scripts for Implementing Practice Guidelines on Mandatory Reporting in Child Sexual Abuse for the Activity 'Let's Try it Out!'

*Note: The use of the sample scripts (below) is at the discretion of practitioners—it is expected that based on their knowledge of child development, they will modify the scripts and their language to fit the child's age and understanding.

Providing Children with Information on the law

- *"If someone were to break into our home and steal our things and hurt out family, what would we usually do?" [Allow the child to respond…it is likely that most children will say they would complain to the police].*
- *"That's right…we would tell the police…because it is not ok for someone to break into our home, steal our stuff and hurt our family. What would the police then do?" [Allow the child to respond…it is likely that children will say that the police will catch the person and put him in prison].*
- *"Yes, the police would then have to catch the person and put him in prison. So, we have rules in our country about how people should behave, what they can and cannot do. If they do things against those rules (like breaking into homes, stealing or hurting people, for example), they would need to be punished".*
- *"In the same way, we have rules in our country about people who hurt children, or do things that make them feel upset and uncomfortable. No one is allowed to hurt children. So, if someone does, the rules say that we must tell the police—so that they can catch and punish this person".*
- *"So according to the rules, we are supposed to tell the police what X [the perpetrator] did to you…and because of which you were hurt and felt upset and uncomfortable. So that the police can act against X—because it was not ok for X to hurt you; and we want you to be safe and protected. What do you think?"*

Eliciting & Responding to Children's Fears and Worries

- *"Many children have told me that they are worried and do not wish for me to report what happened to them and tell the child welfare committee or police about it. Everyone has reasons to feel this way…but everyone's reasons are different. I am sure you too have some really important reasons for not wanting me to report".*
- *"Can you tell me what some of your fears and worries are regarding reporting?"*
- *"Maybe I can try and help you with some of these fears and worries…"*
- *"While I understand your fears and worries about reporting, your physical safety is an important concern for us…I do not want for you to continue to get hurt as I am sure you would not want either…"*

Engaging in gentle processes of negotiation and persuasion

- *"Whenever we need to make a decision about something, it is not just about saying 'yes' or 'no'. We need to spend some time thinking about it, before deciding on what to do. Would that be right?"*
- *"How do we do our thinking? We first figure what our options are—what we can do. Then we think about each option…like if I do or decide this way, what will happen? If I do or decide the other way, what would happen?"*
- *"So, in this situation, where someone has hurt you or made you feel uncomfortable and upset…we can decide to report to the police and legal authorities or we can decide not to report. (Remember we are just going to spend some days/sessions thinking…we are not deciding as yet)."*

- *"Let us first look at what happens if we decide to report…and make a list of the good things that could happen for you/ your family if we report" [let child do it—and either the child or you can write down the list as he/she speaks].*
- *"Now let us make a list of the not-so-good things that you may feel might happen if we report… [let child do it—and either the child or you can write down the list as he/she speaks].*

Explaining Legal Processes that Follow Reporting

- *"As we make decisions on whether to report, it might be helpful if I tell you a little about who I would report to and what would happen after…"*
- *"If we decide to go ahead with the reporting, I would write a letter to the police [or child welfare committee] and tell them your name, age, address, your parents' names; that you had been hurt by X [perpetrator] and about your injuries [if any], how you are feeling now…"*
- *"The police would then come to your house and ask you some questions—maybe a little bit like the ones I asked you, so that they understand who hurt you, how and when. But usually, when police come to talk to children about these things, they don't wear their uniform…did you know that?"*
- *"After the police have written down all that you have told them…because they should not forget anything you tell them—it is important—they may first catch the person who hurt you and take some action against him/her".*
- *"Next, there is a place called the court. Have you heard of it? [If child says yes] What do you know about it? [Allow the child to share and then continue]. The court is a place where people go when someone has hurt them or done something that is against the rules/ laws of the country…remember, like we were talking about breaking into people's houses, stealing etc. So, when people feel that someone did something and unfair to them, they go to court."*
- *"Now, what happens in court? There is a person called a judge…he/she will ask questions about what happened and who caused the hurt or did bad things to people…and he/she will then decide how to deal with the wrong-doer and what punishment to give".*
- *"So, if you decide we should report, after the police have talked to you…and it may even be many months later, we would then need to go to court—where the judge will ask you some questions, just like the police or I did about what happened and how [the perpetrator] hurt you. And then, based on what you say, the judge will decide how to deal with [the perpetrator]…"*
- *"I understand it sounds like there is a lot that will happen if we decide to report…but you are such a courageous person—that I believe you will be able to do what it takes. Also, you are never going to be alone in any of these places or times…your parents will be with you, I could also come if you like…and of course I would be there to support you and help you with everything, throughout."*

Explaining How Confidentiality Works in Reporting

- *"There are some things that we don't wish to share with everyone…we keep them to ourselves or share them with just a few people whom we may trust…like you shared what happened with [the perpetrator] with just your mummy and daddy and me".*
- *"It is alright for us not to want for everyone to know everything about us—we all have a right to decide what to tell, how much to tell and whom to tell".*
- *"So, if we decide to go ahead with the reporting, some people in the police and in the court will know what happened with you—they need to know because it is their job to help children and keep them safe…and they can only help you if they know what happened.*
- *"But others like your teachers and friends at school and around the house, your neighbours need not know…we do not need to tell them anything. Maybe you are worried about them asking you questions about what happened? [If child says 'yes'] I have some ideas on how you could answer those questions…like what you can tell them that will make them stop asking questions and go away…"*
- *"I want you to know that our [hospital/clinic/service] has rules about telling people stuff…we do not share any information…so, you need not worry that we will tell anyone or that the police or court will tell anyone—they don't know your school teachers or friends!"*

Obtaining children's consent or assent—no coercion!

- *"We have been talking about many things in recent days…and on whether or not you are agreeable for me to report about what happened with you. I know it can be confusing sometimes to know what to do…and hard to decide…but I also know that you have tried hard to think about these difficult things...that is very brave."*
- *"What have you decided so far?" [Allow the child to respond and discuss what comes up].*
- *[If the child agrees to reporting]: "I am proud of what a brave person you are…and how you have thought about things and decided that it would be best for action to be taken against [the perpetrator]. Not many children, or even adults have your courage…it is a credit to your caring for other children, that they should be protected…"*
- *[If the child is still unsure of the reporting decision or has decided that he/she does not wish for mandatory reporting to be implemented]: "I am proud of what a brave person you are…and how you have thought about things, despite how difficult it had been for you. Some of these are hard issues to decide on…and we are not in a hurry. As I had assured you at the start, no decision will be taken without discussing with you and without your permission. We can spend some more time thinking and discussion…whenever you feel ready…or even set aside this issue for a while. We can talk about other things, for example, what to do when you feel worried, how you can keep yourself safe in the future… how you feel, your plans, your decisions, your future are all of utmost importance to me…and I would like to help you get clarity on those issues".*

14. The Child Witness in the Adversarial Justice System

Learning Objectives

- To understand the characteristics of an adversarial justice system.
- To identify the adverse impacts of the adversarial justice system on child witnesses.
- To learn what child-friendly court procedures and processes constitute.
- To get a glimpse of alternative justice systems in existence, for child witnesses.

Time

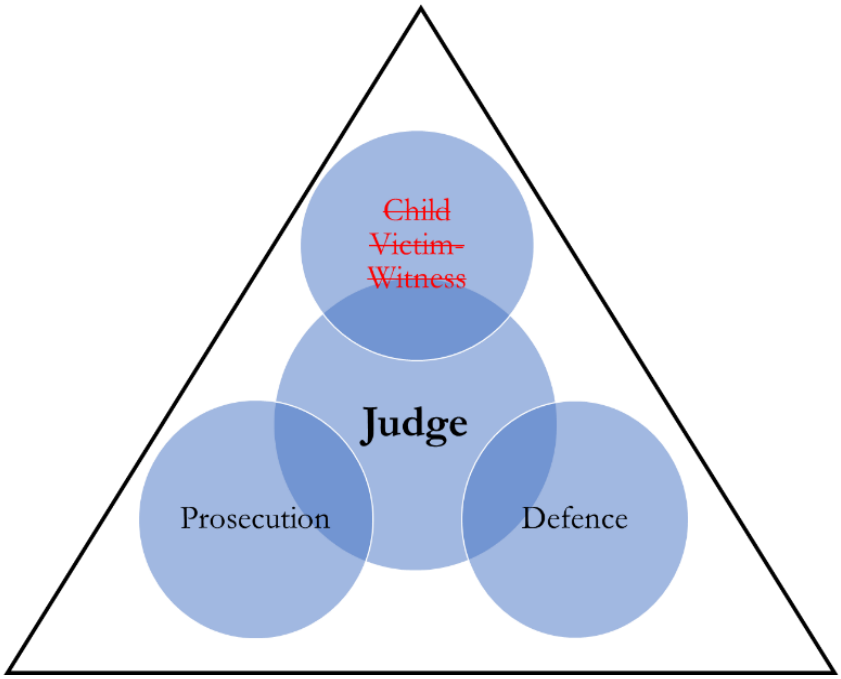
2 Hours

Concept

How does India's Justice System work?

India has an **adversarial system of justice**, so the process of arriving at the truth is based on a judge-led evaluation of two versions of the 'truth', to conclusively decide which version of events offers the best approximation of truth. The adversarial model assumes that the parties' self-interest will ensure that all relevant material is presented and tested before the court. However, the judge must make do with the evidence presented. This means assuming a passive role in the selection and interviewing of witnesses. Even under India's POCSO Act, while the Judge is supposed to question/interview the child, the court cannot substantially change the substance of questions posed by defence counsel during cross-examination. In practice, it is commonly accepted by lawyers that the adversarial model is primarily designed to resolve disputes, rather than discover the 'truth'.

Figure 1: Child Witnesses in the Adversarial System



The adversarial courtroom and secondary traumatisation

"Courtrooms were designed for the large number of adults who become participants and spectators in trials. Their furniture, lighting, acoustics, and uniformed personnel assure a serious and, in some ways, intimidating atmosphere. The theory is that in such an environment, witnesses and jurors will be more likely to take their responsibilities seriously. For children, however, the courtroom can do more than encourage civic responsibility - it can terrify and silence."

- Dziech, B.W., and Schudson, C.B. 1989. **On Trial: America's Courts and Their Treatment of Sexually Abused Children.**

In the context of sexual abuse cases, one of the most debilitating aspects of judicial process is the atmosphere of the courtroom. Children often experience fear and confusion in courtroom settings which impedes upon the child's ability to provide testimony. This has significant implications for the trial of the case in situations wherein the child meets the criteria for a competent witness, but is unable to effectively recall information relevant to the case on account of the daunting courtroom atmosphere. Research in this regard has underscored the importance of the interview context in facilitating or debilitating witness.

The issue of secondary traumatisation lies at the heart of the debate on the impact of the adversarial system on children in sexual abuse cases. Dealing with the court processes in child sexual abuse (CSA) cases can be complex and distressing for children. The child's account is often the only source of evidence, and therefore, the child's lack of understanding about legal processes may serve as a particularly distressing experience requiring mental health interventions to assist children in testifying before courts. Additionally, given the age and the developmental stage of the children, their vulnerabilities are further exacerbated. They may not have the ability to understand the language of the courtroom. Due to their traumatic experience of child sexual abuse, it may also be difficult for them to recall details of the abuse event. In the absence of adequate court preparation, cross examination in court (a defining feature of the adversarial system), may only exacerbate the trauma of victims, thereby leading to their secondary traumatization.

One of the key imperatives for enacting a law such as the POCSO Act, as reiterated in the landmark cases of *State of Punjab v. Gurmit Singh* (1996) and *Nipun Saxena v. Union of India* (2018) (more recently) was expressly to address the barriers to witness testimony in sexual assault cases, currently faced by the criminal justice system, due to the acrimonious nature of case proceedings. Therefore, the point raised in the above quote has to be addressed in CSA cases, if the basic imperatives of a procedurally just trial are to be upheld so as to ensure that POCSO proceedings provide justice without the heavy price of secondary traumatisation.

The Impact of Testifying on Child Witnesses in an Adversarial Context

Through much of the literature on child witnesses and victims in sexual abuse cases, research has affirmed that children experience anxiety surrounding court appearances and that the main fear is facing the defendant. Pursuant to extant research, other reported fears include being hurt by the defendant, embarrassment about crying or not being able to answer questions, and going to jail. Consequently, the more frightened a child is, the less they are able to answer questions. The key findings of some of the available research, on the greatest predictors of inadequate responses, include young age and severity of abuse; postponements resulting in emotional difficulties; and having to testify more than once being positively associated with long-term mental health problems.

On the other hand, the use of shielding procedures, such as testifying via a 2-way video-monitoring system, is reportedly less stressful for children than court appearances. Children providing shielded testimony were generally reported to give more accurate and detailed information. In light of the Section 36 of the POCSO Act, and the recent decision of the Supreme Court in the case of *Smruti Tukaram Badade v. The State of Maharashtra and Anr* (with reference to the establishment of vulnerable witness deposition complexes across the country), this relaxation in the adversarial nature of CSA proceedings serves as a fundamental feature in minimizing secondary traumatization, and indeed, the possibility of the child witness turning hostile.

Research on child witnesses has also facilitated an experiment to investigate the effect which an environment had on children's ability to recall. Children were shown a videotape and the following day half the children were interviewed in a courtroom and the other half in a private room. The results indicated that children, who were in the private room, related more central/key details in free recall, answered specific questions more often, and said "I don't know' or gave no answer significantly less often than the children questioned in the courtroom. A further study to explore the effect of the courtroom environment on the quality of children's evidence and the level of stress they experienced indicated that certain characteristics of the courtroom interfere with the child's ability to give evidence in an optimal manner, and furthermore, increase stress. The children who were questioned in the simulated courtroom provided less detailed descriptions of past events in free recall than children of the same age who were interviewed at school.

Does this mean that testifying is a detrimental experience in all situations?

No. It is not the act of testifying itself which exerts a negative impact on the quality of the child's memory recall with respect to the abuse incident. The important question relates to the environment in which children are testifying. The majority of research indicates that testifying usually does not significantly harm or retraumatize child victim-witnesses—particularly with the increasing use of alternative and less adversarial witness procedures (such as two-way mirrors) and other special measures/relaxations designed to reduce the child's anxiety and accommodate the child's developmental needs.

Procedural Justice and the Adversarial Courtroom

While discussing the issues associated with the adversarial process in regard to child victims and witnesses, we are essentially questioning the fairness of the process from a procedural justice standpoint. In other child contexts (such as juvenile and custody-related jurisdictions), procedural justice may envisage the opportunity for the child's participation and representation in all proceedings affecting the rights and liabilities of the child. However, as is typically the case with children in sexual abuse cases as well, the issue of procedural justice in a child hearing is one that far exceeds the basic requirements of a fair trial i.e., right of participation and adequate representation.

If procedural justice can be broadly defined as the quality of decision-making/adjudicatory procedures, from a child's standpoint, one is essentially entering into a discussion of the common minimum standard of care that must be afforded to all child stakeholders by virtue of their developmental and cognitive abilities. This discussion, and by extension the discussion on the adversarial process is critical, since procedural justice theories dictate that a child's satisfaction with the process ('process fairness') is also significant in addition to satisfaction with the outcome ('outcome fairness'). Specifically, the child's perceptions of the legitimacy of the criminal justice system are tied, in essence, not just to the outcome of the case, but critically, to the child's interactions with its stakeholders. In this regard, the child's interactions with the system have subsequent implications on any evaluation of their capacity for full and effective participation in all case proceedings. Developmental research has

indeed established that young children are able to evaluate the fairness of activities and that they have a more positive perception of activities they deem to be fairer.

Keeping in mind the above, there is considerable debate, in child sexual abuse literature, regarding the most effective system for adjudication of child sexual abuse cases, wherein process fairness concerns can be adequately addressed, along with those related to outcome fairness. In a sense, this struggle for balance relates to two broad issues: a) the defendant's right to effective representation (and, by extension, zealous advocacy); and b) the best interest of the child. In a bid to balance the two, India's POCSO Act, provides a series of exemptions and relaxations (discussed below) to mitigate the issue of zealous advocacy, while still maintaining sufficient room for effective representation of the defendant's case. Keeping in mind the issues related to cross-examination of child witnesses, there continues to be an ongoing conversation in child sexual abuse literature on the most feasible ways of maintaining such a balance. Therefore, this chapter will explore the current overall situation and possibilities for the future.

Study on Participation as Victim-Witnesses

As a part of this study, sixty child respondents who provided testimony in court, were contrasted with a control group of seventy-five children whose cases had not reached the trial stage. The key findings reported were that the children who testified displayed more behavioural disturbances than children who did not take the stand, seven months after their testimony. This was all the more evident when children were required to testify repeatedly, did not have the benefit of maternal support, and whose statements were not corroborated with other evidence.

However, most importantly, the adverse effects of testifying reduced significantly after the prosecution of the case was over. In a follow-up study, which was conducted after a period of more than 12 months, following the conclusion of the trial, it was reported that victim-witnesses, who had testified, viewed the legal system as fairer than those children whose cases did not go to trial.

Special Provisions to uphold procedural rights of Child Witnesses in POCSO Cases

In light of the difficulties with the adversarial system, as outlined above, sections 33-38 of the POCSO Act stipulate key provisions in relation to the child-friendly procedural requirements of a POCSO case before a Special Court. They are as follows:

'33. Procedure and powers of Special Court —

(1) A Special Court may take cognizance of any offence, without the accused being committed to it for trial, upon receiving a complaint of facts which constitute such offence, or upon a police report of such facts.

(2) The Special Public Prosecutor, or as the case may be, the counsel appearing for the accused shall, while recording the examination-in-chief, cross-examination or re-examination of the child, communicate the questions to be put to the child to the Special Court which shall in turn put those questions to the child.

(3) The Special Court may, if it considers necessary, permit frequent breaks for the child during the trial.

(4) The Special Court shall create a child-friendly atmosphere by allowing a family member, a guardian, a friend or a relative, in whom the child has trust or confidence, to be present in the court.

(5) The Special Court shall ensure that the child is not called repeatedly to testify in the court.

(6) The Special Court shall not permit aggressive questioning or character assassination of the child and ensure that dignity of the child is maintained at all times during the trial.

(7) The Special Court shall ensure that the identity of the child is not disclosed at any time during the course of investigation or trial:

Provided that for reasons to be recorded in writing, the Special Court may permit such disclosure, if in its opinion such disclosure is in the interest of the child.

(8) In appropriate cases, the Special Court may, in addition to the punishment, direct payment of such compensation as may be prescribed to the child for any physical or mental trauma caused to him or her for immediate rehabilitation of such child.

35. Period for recording of evidence of child and disposal of case — (1) The evidence of the child shall be recorded within a period of thirty days of the Special Court taking cognizance of the offence and reasons for delay, if any, shall be recorded by the Special Court.

(2) The Special Court shall complete the trial, as far as possible, within a period of one year from the date of taking cognizance of the offence.

36. Child not to see accused at the time of testifying — (1) The Special Court shall ensure that the child is not exposed in any way to the accused at the time of recording of the evidence, while at the same time ensuring that the accused is in a position to hear the statement of the child and communicate with his advocate.

(2) For the purposes of sub-section (1), the Special Court may record the statement of a child through video conferencing or by utilising single visibility mirrors or curtains or any other device.

37. Trials to be conducted in camera—The Special Court shall try cases in camera and in the presence of the parents of the child or any other person in whom the child has trust or confidence:

Provided that where the Special Court is of the opinion that the child needs to be examined at a place other than the court, it shall proceed to issue a commission in accordance with the provisions of Section 284 of the Code of Criminal Procedure, 1973 (2 of 1974).

38. Assistance of an interpreter or expert while recording evidence of child —(1) wherever necessary, the Court may take the assistance of a translator or interpreter having such qualifications, experience and on payment of such fees as may be prescribed, while recording the evidence of the child.

(2) If a child has a mental or physical disability, the Special Court may take the assistance of a special educator or any person familiar with the manner of communication of the child or an expert in that field, having such qualifications, experience and on payment of such fees as may be prescribed to record the evidence of the child.'

In addition to the above, key procedural changes were also introduced to the Criminal Procedure Code and Evidence Act from the perspective of securing child-friendly procedures. These include the following:

Sec 357C. Treatment of victims — 'All hospitals, public or private, whether run by the Central Government, the State Government, local bodies or any other person, shall immediately, provide the first-aid or medical treatment, free of cost, to the victims of any offence covered under … the Indian Penal Code (45 of 1860), and shall immediately inform the police of such incident.]'

Sec. 164 Recording of Confessions and Statements: (5A) '…the Judicial Magistrate shall record the statement of the person against whom such offence has been committed in the manner prescribed in sub-section (*5*), as soon as the commission of the offence is brought to the notice of the police:

Provided that if the person making the statement is temporarily or permanently mentally or physically disabled, the Magistrate shall take the assistance of an interpreter or a special educator in recording the statement:

Provided further that if the person making the statement is temporarily or permanently mentally or physically disabled, the statement made by the person, with the assistance of an interpreter or a special educator, shall be video graphed.

(*b*) A statement recorded under clause (*a*) of a person, who is temporarily or permanently mentally or physically disabled, *shall be considered a statement in lieu of examination-in-chief, as specified in section 137 of the Indian Evidence Act, 1872 (1 of 1872) such that the maker of the statement can be cross-examined on such statement, without the need for recording the same at the time of trial.]'*

Sec. 53A (Indian Evidence Act): ***Evidence of character or previous sexual experience not relevant in certain cases*** — '…where the question of consent is in issue, evidence of the character of the victim or of such person's previous sexual experience with any person shall not be relevant on the issue of such consent or the quality of consent.'

So, what are the implications of these changes on the adversarial system?

Delay in POCSO Cases

In the case of *Dr Atul Krishna v. State of Uttarakhand & Ors (2021),* the Court noted that 'the Trial Court, despite having taken cognizance almost seven years back, has not moved in the matter even an inch thereafter, including to frame charges, as may be necessary, despite 78 adjournments in the case.'

This case is one among many, wherein the Courts have taken serious note of long delays in the trial of sexual offences, particularly those relating to children. However, owing to delays from the investigation stage itself, issues continue to affect the timely adjudication of POCSO cases. What is also significant to note here, is that POCSO cases are required to be completed within a 'reasonable' timeframe, in accordance with the stipulated period of a year under the Act. This does not, however, comport with recent cases wherein the trial was completed in a day's time. The trial must still be completed in a manner that is in keeping with the basic requirements of a fair trial.

Cross examination of children & Character Evidence

The adversarial system of cross examination is considered to be the efficient way of arriving at the truth and ascertaining the credibility of a witness. However, there are numerous issues like court language and miscommunication, emotional distress and trauma of the child, difficulties in recall and inconsistency. The evidence of a child, therefore, cannot be subjected to an adult-level of scrutiny. Put differently, the criminal justice system needs to adopt a child-inclusive definition of a 'reasonable witness' to ensure that adversarial proceedings do not interfere with the child's participation in relevant proceedings.

Activity: Understanding the Nature of Cross Examination

Method: Viewing of film clip

Material: Short video-clip from the movie – *The Devil's Advocate*

Discussion:

- What are your thoughts on this cross-examination of a child victim?
- Were there issues that you feel affect the quality of the child's ability to recall events accurately?
- Can such a line of questioning be characterized as relating to the veracity of the allegations, or would you describe the questions differently?

Changes brought to criminal law, post the Nirbhaya incident, disallow any kind of character evidence from being considered in sexual offences cases, particularly those relating to the child's sexual history. In this regard, in the landmark case of ***Nipun Saxena v. Union of India*** (2018), the Supreme Court noted the following:

'If the victim is strong enough to deal with the recriminations and insinuations made against her by the police, she normally does not find much succour even in court. In Court the victim is subjected to a harsh cross-examination wherein a lot of questions are raised about the victim's morals and character. The Presiding Judges sometimes sit like mute spectators and normally do not prevent the defence from asking such defamatory and unnecessary questions.

We want to make it clear that we do not, in any manner, want to curtail the right of the defence to cross-examine the prosecutrix, but the same should be done with a certain level of decency and respect to women at large. Over a period of time, lot of effort has been made to sensitize the courts, but experience has shown that despite the earliest admonitions, the first as far back as in 1996, the Courts even today reveal the identity of the victim.'

Looking ahead to the future… Are there alternative models of justice for child victims/witnesses of sexual abuse?

Typically, discussions on alternatives to the adversarial system tend to lay emphasis on the fundamentally distinct features of the inquisitorial system (and its greater compatibility with child-related proceedings). Let's take a look at what inquisitorial systems (like those of France and Italy) do differently…

- In this procedure the judge investigates the case himself i.e., oversees police investigation in the case. The accused is seen as the object of the inquiry and has no procedural right to 'confrontation.'
- The confrontation here takes place between the accused and the court, rather than between two parties.
- The inquisitorial procedure "a quasi-scientific search for the truth rather than a dispute" through which the Judge evaluates all available evidence to arrive at a decision or finding.
- Unlike the adversarial system, the Judge (in this model), is not limited by the evidentiary toolbox of the opposing parties.

It is significant to note that while the inquisitorial system does have significant advantages in terms of providing a framework for case proceedings that minimise the possibility of secondary traumatisation, there remain legal concerns with a purely inquisitorial system. Specifically, some of these concerns relate to the possibility of bias, owing to the reality of the system's application, wherein presiding officers assume certain key functions of the defence counsel. Chief amongst these concerns is, ironically, whether the Judge can conduct cross-examinations with the same rigour as that of defence counsel. Many argue that the whole point of cross-examination is lost, if the judge does not engage in sufficient court craft, which may prove to be intrinsic to eliciting the most truthful account of events from the child witness. However, the assumption that the truth can only result from the vexatious examination of vulnerable witnesses is, perhaps, overstated.

Indeed, as aforementioned article notes, the basic point of a cross-examination i.e., to evaluate the veracity of allegations made in a case of CSA, is not necessarily tied to testing the child's susceptibility to miscommunication in the face of confounding and suggestive questioning. The foregoing discussion, in addition to various proposals for incorporation of inquisitive techniques in adversarial proceedings, or 'special measures', to facilitate a more child-friendly atmosphere, raise critical debates on what child-friendly proceedings could look like in the future. More information on this subject is available in the recommended readings below.

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- Caprioli, S., & Crenshaw, D. A. (2017). The culture of silencing child victims of sexual abuse: Implications for child witnesses in court. *Journal of Humanistic Psychology, 57*(2), 190-209.
- Jodi A. Quas et al., Childhood Sexual Assault Victims: Long-Term Outcomes After Testifying in Criminal Court (2005)
- Bottoms, A., & Tankebe, J. (2012). Beyond procedural justice: A dialogic approach to legitimacy in criminal justice. J. Crim. l. & Criminology, 102, 119.
- Anthony J. Hicks & Jeanette A. Lawrence, Children's Criteria for Procedural Justice: Developing a Young People's Procedural Justice Scale (1993)
- Gail S. Goodman et al., Testifying in Criminal Court: Emotional Effects on Child Sexual Assault Victims (1992)

Film Screening & Discussion (B)

Learning Objectives

- To understand how CSA processes occur in institutional settings.
- To understand various systemic and social barriers to disclosure.
- To understand complexities pertaining to mandatory reporting.

Time: 3 hours (Screening - 2 hours 15 minutes; Discussion - 45 minutes)

Material: The movie titled 'Athlete A'. The movie may be accessed on various OTT platforms.

Synopsis of Film

Athlete A is a 2020 American documentary film directed by Bonni Cohen and Jon Shenk. The documentary follows a team of investigative journalists from *The Indianapolis Star* as they broke the story of doctor Larry Nassar sexually assaulting young female gymnasts, and the subsequent allegations that engulfed USA Gymnastics and its then-CEO Steve Penny. It was released on June 24, 2020, by Netflix.

The title refers to gymnast Maggie Nichols who was referred to as "Athlete A" to protect her identity while investigations into her sexual abuse by USA Gymnastics doctor Larry Nassar was ongoing.

While researching a story on the failure of schools to report sexual abuse a reporter at *The Indianapolis Star* has a source reach out to her to suggest she look into USA Gymnastics. The reporters at *The Star* collaborate on a piece that reveals that Steve Penny, president of the organisation, worked to cover for abusive coaches. When the piece was published in 2014, Rachael Denhollander, Jessica Howard and Jamie Dantzscher independently reach out to the team at *The Star* to reveal that they were sexually abused by USA Gymnastics doctor Larry Nassar. Only Denhollander is willing to immediately speak on the record during her interview; she reveals that she is finally ready to come forward and plans on speaking to the police about what happened to her.

In 2015, gymnast Maggie Nichols, a brilliant gymnast who appeared to be on track to make the Olympic team, is sexually abused by Nassar at the Karolyi Ranch. The ranch was overseen by Béla and Márta Károlyi, the fabled trainers who had come out of Nicolae Ceaușescu's Romania and led the U.S. team with a severe-bordering-on-cruel approach that was part of their mystique. Inside it, the Károlyis practiced their special brand of discipline, tormenting teenage gymnasts about their weight, calling them lazy, treating them like machines who needed to

push themselves to the boundaries and beyond. Within the military-like training-camp fortress of Huntsville, Larry Nassar, according to the documentary, was the girls' one friendly authority figure — an amiable quirky goofball who would sometimes slip them food and candy. He never gave them explicit threats, even when committing abuses like putting an un-gloved finger inside a girl's vagina as part of an "exam." He always maintained the fiction that he was their friend. Most of them knew that something was deeply wrong, but they felt they had nowhere to turn. However, Nichols reveals the abuse to her coach who informs her parents. Her parents are called by Penny who informs them he has reached out to law enforcement to investigate the abuse. Despite her selection looking imminent, Nichols was not selected to represent Team USA at the 2016 Rio Olympics.

In 2016 *The Star* publishes its investigation into Nassar and Denhollander goes to the police with her evidence against Nassar. Maggie Nichols's parents, frustrated with the lack of information about their daughter's case reach out to a lawyer who is working with other victims and discover that USA Gymnastics was told of abuse going back at least as far as 2012. The criminal prosecution of Nassar goes forward and he reaches a plea deal in 2017. Nevertheless, *The Star* continues to investigate the abuses perpetrated by USA Gymnastics.

Penny is eventually arrested in 2017 for his role in covering up Nassar's abuse.

Nichols leaves elite gymnastics after being left off the 2016 USA gymnastics Olympics team which the documentary implies was because of her role in coming forward against Nassar. She competes in NCAA gymnastics which reinvigorates her love of the sport.

Discussion

- What was the most unforgettable moment in the film for you?
- What is the process by which Nassar abused the girls? Did he use his professional knowledge and position of authority to perpetrate? If yes, then how?
- What are certain factors (circumstances) that made these young athletes vulnerable to CSA?
- How can institutions enable and propagate CSA?
- What were the barriers (both systemic and social) to disclosure that the various athletes face?
- What are certain issues pertaining to mandatory reporting that could be observed in the film? What was the systemic response to reporting by these athletes?

15. Child Witness Competencies to Provide Testimony: Applying the Child Development Lens

Learning Objectives

- To understand child development and how it determines the child's competency and capacity to provide evidence.
- To apply child development concepts to issues of validity and reliability of evidence provided by child witnesses.
- To learn methods and techniques to assess child's developmental and mental health capacity to provide evidence.

Time

4 Hours

Concept

The Adversarial Justice System and Child Witnesses Competencies

Despite the existence of a special law such as POCSO, and the many allowances it makes to enable child witnesses to depose (see table 1), the law is still required to be implemented within the adversarial justice system. The adversarial justice system 'seeks the truth' by pitting the parties against each other, in the hope of the facts being revealed. This requires CSA victims to depose in court, particularly as child victims are often the only source of information about the crime in the wake of CSA dynamics, and of abuse occurring in private, usually in the

Table 1: Key Legal Provisions on Procedure and Powers of Special Courts for Recording Evidence of Child Witnesses

- Prosecution and defense questions to child witness to be communicated to the judge, who in turn, puts the questions to the child.
- Permitting of frequent breaks for child witness during trial processes.
- Allowing for family member/guardian/person whom child trusts to be present in courtroom.
- Maintenance of dignity of child by disallowing for aggressive questioning and those which result in character assassination of child.
- Conducting the trial through 'in-camera' proceedings and ensuring that identity of the child is undisclosed.
- Using video conferencing or single visibility mirrors/devices to record evidence.
- Safeguarding the child from exposure to accused at the time of statement recording, despite the need for the presence of the accused in court for hearing the child's evidence.
- Ensuring child is not called repeatedly to testify in court.
- Appointment of support persons to assist children through investigative and trial processes.

***Source: Chapter VIII, POCSO Act 2012(Ministry of Law and Justice, 2012)**

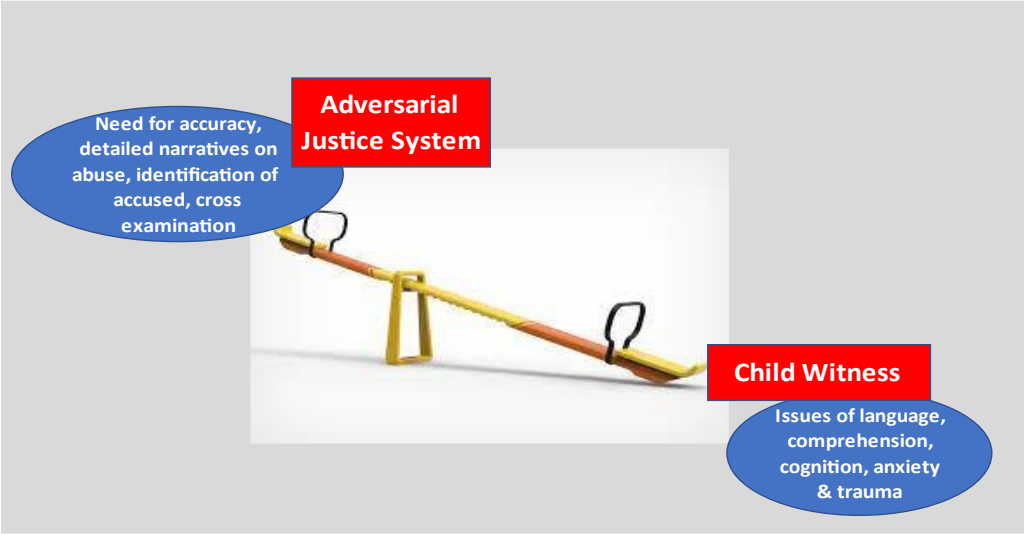
absence of an eye witness.

Much child witness research is focussed on the implications for children's performance in legal proceedings, including for interviewing children in forensic settings and eliciting their testimony in court. It has also highlighted the need to adopt a developmental perspective to consider children's cognitive, memory and communicative abilities, and their emotional states, so as to obtain a truthful narrative from the child. In doing so, it has inevitably touched upon the question that lies at the heart of the child witness testimony—that of child witness competency or children's capacity to provide testimony.

Child witnesses are required to contend with the adversarial justice system, wherein they are expected to provide evidence, preferably through a verbal narrative, that requires not only 'adult-like' language and communication capacities, but also advanced levels of attention, concentration, memory, and other cognitive functions, as well as emotional regulation abilities that would allow them to provide evidence in ways that meet the evidentiary standards of the court. Additionally, child witnesses are expected to be able to respond to often-difficult cross-examination processes, wherein their primary narrative is subject to scrutiny and questioning, with the explicit aim to discredit the evidence they have provided. (Refer to figure 1 below, which shows the tensions that eliciting child witness evidence entail).

As Brennan[9] pertinently states: *"Evidence is displayed to discredit the witness and thus bolster the case for the defendant. The techniques used are all created with words, since they are the major currency of the court, and the extent to which the child's language abilities can be expected to match those of the cross-examiner's, are the subject of my concern. The extent to which truth is prejudiced by the use of these language tactics is a question to which the legal profession must address itself".* (Brennan, 1995), PP 73

Figure 1: Challenges & Tensions in Eliciting Evidence from Child Witnesses



In this context the role of mental health professionals (and/or other child care service providers engaged in assisting child witnesses) becomes critical, i.e. (i) to conducting developmental and mental health assessments to determine child competencies i.e. to ascertain whether a given child would have the capacity to testify in court; (ii)

[9] Brennan, M. (1995). The discourse of denial: Cross-examining child victim witnesses. Journal of Pragmatics, 23(1), 71–91. https://doi.org/10.1016/0378-2166(94)00032-A

provide a report to the court on the child's capacities to testify, including recommendations for any special assistance or support that a child may require (based on her capacities or the lack of them), in order to testify.

Thus, child witness competency assessments, with a view to informing the court of a given child's capacities to testify (and the gaps thereof) are critical to maintaining the precepts of child rights and procedural justice. Take for example a child with mild intellectual disability or a child with Attention Deficit Hyperactive Disorder: recommendations to the court to keep the overall length of the deposition short, granting frequent breaks to such children, and ensuring other enablements with regard to phrasing of questions in brief and simple ways, would be critical to obtaining testimony from them. The recognition that child witnesses do not have the same mental capacities of an average adult witness, and consequently will not have the same competencies to testify in court, is essential to eliciting child witness testimony—and ascertaining the unique capacities of each child witness is the first step in the process.

What the Indian law says about child witness testimony—and the challenges thereof

- **No Minimum Age of Child Witness**

Section 118 of the Indian Evidence Act deals with the competency of the witness. Under this section 'All persons shall be competent to testify unless the Court considers that they are prevented from understanding the questions put to them, or from giving rational answers to those questions, by tender years, extreme old age, disease, whether of body or mind, or any other cause of the same kind'. However, the Indian Evidence Act does not define 'tender years' in terms of at what age(s) children are too young to provide testimonies—the Evidence Act says 'There is no fixed age below which children are incompetent to give evidence'. Similarly, POCSO 2012 also remains silent on the issue of age-appropriateness of a child witness to be able to testify in court.

This raises the question of how to examine or elicit evidence from very young children and/or those with disabilities. While there is no debate regarding eliciting evidence from a child who is under 2 years of age, because it is obvious (and indeed part of general knowledge) that a child so young will not have the capacity to speak and provide narrative evidence.

However, the lines become blurred when a child is about 2.5 to 3 years of age-- and has developed some skills in speech and language. Or would a 10-year old with intellectual disability have the capacity to provide evidence? What about a 14-year old with speech and hearing impairments…? The question is: given their developmental abilities, to what extent such children would be able to provide valid and reliable evidence? And two related questions are: what types of evidence can one obtain from such children, and how to examine and elicit evidence from such child witnesses?

- **No Detailed Parameters for Assessment of (Child) Competency**

Furthermore, according to the Indian Evidence Act, in criminal proceedings, 'a person of any age is competent to give evidence if he or she is able to (1) understand questions put to him or her as a witness, and (2) give answers to them which can be understood.' Thus, the parameters for assessing child witnesses' competencies, and determining whether a given child can provide valid and reliable evidence, are extremely limited i.e. they do not capture a host of issues that the court needs to be cognizant of in making decisions about the competencies of child witnesses.

Defining Child Witness competency

Within international literature and the practice, the law grants two types of child witness competency:

(i) Basic competency, referring to the child's ability to perceive, remember and communicate; this also suggests that children's testimonial performance is strongly related to their (expressive and receptive) language abilities, which are predictors of eye witness memory and suggestibility, and of the accuracy of their responses to free recall and direct, non-leading questions. This competency may be extended to encompassing the socio-emotional and mental health factors that play an important role in children's cognition and memory reports.

(ii) Truth-lie competency, concerning the child's ability to distinguish between fact and fiction, and to understand the importance of telling the truth because the veracity and lie-telling abilities of the child are associated elements of competency.

For further information and understanding on Forensic Issues in Eliciting Evidence from Young Children i.e. (Preschool Children) listen to Karen Hollely of Child Witness Institute, South Africa, on SAMVAD's Youtube Channel:
https://www.youtube.com/watch?v=fZIETQE9OwM&list=PL6M-G4mGr43pEXa4vW0CsOGcVYcvUPivr&index=3

This is part of a 4-part public series that SAMVAD organized as one of its '10 years of POCSO' events in March 2022. The session discusses the relevant cognitive and language limitations of children in this age category and identify ways of eliciting evidence from children that is accurate and forensically sound, highlighting key areas of misunderstanding in cases of child sexual abuse."

Methods for Assessing Child Witness Competency

While the law does not use scientific or detailed procedural methods to ascertain child witness competencies to testify in court, the court is also sceptical of the capacity of children to observe and recall events accurately, to appreciate the need to tell the truth, and to resist the influence of other people, and to be able to distinguish between fantasy from reality. For these reasons, and to ensure that the evidence provided by child witnesses is valid and reliable, the court may, or rather, should assess the testimonial competency of the prospective child witness before the trial begins. However, as lawyers and judges are not necessarily trained in child development and related skills, the role of childcare service providers and mental health professionals becomes critical in this regard.

Core Competencies and their Relevance to Child Witness Testimony

Core Competencies	Relevance to Child Witness Testimony
Identifying Common Objects and their functions	Indicative of basic cognitive abilities.
Describing Actions & Behaviours	Required to describe the abuse incidents/ what the perpetrator did to child.
Identifying Body Parts	
Knowledge of Sequences	
Recognizing Spaces	Required for child's narrative on details regarding place of abuse.
Identifying Similarities & Differences	• Indicative of child's capacities to differentiate between the appearance of objects and people. • Important to establish child's ability to identify perpetrator
Memory	• Required for communication facts about which they are knowledgeable because they directly perceived and remember them. • Also important for provision of details of the abuse narrative.
Descriptive Ability	
Differentiating between Truth & Lies	• Indicative of child's ability to distinguish between fact and fiction or fantasy. • Required for child to be able to provide an accurate account of the abuse incident.

As mentioned earlier, specifically, this role and function entails the following:

- Providing developmental assessments to the child witness.
- Communicating with the court to provide information on:
    - The child witness's developmental capacities.
    - Recommendations for whether child can provide testimony.

- Conditions/assistance child will require in order to provide testimony.

While developmental assessments may comprise of various psychological scales and tools, and professionals are welcome to administer these (particular standardized IQ tests), it is recommended that these formal tests be administered to support and corroborate clinical impressions of the child's abilities as necessary for providing testimony. Drawing from the above discussions on child witness competencies necessary for testifying in court, we may further narrow these to 9 core competencies. Refer to table above for this list of core competencies—and how they are critical to child witness testimony.

Activity 1: Assessing Child Witness Competencies for Testimony—Do It Yourself!

Method: 'Do and learn'

Materials: Picture cards, low-cost aids to assess the various developmental competencies required for child witness testimony (refer to picture cards and activity sheets provided in 'Additional Materials' at the end of this module.

Process and Discussion:

- Divide participants into sub-groups of 4 to 6 persons each.
- Provide a set of all activity sheets and accompanying picture cards/materials.
- Ask each sub-group to work through the activities i.e. practice using them with one to persons in the group playing the role of the child (so as to provide an understanding of how to implement the developmental assessment with children).

Activity : How to Assess Child Witness Competencies

Method: Viewing and discussion of video clips in plenary

Materials: Video clips developed by SAMVAD on assessing developmental competencies of child witnesses. (QR Codes for accessing these videos provided at the end of this module).

Process:

- Explain to the participants that:
  - SAMVAD has developed a bunch of demo videos to show how the key child witness competencies (erstwhile discussed) can be assessed.
  - We will view the clips one by one—with each viewing followed by a discussion on the method used by the child worker/therapist, with the child, in relation to the requisite competencies for testifying in court.
  - You may also compare what you now see with the previous activity you did—how you assessed developmental competencies.
- Play the clips one by one—there are nine clips in all, as follows:
  - Identifying Common Objects and their functions
  - Describing Actions & Behaviours
  - Identifying Body Parts
  - Knowledge of Sequences
  - Recognizing Spaces
  - Identifying Similarities & Differences
  - Memory
  - Descriptive Ability
  - Differentiating between Truth & Lies
- Use the questions listed below for discussion following the viewing of each clip (i.e. do *not* view all 9 clips and then proceed to discussion as the points made for each individual clip are likely to vary).

Discussion:

- Share your thoughts on the method of assessing competency (in each clip)…how this is relevant to provision to child witness testimony?
- Suggest alternative methods to assess these competencies in child witnesses (based on availability of materials, limitations of time and socio-cultural contexts).
- How do you corroborate information provided by the child, to determine its accuracy?
- The need to ensure that assessments and their results are in accordance with normative child development i.e. for example, pre-schoolers cannot be asked very specific questions about time as this concept is still developing in them.

- Consider emotional state of the child i.e. whether he/she is in a state of PTSD, to decide on an appropriate time for the assessment (including time of day—so that child is not hungry/sleepy/tired/cranky…as these could yield inaccurate results).
- The importance of assessing competencies in non-CSA contests—as this helps to establish a child's abilities in neutral situations—making increasing the validity and reliability of these assessments.
- Discuss the importance of systematic documentation of child witness competencies, including:
    - The methods used for assessment (tasks or activities done with the child)
    - Child's responses to each task/activity
    - Analysis of child's response (i.e. was it age-appropriate?) and child abilities (or the lack of them)—to what extent a given ability is present (low/high…)
    - Implications for child's capacity to testify in court
    - Supports and interventions that the child may require in order to testify in court -- these must be predicated on the child's deficits or gaps in (developmental) abilities)

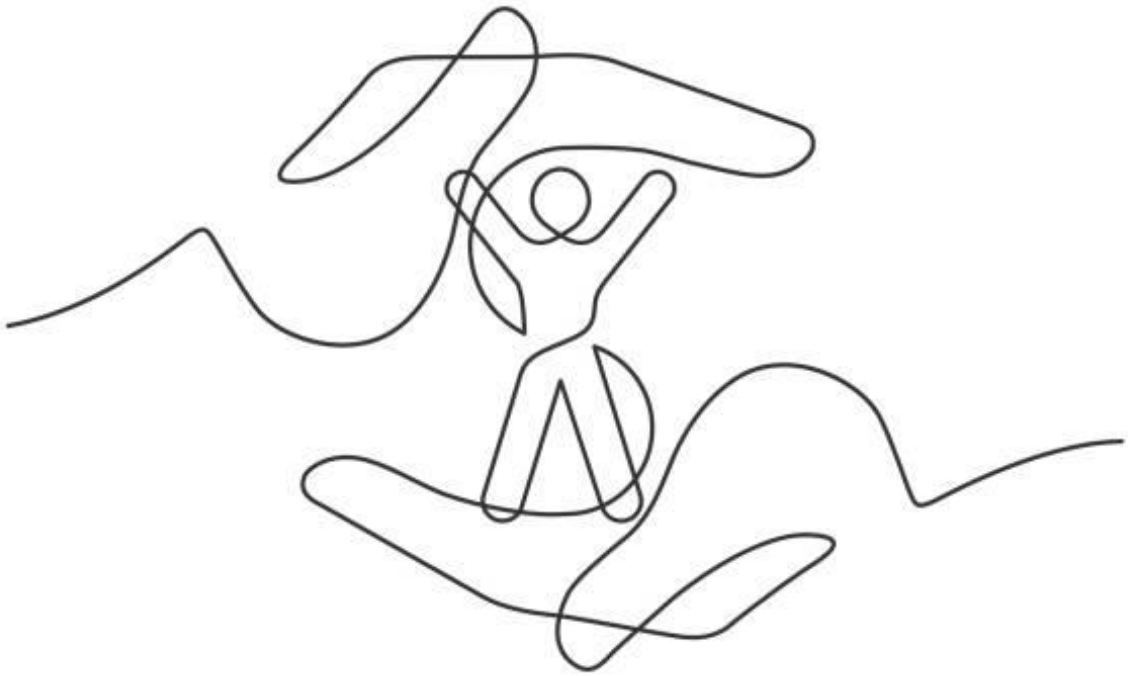


Table: Summarizing Children's Capacity to Provide Evidence, according to Age & Developmental Stage[10]

Age	Ability to Provide Abuse Narratives	Emotional-Behavioural Symptoms Indicative of Abuse
Infancy (0—18 months)	• Unable to make any disclosures of physical or sexual abuse. • Cases can only be substantiated if: ✓ There is an eye witness; ✓ Perpetrator confesses; ✓ Infants are found to have an STD, sperm or semen on their examination, and/or genital injuries.	• Fearful of the offender, • Fussier than normal • Reluctant to have diaper changed • Occasionally imitate sexual acts.
Toddlers (18—36 months)	• Due their limited communication skills, toddlers are unlikely to report the abuse. • Simple phrases may be the only clue that something has happened, such as, "Owie, pee-pee, Daddy" while pointing to their genital area (indicating that Daddy touched or hurt them in this area). • Toddlers cannot sequence time and place very well and will probably not be able to tell you how often something has happened, when it happened, or even where it happened. • Only some children of this age group know their body parts or understand right from wrong. • To substantiate the abuse, a witness, a confession, an STD, or sperm/semen are usually required—and/or evidence of injury.	• Frequently show fear and anxiety around the perpetrator. • May mimic the sexual acts with their own bodies, other children, or dolls. • Regressive behaviours observable. • Difficulty toilet training, sleep disturbances • Angry outbursts and clinginess to caregivers.

[10]. Adapted from 'The Art of The Interview In Child Abuse Cases' by Captain Barbara Craig, Medical Consultant for Child Abuse and Neglect, Department of Pediatrics, National Naval Medical Center, Bethesda, Maryland available on http://www.nccpeds.com/powerpoints/interview.html

Preschool **(3—5-year-olds)**	• During an interview, they become easily distracted, and revert to physical activity, or phrases such as "I don't know" or "I can't remember". • Tend to tell small excerpts of their abuse with minimal detail, disorganized thought processes, and give relevant and irrelevant details. • Time and space relationships are poorly defined; however they can relate things to before and after such as birthdays holidays, dinner, bedtime, etc. • They can on occasion be specific and give enough detail to be good witnesses in court. • Demonstration is a better tool than verbalization for many children this age. • They may confuse he-she-me and sex specific body parts. • Although substantiation may still rely on finding acute injuries, sperm or semen, or an STD, their history becomes increasingly important. • Ask short and specific questions, but do not put words in their mouths. • Asking them to draw or demonstrate what happened might be easier for them than verbal communication. • Make the child feel at ease and safe—they may be fearful of what will happen to them if they tell.	• May exhibit sexualized play, somatic complaints (headaches, abdominal pain, painful urination, genital discomfort, etc) May also have nightmares, regressed behaviour, anger, aggression, withdrawal, mood lability and other psychosocial problems.
Elementary school aged children **(6—9 years old)**	• Children of this age are reluctant and tentative in their disclosures and will withdraw if they perceive non-reassuring reactions from the interviewer. • Role play may be an appropriate tool, as well as drawing and the use of dolls and doll houses. • Building rapport is essential before the interview begins because they are frequently embarrassed and uncomfortable discussing the inappropriate touching. • One way to ease their discomfort is to engage them in a simultaneous	• Feel conflicted and confused, guilt ridden, embarrassed and may be fearful • Behavioural symptoms may include withdrawal, depression, emotional lability, nightmares, poor school performance, aggression, lying, stealing, and other antisocial behaviours. • Physical symptoms may include enuresis,

	activity like drawing, colouring, or working a simple puzzle.	encopresis, dysuria, headaches, abdominal pain, genital pain, and tics.
Puberty **(9—13-year-olds)**	• Usually more at ease with an interviewer of the same sex. • A more formal approach to the interview frequently minimizes the pre-adolescents' discomfort with the discussion. • Keep your questions brief and clinically oriented, yet let them know that their feelings and opinions are also important to the investigation. • Reassure them that they are not at fault for what has happened.	• Shame, guilt—feelings that the abuse was their fault. • They not only feel uncomfortable about the sexual molestation, but are feeling awkward and self-conscious about their bodies and discussions regarding sexual issues.
Adolescents (13—18-year-olds)	• To maximize the outcome of the interview, an open, direct approach is usually the best. • Be serious about their concerns and supportive of their needs. Never criticize or judge their acts. • By being honest with them, they will be more likely to be cooperative with you.	• Behavioural problems may include defiant, aggressive acts, truancy or school failure, criminal behaviour, suicidal ideation or attempts, high risk sexual behaviour, substance abuse, self-mutilation and runaway behaviour. • They may present to the medical clinic with chronic aches and pains, vague complaints, and hysteria.

Case Examples of Mental Health & Developmental Assessments to Establish Children's Capacity to Provide Evidence

Effective legal assistance in the context of child sexual abuse, particularly forensic interviewing of child witnesses, should ideally entail a major role for child mental health services in the following ways:

- To conduct mental health and developmental assessments for affected children in order to screen for mental health morbidity and ascertain the psychological impact of child sexual abuse (CSA).
- To use the developmental and mental health assessments to ascertain the child's capacity to provide evidence/ testimony as child witness.
- To assist legal personnel to interview and gather evidence from the children, using sensitive and child-friendly methods of interviewing.

Such ways of implementing the child sexual abuse law will go a long way in ensuring that evidence from children is accurately and sensitively recorded, and in increasing the concerningly low conviction rates for perpetrators of child sexual abuse in India. The challenges that the judicial system currently faces, with regard to reliability of a child's testimony, due to age and developmental abilities, the appropriateness of gathering evidence from very young children (3 years and below) and methods and modalities of gathering evidence from children, may also be circumvented to some extent.

The use of systematic child-friendly methods may also encourage more children and families to overcome their reluctance to report to legal authorities and to follow through with court processes, thus allowing for prosecution of child sexual abuse perpetrators.

Following the sexual abuse of children in a child care institution in one of the Indian states (allegedly by the caregivers of the institution), a central government agency undertook the investigation of the case. The agency had been issued directives by the Supreme Court to only interview the children with the help of/ in the presence of qualified child mental health professionals. It therefore requested the Dept. of Child & Adolescent Psychiatry to assist with interviewing and evidence gathering from the affected children. The NIMHANS team assisted the agency's investigative officers to interview and gather evidence from the children, using sensitive and child-friendly methods of interviewing. Specific protocols and specialized methods were used, to interview children, depending on their developmental and communication abilities. Before even gathering the evidence or eliciting abuse narratives, a developmental/psychiatric and mental health assessment was done for each individual child, in order to determine the child's capacity to provide evidence and testimony as child witness.

'Additional Materials ' at the end of this module contain examples of case reports to show how developmental & mental health evaluations of children were conducted during the process of evidence gathering. [The names and other identifying details have been removed for confidentiality reasons]. The first example describes a child with intellectual disability; example 2 and 3 are both of children having psychiatric issues i.e. post-traumatic disorders, but with varying capacities to provide evidence and testimony.

Sample Child Witness Competency Reports submitted to the Court

Example 1: Child with Intellectual Disability

Assessment for Children in Institutions/Childcare Agencies
[Children with Intellectual & Developmental Disabilities]
Dept. of Child & Adolescent Psychiatry, NIMHANS

1. Basic Information

Name: XXXXX **Name of Institution/Agency:** XXXXXXXXXXX

Age: 11 yrs **Sex**: F **Class**: - **Date of Assessment**: XXXXXXXX

2. Presenting Problems/Complaints
Referred for mental health evaluation and evidence gathering by XX agency in the context of child sexual abuse in child care institution vide the Supreme Court Order No. XXXX in W.P. (C). No. XXXXX dated XXXXX.

3. Developmental assessment:
a) Caregiver Report:
As reported by the institution caregiver, the child was generally withdrawn and displayed no interest in social interaction. She could follow very basic commands like 'bring the glass' or 'fetch water'. She was dependent on the home-mother for her personal care that included feeding and toileting. There was history suggestive of self-injurious behaviour with no clear antecedents.

b) Developmental Scales: Her social age was 2 years & 5 months (on Vineland Social Maturity Scale) and social quotient was 22. The test scores indicate that her social quotient points to severe intellectual disability.

4. Other Observations of the Child
Child was unkempt. Eye contact was fleeting. Rapport could not be established. She preferred solitary play and was preoccupied the entire time with just one play item (doll). Her attention span was for a few minutes only. She was spitting repeatedly. There was no meaningful language. She was clenching her fists repeatedly, which is suggestive of motor stereotypies.

5. Summary of Child's Problems
Disability (Physical/ Intellectual): Severe intellectual disability

Psychiatric Diagnosis: Autism Spectrum Disorder;
Specific Developmental Disorder of Speech and Language

Medical Problems: Not assessed in detail by NIMHANS team.[Child had multiple excoriations and healed abrasions over the face, neck and arms which were self-inflicted and arising from self-injurious behaviour pertaining to intellectual disability].

Context: Child sexual abuse and trafficking issues within a child care institution

6. Implications for developmental and mental health capacity to provide evidence/ testimony as child witness:
As the child does not have age-appropriate developmental and communication abilities, she does not have the capacity to provide valid and reliable evidence/ testimony.

7. 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).

Example 2: Child with Post-Traumatic Disorder (Having Difficulty Providing Evidence)

Assessment for Children in Institutions/Childcare Agencies
Dept. of Child & Adolescent Psychiatry, NIMHANS

1. Basic Information

Name: XXXXXXX Name of Institution/Agency: XXXXXXXXXXXXXX

Age: 15 yrs Sex:F Class:Grade 3 Date: XXXXXXXX

2. Presenting Problems/Complaints
None reported by child/ agency.
Referred for mental health evaluation and evidence gathering by XX agency in the context of child sexual abuse in child care institution.

3. Institutional History(where all the child has been /lived, for what periods of time, experiences and difficulties, circumstances of coming to this agency)
Initially, the child reported that she was from X (no further address provided).
Later, however, she said that she used to stay along with her uncles and grandmother in Q until she was 10 years old. While she was on her way back from the school, she lost her way and then she was taken to the police station from where she went through Childline, and was placed in the X shelter home. She was in X shelter home for 5 years. [However, shortly after, the child said she does not recall how she reached X].

4. Family Issues Identified (Child's living arrangements/parental relationships/child's emotional relations
The child said she does not recall names of her parents, uncles or grandmother or of the place/area in which they lived.

5. Child's Temperament and Personality (Caregiver's description of child's temperament and personality – aggressiveness, sociability, attentiveness, motivation, emotionality…)
Developmental history not available as current caregivers are relatively new to child; therefore, no reliable source to provide report on child's temperament.

6. Schooling History (School performance/specific learning disabilities/school attendance)
The child reports that she went to school at the time she lived with her uncles and grandmother. She was in grade 3 at the time she left. She says she does not remember the name of the school or the place it was in.

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.)
Unclear/ not known as the child did not report.

8. Physical, Sexual & Emotional Abuse Experiences *(Ask Child/ Child's report)
XXXXXXXXXXXXXXXXXXXXXXXXX
[Evidence recorded but removed for reasons of confidentiality].

9. Feelings and Emotions

9.1. 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.

The child appeared exceedingly anxious but was unable to report details of it, whether in the shelter home or in her current home.

9.2. Depression and Self-Harm Risks

0 1 2 3 4 5 6 7 8 9 10

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

ii) At 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.

No sadness/depression symptoms reported by the child currently. [This needs further evaluation].
However, the child had self-injury marks (of cutting) on her forearm. These were old scars, of cutting that she had engaged in during her time in X shelter. These are indicative of distress experienced in that shelter. There are no new self-injury marks i.e. the child has stopped cutting behaviours since removal from X shelter.

9.2. 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?

No anger reported by the child currently.

9.3. Post-Traumatic Stress Disorder (PTSD)

In the beginning of the conversation, the child said that she is happy in the current shelter home and that she enjoys playing games and interacting with her friends. On further inquiry, however, about PTSD symptoms, she reports that she gets images of the past and things that happened in XX shelter. [No account provided on what types of images come to her]. She said that those images used to come to her more during her stay at that shelter and that they have reduced over time. Now also, if she is sitting alone or not engaged in play or activities, those thoughts and images (of difficult experiences in X) come back to her mind. She said that some months ago, it was harder to get those thoughts and images out of her mind but now she is able to do so, to some extent. She reports that she feels anxious for short periods during the times the images return to her mind.She does not report sleep disturbance or irritability or sadness.

10. Any Other Observations of the Child:
Time-place orientation/ thought processes/ cooperativeness, rapport, social responsiveness/ Attentiveness & Activity level/ Speech and language skills:
The child appeared well-groomed and well-dressed.She was observed to be vocal and interactive and playful with friends (outside the interview room). However, the child was observed to be shy and hesitant; she was cooperative when asked to draw a picture (which she did happily) but she was not cooperative during the interview when she was reluctant to respond to questions. Therefore, much of the interview was implemented through use of close-ended questions. Cross-sectionally, she does not seem to have aggressiveness or attention issues. She was very inhibited and reluctant to disclose details of abuse—and she provided very little information on the abuse/ experiences at the shelter home. She frequently said 'I don't know' and 'I don't remember' or was non-responsive. She demonstrated adequate time-place orientation; she initially drew a complex picture of an adult female, with intricate details and went back into the shelter home, and later, of her own accord informed the superintendent and came back to meet the interviewer, saying that she would like to speak with her to give some information. At that point too, she spoke briefly and was not forthcoming with her information—and appeared inhibited.
Her speech and language abilities were age-appropriate but she was inhibited in her communication in a social situation such as being interviewed. Given that she spent an extended period of time in XX shelter where is appears that opportunities for education and socio-emotional development were lacking, her social skills are not on par with her age.
When observed in her natural environment, the child was found to also have emotional dysregulation expressed in passive manner i.e. she is not willing to participate in group discussions and refers to feelings of anger and says 'I am alone' in ways that are upset and angry during group sessions.

11. Summary of Child's Problems
Disability (Physical/ Intellectual): None

Psychiatric Diagnosis: Post-traumatic Stress Disorder (PTSD); Social Anxiety.

Medical Problem: Not assessed by NIMHANS

Context: Child sexual abuse and trafficking issues within child care institution

Implications for developmental and mental health capacity to provide evidence/ testimony as child witness:
The child has some mental health issues related to PTSD/ chronic trauma and significant social anxiety; her developmental and communication abilities may be age-appropriate and she appears to have the capacity to provide valid and reliable evidence/ testimony. However, her anxiety in social situations, combined with her anxieties as part of PTSD symptoms, may make it challenging for her to provide adequate evidence. Given the impact of chronic trauma and the ensuing mistrust of most persons around, she will require tremendous rapport building using non-verbal communication and creative activities (such as art) followed by gradual verbal interactions to enable her to build trust.

12. 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).
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Example 3: Child with Post-Traumatic Disorder (Having Capacity to Provide Evidence)

Assessment for Children in Institutions/Childcare Agencies
Dept. of Child & Adolescent Psychiatry, NIMHANS

1. Basic Information

Name: XXXXX Name of Institution/Agency: XXXXX

Age: 17yrs Sex: F Class: - Date: 29th September 2018

2. Presenting Problems/Complaints
None reported by child/ agency
Referred for mental health evaluation and evidence gathering by XX agency in the context of child sexual abuse in child care institution.

3. Institutional History(where all the child has been /lived, for what periods of time, experiences and difficulties, circumstances of coming to this agency)
Child reports that she lived at home until a year and a half ago. When she was fifteen years of age her bua and mama took her to Z and sold her into a family. She was coerced to marry a forty year old man. When she protested, the forty year old husband told her 'You cannot go because your aunt has taken money in exchange for you'. The child stayed there for two days and then ran away. She was about to take a train from Z railway station to return home but the police caught her and placed her in a home in Zwhere she stayed for two months. Following this she was transferred to XX shelter home as per the CWC orders (as her family home is in P). Following the rescue of the children at XX shelter, on XXXX (date), the child was placed in YY Home.

4. Family Issues Identified (Child's living arrangements/parental relationships/child's emotional relations
Child lived in a village in P, XX Zilla, XX Thana, XX village. Her father's name is XX (self employed) and mother is Kunti who is a home maker. The child has five brothers and two sisters and reports that she was happy at home. However, low socioeconomic status appears to have been a significant factor. The child reports being sold through marriage to another family.

5. Child's Temperament and Personality (Caregiver's description of child's temperament and personality – aggressiveness, sociability, attentiveness, motivation, emotionality…)
Developmental history not available as current caregivers are relatively new to child; therefore, no reliable source to provide report on child's temperament.

6. Schooling History (School performance/specific learning disabilities/school attendance)
No formal schooling as the child said that she had never been interested in studies. Currently the child is attending non formal education at the institution.

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.)
While at home (before going to place X) the child was working as domestic help in a neighbouring house.

8. Physical, Sexual & Emotional Abuse Experiences *(Ask Child/ Child's report)
XXXXXXXXXXXXXXXXXXXXXXXXXX
[Evidence recorded but removed for reasons of confidentiality].

9. Feelings and Emotions

9.1. 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.

The child's anxiety symptoms are characteristic of post-traumatic stress disorder. (As detailed below)

Depression and Self-Harm Risks

0 1 2 3 4 5 6 7 8 (9) 10

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

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

The child reported experiencing pervasive low mood, decreased interest in previously pleasurable activities, death wishes and suicidal ideations especially when experiencing flashbacks or recollections of the traumatic events. It was observed that the child had multiple incision marks over her forearms from self-injurious behaviour that she had engaged in, in the context of PTSD and severe depression.

vi) 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.

Child reported that she would frequently experience active death wishes and frequent suicidal ideations.

9.4. Anger

iv) 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

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

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

Child's anxiety and depressive symptoms are cross sectionally more prominent than her anger.

9.5. Post-Traumatic Stress Disorder (PTSD)

Child clearly has severe post-traumatic stress disorder. She reported frequent flashbacks, vivid intrusive recollections of the traumatic events which were associated with increased heartbeat, giddiness and other symptoms of autonomic arousal. She reported that that on one occasion she had experienced loss of consciousness (suggestive of a dissociative episode) when she had been highly distressed and this was corroborated by the caregiver.

10. Any Other Observations of the Child:
Time-place orientation/ thought processes/ cooperativeness, rapport, social responsiveness/ Attentiveness & Activity level/ Speech and language skills:
While the child was waiting to be interviewed, she suddenly had an outburst of crying, and she later explained how thoughts of the abuse experiences keep coming back to her mind at random times (a symptom of PTSD). She became very tearful and needed much reassurance during the interview as well. However, despite her intense distress, she was also resolute in that she wished to narrate all that had happened to her, saying several times over that despite her distress she would like to tell the truth and recount what had happened to her. She was thus able to provide clear sequential accounts of her abuse experiences including details of time, place and person—and was amenable to soothing and reassurance at times when she became emotional and highly distressed during some parts of the interview.

11. Summary of Child's Problems
Disability (Physical/ Intellectual): Nil

Psychiatric Diagnosis: Post traumatic stress disorder and severe depressive episode

Medical Problem: Not assessed by NIMHANS

Context: Child sexual abuse and trafficking issues within child care institution

Implications for developmental and mental health capacity to provide evidence/ testimony as child witness:
As the child has age-appropriate developmental and communication abilities, she has the capacity to provide valid and reliable evidence/ testimony. She also has some mental health issues by way of depression and PTSD—but this in no way impacts the validity or reliability of her evidence. The way in which her PTSD symptoms manifest are such that the child is open to sharing and expressing her abuse and distress experiences. However, given her high levels of intense distress, she requires gentle and sensitive ways of inquiry, with adequate preparation, soothing and reassurance prior to and during the course of her narrative.

12. 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).
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Suggested Readings

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- Munro, F. M., & Carlin, M. T. (2002). Witness competency—Truthfulness and reliability assessment: The role of the psychologist. *Legal and Criminological Psychology*, *7*(1), 15-23.

Additional Materials

Materials for Activity on 'Assessing Child Witness Competencies for Testimony—Do It Yourself!'

Establishing Child Competency (1)
Identifying Common Objects, Size, Shape & Colour

Objective:

- **To establish basic cognitive abilities.**

Materials: Daily objects of use (such as spectacles, book, cup…) or pictures of the same

Method:

- Explain to child: "We are going to play a game now in which I ask you some simple questions…if you can answer, that's fine, if not, that's ok too. Let's start…"

(i) Pick up objects or pictures of objects and hold them up…present them to the child, one by one.

- Ask the child:
    - What is this?
    - What is this used for? (Or what do we do with this?)
    - Alternatively, say "when it rains, we use…" or "people who cannot see properly need to use…" or [ask child to pick the object/picture that would fit]

(ii) Point to child's clothing or yours, or to different objects in the room…

Ask the child:

- What colour is this?
- Can you show me something on this table that is [red] or [blue] colour?

(Ask about primary colours such as red/blue/green/yellow…avoid making it difficult with complex colours such as 'purple' or 'turquoise blue' as younger children may not be familiar with such colours).

(iii) Point to two to three objects on your table (such as paper weights or pens), of varying size.

ask the child:

- which is the biggest/ smallest/longest/shortest…

Or

If child's parents/caregivers are present,

Ask the child:

- Who is taller…mummy or you?
- Who is bigger, daddy or you?

(iv) Present the child with paper cut-outs of shapes (square, triangle, circle)…or point/refer to objects that are in these shapes.

Ask the child:

- What shape is this?
- Have you eaten ice-cream in a cone? What shape is the cone?
- What shape is this book?
- What shape are the windows of your house?

Or

Ask child:

- Can you show me something on this table that is round?
- Can you show me something in the room that is square?

(Make sure that there are square/round objects in your room!)

Pictures of Daily Objects (to Print as Cards)

	
	
	

	
	
	

*You may add any other pictures that you wish, as available.

Establishing Child Competency (2)

Describing Actions & Behaviours

Objective:

- To establish child's ability to describe the abuse incidents/ what the perpetrator did to child.

Materials: Pictures of actions being performed by a person.

Method:

- Show child one picture at a time.
- Ask child: what is the person in the picture doing?
  Or
- Demonstrate simple actions of eating, sleeping, raising your hand, crying.
- Ask child: what am I doing now?

Pictures of Actions and Behaviours (to Print as Cards)

	
	

	
	
	

*You may add any other pictures that you wish, as available.

Establishing Child Competency (3)

Identifying Body Parts

Objective:

- To establish child's ability to describe the abuse incidents/ what the perpetrator did to child.

Materials: Pictures of girl or boy, showing anatomical (body) parts or girl/boy doll

Method:

- Tell the child: "We are now going to play (another) game. Just like I asked you the name of different things, I am going to show you a picture now of a boy/girl [or a doll] and ask you to name different body parts of the boy/girl [doll]…let's see how many body parts you can name! Shall we start…?"
- Use the picture or doll and point to different body parts, one by one.
- Ask the child:
    - What is this? What do you call this body part?
    - Where is his/her nose/ teeth…[body part]? Can you point to it?
- Start with 'non-private' body parts…eyes, nose, ears, mouth, teeth, head, hands, legs, fingers…then move to asking to name/point to private parts.

Pictures showing boy/girl bodies (For Print)

Establishing Child Competency (4)

Knowledge of Sequences

Objective:

- To establish child's ability to describe the abuse incidents/ what the perpetrator did to child.

Materials: Sequential picture cards

Method:

Ask the child to do the following:
Arrange each set of cards 'in order':
If you have to brush your teeth, what do you do first…what next…? Can you arrange the pictures like that?
When you wake up in the morning, what do you do first, what next…? Can you arrange the pictures like that?
Alternatively:

- "Tell me what you do from the time you wake up in the morning, to the time you go to sleep…all the things that you do. Let's start with what you do as soon as you wake up…"
- "If you have to brush your teeth, tell me how you do it…first what do you do?' [Child may say 'I take my tooth brush and wash it] 'next, what do you do…? [Child may say 'I take the toothpaste and open it, to put paste on the brush'…]

Pictures showing Cards for Sequencing (For Print)

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Sequencing Cards (2)

Establishing Child Competency (5)

Understanding of space and time

Objective:

To establish child's orientation to place and time.

Materials: None

Method:

- To establish time concept, ask the child:
  - When we go to sleep at the end of the day, is it dark or bright outside?
  - When we are eating lunch, it is dark or bright outside?
  - When we wake up, can we see the sun or moon/stars?
  - When do you go to school…?
- To establish knowledge of spaces, ask the child:
  - The place where you live is called….?
  - We take a bath in the….?
  - When you want to buy vegetables or milk, and other things you need, you go to the…..?

- Cars, cycles, buses are seen on the….?
- Do your aunty and uncle live in the same house as you? (Ask caregiver to check if child's response is accurate).

Establishing Child Competency (6)

Identifying Similarities & Differences

Objectives:

- Indicative of child's capacities to differentiate between the appearance of objects or people.
- Important to establish child's ability to identify perpetrator.

Materials: 'Spot the Difference' Cards/pictures or available objects

Method:

- Show the child the two cards with the same houses on it. Present each, one by one.
- Ask the child:
  - What is this?
  - [Correct, they are both houses]. Are they the same? Do they look the same? How so?
- Now present two cards with different houses on them:
- Ask the child:
  - Are they the same? Do they look the same? How so?

Or

Present the child with the 'Spot the difference' picture.
Ask the child: "Can you see any differences between these two pictures? Look carefully…and tell me…"

Or

- Point to two objects in the room that belong to the same category…such as cups/spectacles/watches/clocks/chairs…but that are different in appearance.
- Ask the child:
  - What is this? (in reference to each pair of objects)
  - Are they the same? Do they look the same?
  - What differences can you see?

Or

- Do mummy and daddy look the same?
- What are the differences in the way they look?

Spot the Difference Picture Cards (For Print)

Establishing Child Competency (7)

Memory

Objectives:

- To understand child's ability to recall and communication of facts about events witnessed or experienced.
- To establish child's ability for provision of details of the abuse narrative.

Materials: Picture Cards (each card must have an identical pair)

Method (a):

- Tell the child: "We are going to now play a really fun memory game…"
- Mix the cards and place them face down on the table.
- Use an example and explain to child: "Each card has a pair…like here is a butterfly card [open and show card to child]…we have to find the other butterfly card to match this one. We take turns to play…whoever finds the most pairs is the winner."

- Open one card (face up) and ask the child to find the pair to it.
- Several rounds of this is played…until the child has the opportunity to 'open' each card and possibly its pair—by remembering where it was.

Method (b):

- Ask child if he/she remembers an event that happened a year ago—preferably a happy event, such as a birthday or festival celebration.
- Next, tell the child:
  - Tell me as much as you can remember about that day.
  - What were you wearing?
  - Who all were there?
  - What did you eat?
  - What else do you remember about that event?

Memory Cards (For Print—2 sets)

Establishing Child Competency (8)

Descriptive Ability

Objectives:

- To understand child's ability for communication of facts about events witnessed or experienced.
- To establish child's ability for provision of details of the abuse narrative.

Materials: Picture or picture (story) book

Method:

Show the child (a given) picture.

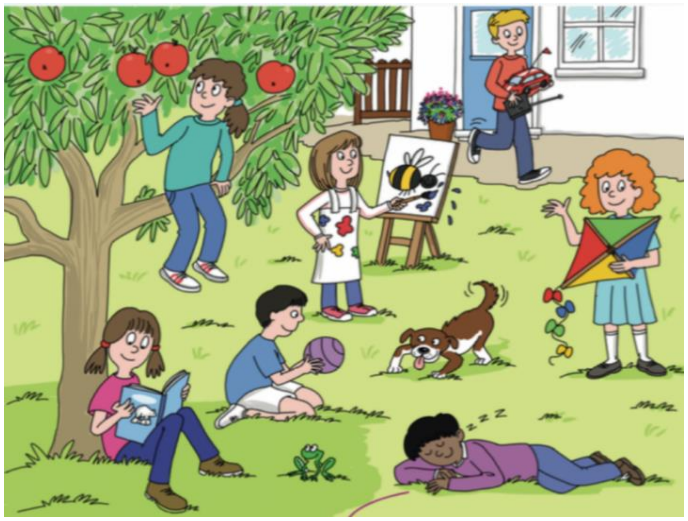
Ask the child (with gentle prompts to encourage the child to say more):

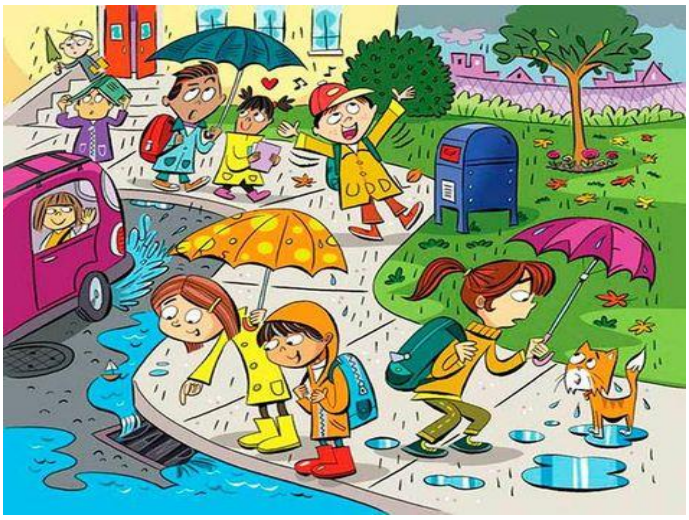
- Tell me about this picture…tell me all that you see in it…
- What do you think is happening here?
- What are people doing?
- What colours are their clothes.

Or

Use a picture story book, to ask similar questions.

Pictures for Describing (For Print)





Establishing Child Competency (9)

Differentiating between Truth & Lies

Objectives:

- To establish child's ability to distinguish between fact and fiction or fantasy.
- To understand if child would be able to provide an accurate (truthful) account of the abuse incident.

Materials: None (except for objects that are around you).

Method:

Tell the child:

- We are now going to play another fun game together. It is about being able to tell what is true and what is not true (false).
- Let me start with an example: If I say that your hair is blue, would that be true or false? [child may respond 'false'].
- If I say that the tree has green leaves, is that true or false? [child may respond 'true']
- So, I see that you understand the difference between what is true and what is false or not true. I am going to tell you about many things like this now…you tell me true or false…
- Continue to ask the child, in reference to the general environment and objects:
  - If I were to say it is raining now, would it be true or false?
  - If I were to say that we are sitting in your bedroom now, would it be true or false?
  - If I were to say you are younger than your mummy, would it be true or false?
  - If I say this cup is bigger than this cup, would that be true or false?
  - If I say this book is fatter than this book, is that true or false?
- Possible conclusion: I see that you know the difference between true and false [if child recognizes difference correctly]—as we talk more, whenever I ask you questions, I would like you to always tell me what is true…it may be what happened to you or what you saw.

Videos for Activity on 'How to Assess Child Witness Competencies'

Identifying Objects

https://www.youtube.com/watch?v=-96ULQXrUp4&list=RDCMUCIGIGYC4PRDzSFSWrYoI_xw&index=20

Describing Actions and Behaviours

https://www.youtube.com/watch?v=Z-6WtxiYleI&list=RDCMUCIGIGYC4PRDzSFSWrYoI_xw&index=19

Similarities and Differences

https://www.youtube.com/watch?v=0Su-J8kR1bc&list=RDCMUCIGIGYC4PRDzSFSWrYoI_xw&index=21

Sequencing Abilities

https://www.youtube.com/watch?v=t2B-S5TcgGY&list=RDCMUCIGIGYC4PRDzSFSWrYoI_xw&index=17

Memory

https://www.youtube.com/watch?v=WejGMOU0I_A&list=RDCMUCIGIGYC4PRDzSFSWrYoI_xw&index=12

Identifying Body Parts

https://www.youtube.com/watch?v=gB_03gQdc_4&list=RDCMUCIGIGYC4PRDzSFSWrYoI_xw&index=13

Descriptive Abilities

https://www.youtube.com/watch?v=MORg_pKT-6g&list=RDCMUCIGIGYC4PRDzSFSWrYoI_xw&index=25

Truth Vs Lie

https://www.youtube.com/watch?v=NQMkkDAFIjU&t=52s

16. Eliciting Evidence from Child Witnesses

Learning Objectives

- To learn about forensic interviewing in the context of sexually abused child witnesses.
- To develop skills in child-friendly methods and techniques to elicit evidence.

Time

2 hours

Concept

Childhood trauma, child sexual abuse dynamics, child development (and witness competencies) and the child's inner voice form some of the foundation pillars on which evidence gathering rests. Now, we will apply our understanding of these four pillars to understand methods and techniques that mental health professionals and medical professionals may use to elicit the child's statement of abuse.

Activity: Forensic Interview vs Therapeutic Interview

Materials: None

Method: Discussion

Process:

- Go around the room and ask the participants "What do you think is the key difference between a forensic interview and a mental health interview?"
- Elicit responses from the participants.

Discussion:

- Summarize the discussion by highlighting that the key difference between a forensic interview versus a mental health interview is the purpose for which the interview is being conducted. While a forensic interview in context of child sexual abuse is used by a professional to gather all the information about the alleged incident of abuse to assist the courts and law enforcement agencies in determining whether the incident of abuse had occurred or not. The purpose of the interview is to produce evidence that will stand in the court as the criminal prosecution is initiated. These interviews require objectivity, employ non leading techniques, and emphasize on careful documentation of the interview, so that the interview findings can stand up to the scrutiny in the court.
- An interview by the mental health professional however, focusses on understanding the context ad dynamics of the abuse, and subsequently on healing and management of the emotional and behavioural problems, or any mental health issues that may have resulted from the abuse incident. The purpose of the interview and work of a mental health professional after the abuse is purely to facilitated healing and recovery, by responding to some of the disempowered inner voices related to the abuse incident.

The Process of Evidence Eliciting from Sexually Abused Child Witnesses

A systematic process, including methods and techniques to elicit the child's statement are described below.

Activity: Evidence Eliciting from Sexually Abused Child Witnesses

Method: Viewing demo video clips

Material: Demo videos on the various processes of evidence eliciting (QR Codes for 4 videos available at the end of the module under 'Additional Material'.)

Process:

- Play each of the 4 videos and discuss as suggested.
- Ask the participants to observe the methods and strategies shown on the demo video.

Discussion:

- Ask the participants to share their thoughts on the video:
  - What were some of things said/ steps followed by the counsellor to the child?
  - What are some the child's inner voices being answered through these steps?
  - How do you think these steps will help in the interviewing process?

Rapport Building and Introduction

Rapport Building is the first stage towards building a relationship with children. It lays the basis for any interaction one wishes to have with a child. Without building trust and rapport with the child, it would be especially difficult to elicit a statement from a child about abuse.

It involves 3 broad steps: greeting the child and introducing yourself; using toys and play activities to initiate communication with the child; and neutral conversation to get to know the child and make him/her comfortable.

Greet the Child and Introduce Yourself

- Say 'hello' or '*namaste*' (maintain a casual disposition, in a friendly manner).
- Tell him/her your name and then, ask the child his/her name.
- Sit at the same physical level as child: if child is on the floor, sit on the floor…if child is sitting on a chair, sit on the chair next to her.
- Avoid being on the other side of the table or standing over the child!

While greeting and introductions might sound obvious, many mental health professionals/ medical professionals/ child care service providers either forget or do not think it is necessary to greet or 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 experiences?

Further, many sexually abused children, by this time have been compelled to be a part of various enquiry processes, answering the same type of questions over and over again. So, the mental health professional/ medical professional/ child care service provider needs to be able to convey that he/she is different and special, and in some way more sensitive than certain others the child may have encountered.

Finally, in a world where adult-child relationships are extremely hierarchical, thereby increasing feelings of mistrust and disempowerment among children, an introduction also enables a more equal platform between the mental health professional/ medical professional/ child care service provider and the child, and thereby increases the

chances of the child trusting the mental health professional/ medical professional/ child care service provider and sharing abuse experiences.

Introduce Yourself and the Space

- Tell the child who you are and what this space is that he/she has come to?

  "My name is…my job here is to make sure that children are safe and no one hurts them. If we hear that someone is hurting or troubling children, then we do things to stop that from happening."

- Respond to child's inner voice (fears & anxieties)

  "You may be wondering about this busy place and many rooms…many people come here, just like you to talk about people who have hurt or troubled them…that's why we need a big space like this and many people to help."

  "Although this place may seem a little scary and confusing, you are safe here…and after we have spent a little time talking, you can go back home with your parents [caregiver]".

It is difficult for children to enter into a conversation with someone they do not know and in a space that they are afraid of or do not understand i.e. there is no context to a conversation unless children understand these. As part of systemic procedures, sexually abused children would have had to visit several spaces such as hospitals, CWC, even police the police station at times (though this is against the POCSO law), during the course of which they have met many people to whom they have had to narrate their story. Children therefore become tired and anxious and less cooperative when they have to repeatedly go through these visits and narrations, especially as they are not aware who these people and places are. It is therefore important to allay children's questions and fears about the mental health professional/ medical professional/ child care service provider's role and the space where the child is being interviewed before starting the inquiry, so that they know who they are speaking with and why.

It is important to keep the introduction of the mental health professional/ medical professional / child care service provider and the space simple and truthful and in accordance with the child's age and developmental level. For instance, introducing oneself as 'I am the Dean of Department of Child and Adolescent Psychiatry Unit of XYZ Hospital or even 'I am a counsellor' is not useful as young children are not sure what to make of these technical terms/ roles; such terms are not only intimidating but also not self-explanatory. Therefore, the function of the mental health professional/ medical professional / child care service provider and of the space should be explained to the child. It is also important that during the interview process if a camera or microphone is being used, the child is familiarized with the equipment and explained why these devices are being used during the interaction or the interview process. As seeing these fancy technical equipment can be can be overwhelming for the child. They may worry that if they say something on camera and it gets recoded it may be used against them, they will get in trouble if they are unable to explain something/ say something incorrectly or the recording may be shared with other people. Therefore, the child(ren) can be told before the recording:

"As you can see, we have a video-camera and microphones here. They will record our conversation, so I can remember everything you tell me. Sometimes I forget things and the recorder allows me to listen to you without having to write everything down."

In case you are not recording but taking down notes, you may say:

"I will note down the things that you tell me in my notebook as you speak to me. It is only because I sometimes forget somethings…when I write down, I can always look back at my notes to remember all that you will tell me."

Since adolescents are older, it would be necessary to introduce oneself and space first, as they will want to understand these issues before they agree to engage in any sort of interaction or the process of evidence eliciting.

This introduction would be slightly different from the one provided to younger children as adolescents usually have some understanding of court and judges and their functions. In fact, in case of children, while rapport building is followed by introducing yourself and the space, in case of older children and adolescents, introducing yourself and the space, need to be done first, followed by rapport building or getting to know the child.

Use toys and play activities

- The 'Mobile Magic Bag': Keep a small bag of toys (dolls, puzzles, picture books, colouring books…)
- Give the bag to the child as soon as (s)he comes to meet you for the interview (while they are waiting)
- Enter play with child and spend 5 to 10 minutes engaging child in play activity… *'What are you doing? What is the doll doing? May I see what you are colouring?'*

Creating Child-Friendly Spaces: The Mobile Magic Bag

Providing children with toys, play and art materials is one part of helping them feel less threatened in what is a potentially intimidating space, creating some sense of normalcy; children may also infer from the availability of play materials that other children come to this space and that this space is therefore geared to receiving children. All this helps them feel more relaxed and comfortable, thereby preparing them to be more trusting and communicative, thus increasing the chances of providing a coherent statement (or reducing the chances of retraction of statement, which happens frequently because children feel threatened, fearful and uncomfortable in a strange and formal spaces). Older children and adolescents (12 years+) can also be given materials to engage them while they wait for the interview (with the mental health professional/ medical professional/ child care service provider) and after. However, materials should include board games, books and art materials (not toys and dolls, which are meant for engaging younger children).

The most critical part to creating a child friendly space is the skills of the mental health professional/ medial professional/ child care service provider—this is what finally makes for a child-centric service and therefore an

environment where children feel reassured and at ease. In the absence of mental health professional/ medial professional/ child care service provider's skills to engage children, even toys and play materials may not have the desired effect or render the space truly child friendly.

Engage in Neutral Conversations with Child

Often, adults' idea of talking with children is asking questions. However, a conversation is not a series of questions that is asked by one person and answered by the other—this would be an inquiry, rather like what the police do, thus creating a sense of power and hierarchy rather than one of comfort and openness. It is therefore necessary for the magistrate/judge to engage the child in a casual conversation about the child's everyday life, such as school, games, interests and hobbies. The interaction can involve questions but must also include some statements and sharing/ responses by the professional, so that the child does not get a sense that it is an interrogation.

The mental health professional/ medical professional/ child care service provider entering into the child's play activity for a few minutes, followed by neutral questions and general conversation, provides a less formal, less intimidating and more casual and child-friendly way of initiating interactions with the child, and provides a scaffolding for further conversation, building up to queries about the child's abuse experience. In other words, if the professional (interviewing the child) does not spend some time building a rapport with the child, there is no context for the child to engage in interactions with him/her, let alone discussing difficult and traumatic experiences of abuse.

- *"What did you eat for breakfast today?"*
- *"How did you come here today?" (Bus, car…)*
- *"Guess what I saw on my way here…"*
- *"…blue is your favourite colour? Red is my favourite colour…like you, I also like ice-cream very much…"*
- *"I would like to know a little more about you… tell me where you live and what school you go to…" **
- *"Tell me a little about the things you like doing…" **
- *"What do you think you want to do when you grow up…"*

*(*For use with slightly older children (ages 8+)*

Providing Food and Refreshments during Child Interviewing Processes

Many mental health professionals/ medical professionals/ child care service providers have reported how they make children comfortable by providing them with food and refreshments such as chocolate, juice etc. While the intention is to show friendliness and concern to the child, there are two innate problems with this well-intentioned gesture. For many children, the processes of sexual abuse perpetration have entailed precisely such actions of proffering food and sweets, to lure them and then abuse them. Therefore, such actions might confuse children causing them to misunderstand the actions of the mental health professionals/ medical professionals/ child care service provider, thereby creating fear and hesitation to interact further. Another problem with this well-intentioned action is that there is the danger of the child mis-interpreting this gesture as a lure and inducement to provide information. This would then compromise the neutrality that is required when conducting interviews for evidence gathering in the context of a sensitive issue such as child sexual abuse.

Of course, many children travel long distances for the interview; they are tired and in need of food and refreshments and a space to relax before entering the interview process/ providing evidence. Therefore, it is suggested that all food and refreshments be provided to the child:

- Outside the interview room (i.e. not in the space where the evidence is to be gathered).
- Before the interview begins.
- By persons who do not play any role in interviewing process (therefore not by the mental health professionals/ medical professionals/ child care service provider).

Mental health professionals/ medical professionals/ child care service provider therefore need to use other rapport building skills, not food, to create a relaxed, comfortable and child-friendly space for evidence gathering.

And yes, it is possible to talk to children about serious and sensitive matters without chocolate! The Dept. of Child & Adolescent Psychiatry at NIMHANS, interviews over a hundred children every day in their out-patient facility and there are no biscuits, chocolates or sweets!

Taking the Statement: How to Inquire about Abuse

Abuse Inquiry

Asking the child open questions such as:

- "*Now that I know a little about you, I want to talk about why [you are here] today.'*
- *"I heard you talked to 'X' about something that happened – tell me what happened."*
- *"I heard you saw [the doctor, a policeman, etc.] last week – tell me how come/what you talked about."*
- *"Is [your mom, another person] worried about something that happened to you? Tell me what she is worried about."*
- "I understand someone might have troubled you – tell me what happened," -"I understand someone may have done something that wasn't right – tell me what happened."
- "I understand something may have happened at [location] – tell me what happened."]

All the above statements are ways in which the inquiry can be initiated with the child. In interviewing, there are two types of questions: close ended questions and open-ended questions. You will notice that all of the above are phrased as open-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.

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.

Open-ended questions encourage the child to give his/her perceptions, opinions, and viewpoints so that the mental health professional/ medical professional/ child care service provider is better able to understand events and issues from the child's perspective. 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 purpose is to detail out and event and understand how a child felt or responded, then open-ended questions are more useful. The mental health professional/ medical professional/ child care service provider's skill lies in how to use the two types of questions, in combination, in an interview with a child, in order to be able to elicit an account of the abuse event.

Non- Leading Questions

↓

Minimally Leading Questions

↓

Moderately Leading Questions

↓

Maximally Leading Questions

(Only for confirmatory details)

Techniques of Inquiry: Leading Questions

Other than open and close ended questions, way to categorize questions is leading versus non-leading questions or techniques of inquiry. Even within this, there is a spectrum:

i) Non-leading Techniques of Inquiry: Questioning should proceed from general to more detailed. Talk about "things that happen" in the child's life — things that happen at home, in school, or in another setting. Such neutral approaches serve as excellent openers to discussion. Then work toward a key question such as:

- Do you know why you are here today? What was explained to you about why you are here today?
- Is there something that you want to tell me?
- Is there something that you wish to tell me? (or need to tell me?)
- Are there any worries you have about home or school…?

ii) Minimally Leading Techniques:

- I understand that you have had some trouble sleeping recently. Could you tell me if anything has happened that would make you to have trouble sleeping?
- Has anyone done things to harm you or upset you?
- I understand there have been some problems in your family. Can you tell me about them?

iii) Moderately Leading Techniques: These questions further narrow the range of possible responses a child might make. Example:

- Did anything happen to you when you went to visit (person)?
- How did you get along with (person) when she went to see him?
- What do you and (person) do when you go to visit?
- I understand that some things have happened between you and [the abuser]. Tell me about those things.
- Is there anything that has happened to you recently that has made you really upset?
- Can you tell me what happened between you and [the abuser]?
- I'd like you to tell me about the things you like about [the abuser]and the things you don't like about [the abuser].
- I need to know how your pee-pee got hurt. Can you tell me how that happened?

iv) Maximally Leading Techniques: These include questions which tell the child what the investigator wants to discuss. In maximally leading questioning, the interviewer does not follow the lead of the child's responses, but introduces content to the child, often communicating the interviewer's desired response. Example:

- Did he [the abuser] touch your pee-pee with his finger?
- Did he [the abuser] take off his clothes when he laid down on top of you?
- He [the abuser] put his finger in your pee-pee, didn't he?
- Did [the abuser] he touch you under your clothes or over your clothes?
- These are close-ended questions, which also assume that abuser has engaged in certain behaviours with the child (thereby leaving out others).

As the interviewing methods proceed from non-leading and minimally leading, toward more directive and leading questions, the risk of contamination of the child's report increases. Children may make reports which are not entirely accurate. It is therefore recommended to begin with open, non-leading questions moving on to minimally leading questions and then using moderately and maximally leading questions to close with confirmatory details.

As discussed earlier, in addition to eliciting a narrative on the immediate abuse, it is also important to understand the methods and processes used by the perpetrator to sexually abuse the child for mental health professional/ medical professional/ child care service provider to get stronger evidence on all abuse processes and to be able to prepare for risks of retraction of statement by children. The above questions enable the mental health professional/ medical professional/ child care service provider to establish the nature of the relationship between the child and the offender, what interactions they had had even before the actual sexual act took place but which were used by the offender to lead up to the sexual act.

Some possible ways of exploring and finding out about the grooming process and the dynamics are:

- *"Where and how did you meet this person [alleged perpetrator]? How do you know whom/her?"*
- *"How long have you known this person?"*
- *"What are some of the activities he/she used to do with you? (incl. the types of games he/she used to play…)"*
- *"Tell me about any time he/she gave you sweets or toys (or things you liked) …were they given only if you did something you were asked to?"*
- *"Has this person ever said anything or done anything that made you feel frightened or uncomfortable?"*

On Children's Stream of Consciousness and Sequencing

"*Only answer the question I ask you…nothing more, nothing less. What you are telling me is question number 9 but we are on question number 2 now…*" says the judge or the public prosecutor, to the child. The child then feels too intimidated to reveal further information, for fear that he/she is incorrect or speaking out of turn. The child may be about to reveal critical information but that is now lost.

Legalistic procedures are often rigidly ordered with public prosecutors and defense lawyers asking questions in a sequential manner, and expecting their clients to answer accordingly. However, children's stream of consciousness is not geared to rigid legalistic thinking and processes. A format with questions to ask children is always useful, but in child interviewing, we need to be completely flexible. This means allowing children to tell their story in ways they wish to, rather than conducting the interview as a question-answer session. This is because children may have urgent things to say, based on what they prioritize in their minds—this could often be revealing and contain information that is also legally important. Thus, the more we allow children to sequence their narrative, rather than using rigid legalistic frameworks to sequence their narratives for them, the greater the chances that we will be able to obtain a coherent narrative of abuse incidents.

Lastly, many times the interviewer (mental health professional/ medical professional/ child care service provider) tend to ask children about prior disclosures and reasons for 'late' disclosure' or non-disclosure, in certain situations. While there is nothing inherently objectionable about these questions on disclosure, it is recommended that issue of disclosure is avoided during the interview i.e. not ask children whom they have told and why they did not tell, because children interpret these questions as the mental health professional/ medical professional/ child care service provider being judgemental and critical. They feel that they are being blamed them for not disclosing;

this result is greater fear and anxiety and reluctance to engage further engage or interact, and consequently in an inaccurate or incomplete statement of abuse.

Use gentle probes

Sometimes children's responses may be ambiguous and not as specific as the inquiry requires. Probes refer to asking follow-up questions, to obtain more detail as and when necessary. However, probes must be used gently, with the mental health professional/ medical professional/ child care service provider waiting for the child to respond to each question asked.

Use pictures or dolls to assist the child

"I will show you a picture [here is a doll] …perhaps you can point to where this person touched or hurt you…" This is important because children may either not know the names of body parts, due their young age and/or inadequate cognitive skills; or may be hesitant to mention names of body parts, especially private parts, given the socio-cultural taboos that surround these issues. During the eliciting of evidence or the interview, it may therefore be useful to show pictures of boys/ girls so children can simply point to body parts that were touched or hurt by the perpetrator. Such pictures are freely available on the internet (see sample above) and simply require to be downloaded and printed. A doll (from the magic bag) could also instead of pictures. Pictures and dolls are also for older children, even adolescents, who may be too shy or embarrassed to name private parts.

It is essential to bring the interaction to a close by thanking the child for coming all the way to interact with you- the mental health professional/ medical professional/ child care service provider. It is also recommended that the

mental health professional/ medical professional/ child care service provider appreciates the child for providing the statement. Some possible things that can be said at the end of the interview are as follows:

- *"You've given me lots of information and that really helps me to understand what happened."*
- *"You have told me lots of things today, and I want to thank you for helping me."*
- *"I want to especially tell you how brave you are for telling me all that happened…things like this happen to many children but they don't always want to tell others about it…because they are afraid. You may also have been scared but you were brave to tell people about it—I am sure your parents are proud of you…I am too."*

Asking if the child has any further information or thoughts to share is also a useful way to ensuring that nothing has been missed out during the interview. The mental health professional/ medical professional/ child care service provider can say:

- *"Is there anything else you think I should know?"*
- *"Is there anything else you want to tell me?"*
- *"Are there any questions you want to ask me?"*

At this stage, one must be prepared for any questions that children may have about how the information provided by them will be used and/or what will happen to the perpetrator (a question that children commonly ask). Here is an example of possible responses: *"As I said earlier, no is allowed to hurt children or make them uncomfortable. If anyone does this, there will be actions taken against him/ her. I have noted what you have told me and this will be shared with people who will take actions against the person you have spoken about. I do not know at this point what those actions will be—that will be decided later—but I can assure you that they will be actions that will not allow him/her to hurt you or other children anymore.'*

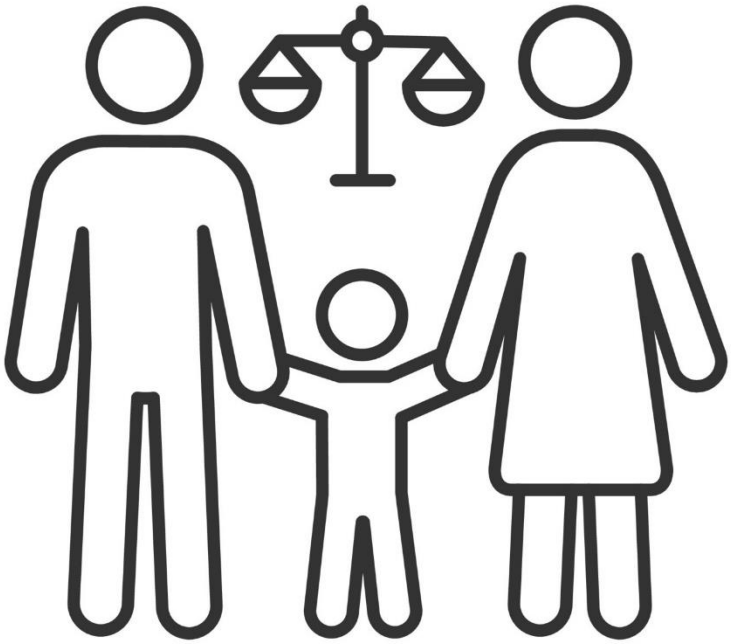
You may notice that this response does not contain words such as 'punishment' or state that the 'perpetrator will be punished'. This is because where CSA processes have been by known and trusted persons, through processes of lure and manipulation, children are likely to be in a state of confusion; telling them that the perpetrator is going to be punished as a result of the child's report may make a child who is confused and unclear on abuse processes feel guilty, thereby traumatizing the child further or even leading him/her to retract the at a later stage of legal procedures.

Child-Friendly means Using the Language of Simplicity and the Child's Terminologies

- *"Did you intimate your mother after the incident occurred?"* can be *"Did you tell mummy what happened after?"*
- *"Did your mother enquire about your whereabouts after the incident? Can be "Did mummy ask you where you were at the time and after what happened to you?"*
- *"Did he touch you in the vagina?"* is *"Did he touch you in the pee-pee [or whatever the child calls this part—find out beforehand what words the child uses for private parts]?"* (for a young child) and *"Did he touch you in your private parts?"* (for an adolescent)

Remember that you are talking to a 6-year-old (or perhaps a 12- or 16-year-old), not a 40-year-old person (or one with a qualification in mental health or law)! Think of your childhood...your children...what terms do you use in your family or household to describe private parts? How do you communicate with your children at home?

- It is critical, however, to document precisely what the child means by 'pee-pee' or 'wee-wee'—make a note to the effect that 'the child pointed to the anal/vaginal area, indicating this as the 'pee-pee'. Else, the defence lawyers are likely to question your evidence in court (as no assumptions can be made about what the child meant by the term use, unless that is clearly verified and documented).
- It is always a good idea to state in your reports what language you used to speak with the child—so that the court is reassured that the child comprehended the questions you placed to him/her.



Additional Guidelines for Inquiry: A Note on Children's Attention

Remember that the quality of information provided by young children begins to decrease with increased attempts to refocus. In other words, once a three-year-old has lost interest and has been refocused to the interview process several times, she or he may begin to answer questions randomly, without thoughts or consideration of the questions posed. Thus, the guidelines below maybe used to keep the time limit while interviewing children.

General Reference: Duration of Engagement	
3-year-olds	**15 minutes**
4–5-year-olds	**20-25 minutes**
6- 10-year-olds	**30-45 minutes**
10-12-year-olds	**Up to an hour**

Give the Child a Break!

This sounds obvious and like the child-sensitive thing to do—even the POCSO Act states that children should be given frequent breaks. However, in practice, it has been observed that the pressures of time, the schedules and work-load of judges and other judicial personnel are often accorded priority and so children are urged to carry on.

'Just a little longer so that we can finish' is the plea that is made to children. The danger in this is that when children are tired or restless and pushed beyond their limit of tolerance, they are likely to be less cooperative and more suggestible i.e. they more readily acquiesce to any statement or question that is put to them. Evidence thus elicited is therefore not reliable.

Children with developmental disabilities and psychiatric disorders ranging from attention and hyperactivity problems to intellectual disability are observed to have poorer attention spans and lower levels of frustration tolerance. Such children therefore would require more frequent breaks than others. And if they reach a point when they cannot engage any longer, it would be in the best interests of the child as well as of the evidence to simply stop and continue at another time.

Activity: Practice Eliciting Narratives of Sexual Abuse from Children

Method: Role Play

Materials: Case studies used for the inner voice activity/ or any case that the participants are familiar with.

Process:

- Request participants to get into pairs.
- One person assumes the role of the child and the other that of the mental health professional/ medical professional/ child care service provider who will interview the child to elicit evidence.
- Tell them: 'imagine that the child is sitting before you now.
- Give the participants 15 minutes to discuss how they would elicit the statement and briefly rehearse using all the steps and techniques discussed during the session.
- Ask any 3 pairs (or more if time permits) to volunteer and role play the evidence eliciting process in plenary.

Discussion:

Ask the participants to observe each role play carefully and discuss the following in plenary:

- Were the steps outlined above effectively implemented?
- Which ones were and which ones not?
- Suggestions for doing things differently?
- Remind participants (as appropriate) of various issues and concepts discussed through the earlier parts/ sessions of the training program and how they apply in practice.

Suggested Reading

- Cooper, A., Quas, J. A., & Cleveland, K. C. (2014). The Emotional Child Witness: Effects on juror decision-making. *Behavioural Sciences & the Law*, *32*(6), 813–828. https://doi.org/10.1002/bsl.2153
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- Westcott, H. L., Davies, G. M., & Bull, R. (Eds.). (2003). *Children's testimony: A handbook of psychological research and forensic practice* (Vol. 45). John Wiley & Sons.
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- Nicolas, S., Collins, T., Gounden, Y., & Roediger III, H. L. (2011). Natural suggestibility in children. *Consciousness and Cognition: An International Journal*.
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- Volpini, L., Melis, M., Petralia, S., & Rosenberg, M. D. (2016). Measuring children's suggestibility in forensic interviews. *Journal of forensic sciences*, *61*(1), 104-108.

Additional Materials

Videos for Evidence Eliciting from Sexually Abused Child Witnesses

Introduction

https://www.youtube.com/watch?v=fKIiqx4jL3Q&list=PL6M-G4mGr43pM6A2Bq2wsANUiFBOVTTeN&index=3

Rapport Building

https://www.youtube.com/watch?v=G4_U9OGbwFQ&list=PL6M-G4mGr43pM6A2Bq2wsANUiFBOVTTeN&index=4

Abuse Enquiry

https://www.youtube.com/watch?v=RxtZV73VM2w&list=PL6M-G4mGr43pM6A2Bq2wsANUiFBOVTTeN&index=1

Closing Interview

https://www.youtube.com/watch?v=3iVPwWh1Kks&list=PL6M-G4mGr43pM6A2Bq2wsANUiFBOVTTeN&index=2

17. Cautions in Child Witness Interviewing & Court Preparation: Understanding Issues of Suggestibility & Tutoring

Learning Objectives

- To understand Issues of Suggestibility & Tutoring
- To help children to feel empowered and confident, and minimize impact of re-traumatization experienced in recounting their abuse experiences.

Time

2.5 hours

Concept

How do you think the Court perceives preparation of a child witness?

Activity: The Court's Perception of Child Witnesses

Method: Group discussion on video.

Material: Video clip on 'Stereotyping Child Witnesses' provided in 'Additional Matreials' at the end of this module.

Process:
- View the video clip.
- Engage in a discussion based on the prompts below.

Discussion:
- Why do you think courts tend to stereotype the child witness?
- What are the implications of such stereotyping?

As Justice Madan B. Lokur, (Former) Judge, Supreme Court of India and (Former) Chairperson, Juvenile Justice and Child Welfare Committee of the Supreme Court of India in his address highlights, historically, courts have viewed children as being greatly susceptible to suggestibility and tutoring as they are prone to exaggerate and imagine things. As a consequence, they have called for greater scrutiny while evaluating child witness testimonies.

In *Dharma Dass and Another v. The State 1966 CriLJ 441* a CSA case from pre-POCSO times, children were observed to be 'dangerous witnesses' due to their vulnerability to tutoring:

> *"...it is absolutely clear that a child witness is always a notoriously dangerous witness, capable of being tutored..., and therefore unless the possibility of coaching is eliminated and independent corroboration is available the courts shall be very slow in accepting the solitary testimony of a child witness".*

In the previous sections of this manual, we have discussed key issues related to child witnesses, such as evaluating witness competency and eliciting evidence (forensic interviewing). In addition to these two key issues, the issue of credibility is also a key aspect in the appreciation of child witness testimony. As highlighted in much of the case law on the subject of child witnesses, children are perceived to be inherently unreliable by virtue of their perceived status limitations i.e., they do not have 'reliable memory' and are exceedingly 'suggestible'. Keeping in this mind, this chapter will discuss two areas of ambiguity in child witness credibility i.e., suggestibility and tutoring.

In a multitude of cases, judicial interpretations have generally prescribed caution while evaluating the competence of a child witness, and subsequently, while evaluating the credibility/veracity of the child's testimony. While Section 118 of the Code of Criminal Procedure, 1973 (CrPC) stipulates who is competent to testify, there are certain important aspects that must be considered in regards to the credibility of witness testimony in the context of children as well. From a judicial point of view, the question of credibility usually relates to certain cognates of a child's developmental status in regards to suggestibility, susceptibility to tutoring and likelihood of misrepresentation. For instance, in the case of *Dattu Ramrao Sakhare v. State of Maharashtra (1997) 5 SCC 341,* the Court while reiterating the requirements under Section 118 of the Indian Evidence Act, held that the child witness' behaviour must be comparable to "any other competent witness" and there must be "no likelihood of being tutored" i.e., the Court adopted a 'reasonable adult' standard in regards to evaluating the competence and credibility of child witnesses. This poses certain difficulties when seen in light of the existing developmental research on the child's ability to be an effective witness.

There is consensus in the available literature on developmental research that behavioural cues and demeanour of the child are not reliable indicators of the credibility/veracity of the child's testimony. Yet, perceptions of witness-demeanour and understandings of normative emotionality play an important role in decision-making on credibility. Child victims of abuse are expected to be emotional during their testimony. The perception of such emotionality impacts rendering of favourable verdicts and viewing the child as credible. What is perhaps more alarming, in this context, is that the prevailing notions of how a 'reasonable person' behaves when telling the truth i.e., clear, cogent and consistent, is fundamentally at odds with research on the point. Often, the witness may recount certain information in a haphazard manner, on account of the difficulties with recollecting a traumatic event. Additionally, the witness may not seek to come across as convincing on account of the child's belief in the veracity of the allegations.

Activity: Children as Witnesses

Method: Group Discussion.

Material: Training video on 'Myth or Fact? Are Children Reliable Eyewitnesses? By Amanda Gellis and Julie Joyce' provided in 'Additional Matreials' at the end of this module.

Process:

- View the training video.
- Engage in a discussion based on the prompts below.

Discussion:

- What are the elements of suggestive questioning?
- How does suggestive questioning affect the veracity of the child's testimony?
- Can the effects of suggestive questioning subsequently be mitigated?

What is suggestibility (with reference to child witnesses)?

While there exists vast literature to glean from in regards to forensic interviewing protocols and best practices, there are certain key issues that remain significant concerns in the interviewing process and could in some cases lead to contamination of children's narrative evidence, thereby compromising the prosecution of the case.

Historically, the most widely cited concern has been the belief that children are inherently more suggestible than adults, and must therefore, be viewed with scepticism in reported allegations of abuse. One of the most comprehensive definitions of suggestibility was provided by Thomas D. Lyon in his Cornell Law Review article, *The new wave of suggestibility research: A critique* as "the degree to which children's encoding, storage, retrieval, and reporting of events can be influenced by a range of social and psychological factors".

The causal mechanisms for suggestibility can broadly be classified into (a) cognitive factors and (b) social and motivational factors. Cognitive factors include the manner in which a child's memory develops w.r.t. an event (the processes of encoding, storage, retrieval and reporting described above), their linguistic competence, their semantic, scripted and stereotypical knowledge and their ability to monitor the source of their memories. Social and motivational factors include the "principle of cooperativity", which states that listeners interpret speakers' utterances on the assumption that they are informative, true, relevant and clear. This is because of the social conventions and context of the interview, where the child is being questioned by an adult.

Activity: Factors and Reasons for Suggestibility

Method: Group Discussion.

Material: Dr. Karen Muller on the Reasons for Suggestibility and Factors for Suggestibility

Abstract: This excerpt from Dr. Karen Muller's seminar on 'Suggestibility and Tutoring Concerns in Court Preparation Programs for Child Witnesses', organised by SAMVAD. Dr. Muller introduces some major reasons for suggestibility and factors which affect suggestibility among children.

Process:

- View the training video.
- Engage in a discussion based on the prompts below.

Questions for Discussion

- What are the major reasons for suggestibility among children?
- What are the important factors which affect suggestibility among children?
- Are the reasons and factors explained by Dr. Karen applicable for adults?Can we limit the susceptibility of a child to suggestion? If yes, how?

While research has generally disclosed chronological age to be a significant predictor of suggestibility, there is considerable evidence to suggest significant variability in proneness to suggestion amongst children of the same age-group. Individual difference characteristics have been evidenced to have an impact on children's and adult's

resistance or proneness to suggestion. Individual differences, according to Gudjonsson Suggestibility Scale, generally relate to two broad categories: a) 'yield' characteristics that relate to suggestibility resulting from leading interviewing techniques; and b) 'shift' characteristics that relate to children's sensitivity to negative feedback from adults and subsequent alteration of responses.

Crucially, suggestibility research today sheds light on the many observable factors and trends that are salient in discussions of child witness credibility. These trends indicate that proneness to suggestion is not linearly co-related to chronological age, implying that despite age increases, suggestibility can be a concern. Chief amongst these trends is the research on 'reverse developmental trends' i.e., conditions under which adults and older children are more prone to suggestion due to an increased likelihood of drawing false inferences. Therefore, issues pertaining to suggestibility and credibility of child witnesses in the context of CSA requires an evidence-based approach to facilitate appropriate evidence collection.

Types of Suggestive Questining in Child Interviewing

While forensic interviewing techniques are perhaps most crucial when it comes to children's susceptibility to suggestion, it is important to note that there are different strands of suggestive questioning that can affect the veracity of the child's testimony. Young children (between 3 to 6 years) are observed to be more susceptible to suggestion and false reporting, in the following interview contexts:

i. **Suggestive questions**

ii. **Other people technique**

iii. **Selective reinforcement / Positive & Negative Reinforcement**

iv. **Inviting Speculation/Instructions to imagine or pretend**

v. **Persistent, repeated questioning over periods of several weeks**

Let's briefly take a look at these variants of suggestive interviewing techniques, and their consequent impact on child witnesses. The McMartin Pre-School case is instructive in this regard, wherein seven teachers (several elderly women) were accused of abusing several hundred children over a 10-year period in Los Angeles. While the investigation commenced in 1983, the case remained open till the early 90s, and is often cited as one of the most protracted and expensive trials in California history. Yet, charges against most of the suspects were subsequently dropped without trial, and more significantly, no convictions were entered into against any of the accused. As research on the subject has since noted, there were severe discrepancies in the evidence eliciting processes employed with children in this case, by the social service agency under contract to the prosecutor's office, with many contending that therapeutic interviewing techniques were inappropriately utilised in a forensic context (amongst other major oversights and apparent errors). Keeping in mind the bundle of suggestive interviewing techniques used in this case, the following is a series of common suggestive techniques and respective examples from the aforementioned case transcripts:

(i) Suggestive questions

This technique consists of introducing new information or additional detail into an interview, even though that information has not already been provided by the child.

Example: "*Can you remember the naked pictures?*" (when no picture taking or nudity had been mentioned).

Example:

(I = Interviewer. C = Child)

I: Who do you think played that game [horsey]?

C: Ray and Miss Peggy.

I: Ray and Miss Peggy? Did Miss Peggy take her clothes off?

C: Yeah.

I: I bet she looked funny, didn't she? Did she have big boobs?

C: Yeah.

I: Yeah. And did they swing around?

C: Yeah.

In addition to probing for excessive detail that wasn't central to the abuse inquiry, it is evident from the above that the interviewer posed close-ended and highly suggestive questions that were central to the allegations of child sexual abuse, thereby requiring children to simply confirm critical details with a yes/no response.

(ii) Other People Technique

In this variant, the interviewer informs the child that they have already received information from another person regarding the topics of the interview. Consider the following:

Example:

"We know about that game [XXXXX] cause we just have had . . . twenty kids told us about that game. ... . Do you think if I ask you a question, you could put your thinking cap on and you might remember…?"

As is evident from the above, by telling a child about the statements of other people, an interviewer may create pressures toward conformity i.e., influence the child's tendency to change or modify one's own behaviour so that they are consistent with those of other people. Naturally, this technique could elicit blatantly incorrect responses from the child, even in the absence of memory distortion.

(iii) Positive and Negative Consequences

In this paradigm, the interviewer offers the child positive or negative incentives to answer questions in a particular manner (i.e., pressure to confirm/deny an allegation). Alternatively, the interviewer may also exert coercion on the child, through this interview technique, to answer a question despite having no knowledge of the incident, thereby forcing false positives in certain instances.

❑ **Positive Consequences:**

This entails the act of giving, promising, or implying praise, approval, agreement, or other rewards to a child or indicating that the child will demonstrate desirable qualities (e.g., helpfulness, intelligence) by making a statement. A simple "yes" by an interviewer, indicating that the interviewer has understood the child, would not be considered Positive Consequences.

Example:

(After a series of suggestive questions, one child agreed that a teacher photographed children while they were naked).

Interviewer response:

"*Can I pat you on the head...look at what a good help you can be. You're going to help all these little children just because you're so smart.*"

❑ **Negative Consequences**

This entails the act of criticizing or disagreeing with a child's statement or otherwise indicating that the statement is incomplete, inadequate, or disappointing to the interviewer. However, simply repeating the question cannot be considered to be indicating negative consequences unless surrounding parts of the interview indicate that the interviewer was being argumentative.

Example:

"*Are you going to be stupid, or are you going to be smart and help us here?*"

(Interviewer to child's puppet): "*Well, what good are you? You must be dumb.*"

As can be observed from the above examples, the positive/negative consequences technique can be deployed to much harm, given its coercive quality and exploitation of the power dynamic between the child and adult interviewer (who is, as far as the child is concerned, an adult in a position of trust and responsibility).

(iv) Asked-and-Answered Questions

In this technique, the interviewing process entails asking the child a question that she or he has already unambiguously answered in the immediately preceding portion of the interview. However, repetition of a question would not be considered asked-and-answered if the interviewer is simply reflecting back he child's statement, without trying to elicit a new answer. Given the act of repetition, this technique raises the possibility of embellishments or contrary statements in subsequent repetitive accounts of the same incident (at the interviewer's behest).

Example:

I: Can you remember the naked pictures?

C: (Shakes head "no")

I: Can't remember that part?

C: (Shakes head "no")

I: Why don't you think about that for a while, okay? Your memory might come back to you.

In light of the above, it is critical to note that children are likely to change their answers in case of a forced choice question (as above). Forced-choice questions, typically, do not offer a child the choice to provide an answer through free-recall, since the child is asked to recall the same incident multiple times, thereby giving the child the distinct impression that they are not recalling the 'right answer', and must, therefore, answer differently.

(v) Inviting Speculation

While inviting speculation, the interviewer is asking the child to offer opinions or speculations about past events, or framing the child's task during the interview as using imagination (e.g., "pretending") or solving a mystery (e.g., "figuring something out"). Commonly used refrains in this regard, include the following: "Let's figure out what happened"; "What do you think happened?"; or "Let's pretend and see what might have happened."

Example:

I: What…do you think…[let's] ask Mr. Rags [a puppet]. Maybe he could get his pointer and we configure this out.

C: (unclear, silent)

I: Now, I think this is another one of those tricky games. What do you think, Rags?

C: Yep.

I: Yes. Do you think some of that yucky touching happened, Rags, when she was tied up and she couldn't get away? Do you think some of that touching that—Mr. Ray might have done some of that touching? Do you think that's possible! Where do you think he would have touched her? Can you use your pointer and show us where he would have touched her? [Emphasis added]

Typically, such questions might elicit speculations from children on the basis of what they have heard from other sources, rather than providing information about what they have personally observed.

(vi) Persistent, repeated questioning over periods of several weeks

In one research study on suggestibility & false reporting in young children, certain important findings were highlighted, with reference to the impact of persistent, repeated questioning over different periods of time. As noted in the study, parents helped researchers make a list of two events that had occurred in each child's life and eight that had not. In weekly sessions, the researchers then reviewed the list with the child, asking for each event, "Has this ever happened to you?". The following observations were made at regular intervals:

- Week 1: A 4-year-old boy, answered truthfully, "No, I've never been to the hospital," the first time he was asked if he had ever gone to the hospital because his finger had been caught in a mousetrap.
- Week 2: The boy replied with, "Yes. I cried."
- Week 11: By week 11, the boy offered an elaborate tale-- about his brother's pushing him into the mousetrap, near where his father was getting firewood.

The most critical finding in this study was that 56% of children reported at least one false event as true, and some children reported all the false events as true. An examination of the children's videotaped statements reveals internal coherent, detailed, yet false, narratives. The most likely causal mechanism for such false assents is source misattributions, where the child confuses two or more sources of memories, in this case confusing the actual experience with merely thinking about it.

From the above, it is clear that different types of suggestive techniques affect the child's ability to recall critical information related to the sexual abuse incident in different ways. Ultimately, the common issue is one of memory distortion, and in certain instances, coercion to answer differently.

Activity: Identifying suggestible statements

Method: Quiz

Material:

- Can you tell me about what happened once you entered the classroom? (Answer: Not Suggestible)
- She locked the door and lifted her top, didn't she? (Answer: Suggestive)
- Why don't you think about that day clearly, again? You might recall what actually happened once he locked the door. (Answer: Suggestive)
- Don't be difficult. Look at how helpful Avinash was while answering our questions. Didn't he lock the door and ask you to pull your shorts down? (Answer: Suggestive)
- I understand you can't recall all of what happened that day. Could you instead tell us what you think might've happened? (Answer: Suggestive)

Process:

- The statements above are read out alound.
- After each statement is read out, participants have to identify whether it is suggestive or not.
- Participants have to identify the type of suggestibility for each statement.
- Participants have to then reason as to why a particular statement is suggestive or not.
- Last but not the least, participants have to re-state each statement in their suggestive or non-suggestve form (as the case may be).). For example, if a statement is suggestive, participants have to restate the question in its non-suggestive form and vice-versa.

What is Tutoring (with reference to child witnesses)?

While we have discussed key aspects related to suggestive interview techniques above, the other imperative in any discussion on child witness credibility is the subject of tutoring. The underlying difference between tutoring and suggestion, is essentially in the differential impacts of both on the child's testimony. As seen earlier, suggestive methods of questioning typically result in memory distortion, thereby inevitably compromising the child's ability to recall the 'truth'. Put differently, a child who has provided incorrect information, as a result of suggestive questions, is not lying. The child is simply incapable of recalling the truth owing to distorted memory.

Tutoring, on the other hand, is not the incorporation of false memories, but relates to the external pressures on the child that may exert a coercive influence on the child's subsequent testimony. Therefore, in this situation, the child may be deliberately recalling false narratives, while being cognizant of the truth of the matter. Therefore, in cases of tutoring, ecological interventions play a central role in ensuring the child is able to safely recall the facts of the impugned incident without any fear of consequences. These ecological interventions include placement of the child in a child care institution; ensuring denial of bail to the accused (particularly in cases where the alleged perpetrator is influential); and, crucially, providing key mental health interventions to counter the myriad impacts

of trauma from the sexual abuse. In summary, therefore, tutoring includes situations when children are coached or told what to say…even pressured or threatened to recall things (that may not even have happened).

Activity: Identifying instances of tutoring

Method: Quiz

Material:

- When you/family member tell a child to tell the court something that did NOT happen. (Answer: Tutoring)
- When you/family member tell a child NOT to tell the court something that did happen. (Answer: Tutoring)
- When you tell the child exactly what to say i.e. give the child the words to say what was essentially her experience (even if it happened and is true). (Answer: Tutoring)
- When you read the child's (164) statement to her, before court deposition, to help her remember her statement. (Answer: Not Tutoring)
- Ask child to rehearse what she is going to say in court with you providing cues on: 'who', 'place of abuse' and 'what happened'. (Answer: Not Tutoring)

Process:

- The situation statements above are read out alound.
- After each situation is read out, participants have to identify whether it can be called tutoring or not.
- Participants have to then reason as to why a particular situation does or does not count as tutoring.

Activity: What does the Court consider as tutoring?

Method: Case Discussion

Participants are requested to peruse through the case transcript of a cross-examination as detailed below.

Materials:

Process:

- Ask participants to read the case material on the screen.
- Engage in a group discussion based on the prompts below.

Discussion:

- Let's look at one exchange from the Child's Cross-Examination…**Why do you think the Court inferred possible tutoring of the child victim?**
- Is the child's testimony in the case indicative of possible tutoring?
- What are your thoughts on the court's manner of questioning? Does this provide sufficient clarity on the likelihood of tutoring?

Tutoring or bad lines of questioning: A dilemma?

In the context of tutoring, addition issues pertaining to child witness credibility can be observed. Specifically, in a study conducted with judicial personnel (Bala et al., 2001), it was reiterated, across the board, that Defense Counsel often deliberately ask developmentally inappropriate questions through the use of complex language, moving back and forth between different events (during examination), and close-ended questions, to confuse the child-witness and dispute the credibility of the testimony. In the case of *Rinku v. State (NCT of Delhi)* 2019 SCC OnLine Del 10376, transcripts reproduced from the child's testimony showed that the Defense Counsel sought to prove that she was testifying on the directions of her mother. The Court had to clarify the question to probe whether the alleged incident took place or whether the child's recollection was a fabrication. To the Court's question, the child responded that the impugned incident actually took place. This exchange is not atypical in the sense that the reliability of the child's witness testimony is not only dependent on the veracity of the allegations, but on the manner in which questions are put to the child as well. Thus, while balancing the requirements of due-process is imperative to the administration of justice, it may also be contended that the procedural safeguards implicit within the traditional framework of adversarial justice need to be re-evaluated to adequately protect the child's interests.

What does NOT count as Tutoring…? Some experiences from the NIMHANS Team's experiences in the Muzaffarpur Child Abuse and Trafficking Case

During this case, as a part of the court preparation interventions implemented by the NIMHANS Team, children were provided cues for memory retrieval as a part of court preparation interventions. These included the following key interventions which were implemented with the implicit understanding that each intervention would have to be strictly conducted in accordance with evidence-based forensic practises:

- Children were reminded of how the mental health team had elicited accounts of their experiences of abuse in the child care institution from them some months ago, in the presence of the investigative officers. It was explained that they now needed to provide these narratives in court. The evidence recorded for each individual child was then read to her, so as to refresh her memory.
- These processes were implemented twice –a few weeks before the trial, and on the day before children were due to appear in court for the trial. Children were asked whether there were any other details they remembered, at that point, in relation to the narrative already provided.
- Open ended questions were posed about details previously provided in their statements, about the perpetrators (their names), other persons present and possibly aiding and abetting the perpetrators in the act of abuse, time of day (if the child knew it), the specific space within the institution wherein the abuse took place and details of the acts of abuse.

Suggested Reading

- Cooper, A., Quas, J. A., & Cleveland, K. C. (2014). The Emotional Child Witness: Effects on juror decision-making. *Behavioural Sciences & the Law*, *32*(6), 813–828. https://doi.org/10.1002/bsl.2153.
- Lyon, T. D. (n.d.). *New wave in Children's Suggestibility Research: A critique*. Scholarship@Cornell Law: A Digital Repository. https://scholarship.law.cornell.edu/clr/vol84/iss4/3/.
- Bruck, M., & Ceci, S. J. (1999). THE SUGGESTIBILITY OF CHILDREN'S MEMORY. *Annual Review of Psychology*, *50*(1), 419–439. https://doi.org/10.1146/annurev.psych.50.1.419.
- Goodman, G. S., & Melinder, A. (2007). Child witness research and forensic interviews of young children: A review. *Legal and Criminological Psychology*, *12*(1), 1–19. https://doi.org/10.1348/135532506x156620.
- Ceci, S. J., & Bruck, M. (1993). Suggestibility of the child witness: A historical review and synthesis. *Psychological Bulletin*, *113*(3), 403–439.
- Hritz, A. C., Royer, C. E., Helm, R. K., Burd, K. A., Ojeda, K., & Ceci, S. J. (2015). Children's suggestibility research: Things to know before interviewing a child. *Anuario De Psicología Jurídica*, *25*(1), 3–12. https://doi.org/10.1016/j.apj.2014.09.002.
- Garven, S., Wood, J. M., Malpass, R. S., & Shaw, J. (1998). More than suggestion: The effect of interviewing techniques from the McMartin Preschool case. *Journal of Applied Psychology*, *83*(3), 347–359. https://doi.org/10.1037/0021-9010.83.3.347.
- Ceci, S. J., Loftus, E. F., Leichtman, M. D., & Bruck, M. (1994). The possible role of source misattributions in the creation of false beliefs among preschoolers. *International Journal of Clinical and Experimental Hypnosis*, *42*(4), 304–320. https://doi.org/10.1080/0020714940840936.

Additional Materials

Videos for activity on 'The Court's Perception of Child Witnesses'

Stereotyping the Child Witness

https://drive.google.com/file/d/1zRvmRV55h7VsrXfbeF1JitCs9-zi_2ct/view?usp=sharing

Video for the activity on 'Children as Witnesses'

Do Children Make Reliable Witnesses?

https://www.youtube.com/watch?v=uqhNQ2iV0OQ

Suggestibility and Tutoring Concerns in Court Preparation Programs for Child Witnesses (Child Witness Institute)

https://www.youtube.com/watch?v=nHQj7Tn8sVA&list=PL6M-G4mGr43pEXa4vW0CsOGcVYcvUPivr&index=2

Video for activity on 'Factors and Reasons for Suggestibility'

Dr. Karen Muller on the Reasons for Suggestibility and Factors for Suggestibility

https://drive.google.com/file/d/1WvgGC0Ta_2w3v4nR3ZVFcsumqeDGFydu/view?usp=sharing

Material for activity on 'What does the Court consider as Tutoring?'

Altaf Ahmed @ Rahul v. State (GNCTD Of Delhi)

Brief facts (disputed)*: The child (aged 6 years) was playing with her two sisters, while her mother was lying down, as she was unwell. After some time, the children went outside to play. The child reported that the accused pulled her to his room, while they were outside. The accused's room was right next to the child's room (where her mother was lying down). While inside the accused's room, the child reported that he pulled down her underwear, put his saliva on her 'susu part' and then inserted his finger. She cried and her mother came outside. During the child's testimony, she 'improved' her initial account and claimed that the accused also put his mouth to her 'susu part'.

The Court noted two important factors that indicated tutoring:

'Material improvements' in the child victim's testimony i.e., changes between her initial statement (u/s 164 CrPC) & In-Court examination;

Child's admission that her mother told her what to say to the Court and Doctor (during medical examination)

Child: It is correct to say that, at home, mamma teaches me and helps me prepare for the exam. When I was getting ready in the morning, I asked her where she was taking me and why she was taking me there. It is correct to say that mamma told me what to say in court. It is incorrect to say that, in the hospital also, mamma told the doctor what happened to me.

Court Question: In the hospital, who told Doctor uncle about the incident?

Child: I told him. Before going to the hospital, I asked mamma where she is taking me and why she is taking me there.

Court Question: Do you know the difference between 'where' and 'why'?

Child: The meaning of 'why' is where are you taking me. Before going to the hospital, mamma told me what to say to Doctor uncle.

Court Question: What you said to Doctor uncle and what you said today in court…did that happen to you or did your mamma tell you to say this?

Child: It happened to me.

Film Screening & Discussion (C)

Learning Objectives

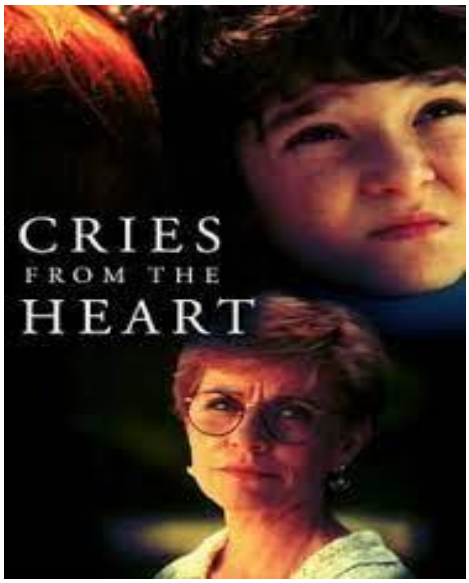
- To get a depictive understanding of the nuanced and complex CSA processes in children, especially the process of grooming.
- To understand how experiences of abuse are internalised and stored in memory (not always accurately).
- To get a glimpse of the difficult dynamics of reporting from a CSA victim's perspective.

Time

2 hours 20 minutes (Screening - 1 hour 35 minutes; Discussion - 45 minutes)

Material: The movie titled **'Cries from the Heart'**. The movie may be accessed on various OTT platforms.

Synopsis of Film



Michael, a 7-year-old autistic kid who cannot write or communicate, is raised by his divorced mother, Karen Barth. Following an incident where Michael wanders off and ends up at the neighbourhood playground, Karen's ex-husband Roger advises that Michael be placed in a special residential school because he may require more specialised care than Karen can offer. Karen is initially reluctant to enrol Michael, but she agrees to go to the campus anyway. There, she meets with therapist Terry Wilson, who explains how the programme will benefit Michael. This finally persuades Karen to enrol Michael, even though the school has mandated that she not return for six weeks. After first objecting to Terry's methods, Karen reluctantly accepts that the time apart is required for acclimatisation and accepts a position at a nearby greenhouse. In the meantime, Michael starts to make slow but steady progress, picking up skills like tying his own shoes and helping with dinner preparation in the cottage he shares with his carer, Jeff.

At some point, Terry recommends to Jeff and Eliot, the head of the school, that they attempt a type of facilitated communication in which Michael types his ideas on a computer keyboard while Terry holds his hand. While Eliot is hesitant, Jeff dismisses Michael outright, saying he's "not that bright" and "can't even spell." To test if it works, Eliot eventually consents to allow Terry a month of one-on-one time with Michael alone. Terry persists even though Michael first only types gibberish.

Eventually, a breakthrough happens when Karen pays him a visit and, in a tearful moment, he types "MOM HI" to her, ending his protracted quiet. Michael types "YES" in response to Karen's question about if he knows how much she loves him, followed by "DAD GONE," which Karen also agrees with. Michael then types "I BRAK CAR MY FALT," which tells her something she didn't know. This shocks Karen, who says to Michael, "No. No, it's not your fault, honey." Then she tells Terry that Michael damaged the car glass because he was angry the night she and Roger got divorced. Karen reassures him that their divorce was more likely the result of their poor communication than the car. She gives Michael a head kiss after telling him that she and Roger adore him very much.

Afterwards, Karen tells Roger about her first chat with Michael, acknowledging that she was mistaken about Terry before and thanking him for recommending the school. Roger feels guilty for never explaining his departure after learning that Michael believed he was to blame for the divorce. Karen reassures him that she corrected Michael and that he may now tell them even if he isn't convinced. Karen even got paid more at the greenhouse, so things appear to be improving.

But as soon as Jeff leaves for a two-week vacation in Florida, problems start to appear. Michael starts behaving out, experiencing nightmares, ignoring his responsibilities, and becoming more difficult to manage. Terry, in need of clarification, asks Michael why, and he responds by typing "JEFF." Terry is taken aback when Michael further explains this by putting "KEEP JEFF AWAY," since she first believes it has to do with Jeff being away.

When Terry inquires inquisitively, "Keep Jeff away? Michael asks, "Why?" and, based on his agonised countenance, types down the unimaginable: "SEX"—a reference to being molested. Terry replies, "Oh, my God," in a voice of astonishment and horror. Informed with this horrible news, an enraged Karen criticizes Terry for letting Jeff hurt Michael, and demands that she wants Michael immediately, and Eliot and Terry reluctantly agree. Michael walks into the room during a chat, and Roger and Karen give him a hug. Michael types "I SHAME" at the computer, but Karen corrects him, telling him he has nothing to be ashamed of and that Jeff was wrong in what he did. Karen insists that Michael be taken out of the school, claiming that Jeff won't harm him. But Terry objects, claiming that Michael needs the school or something comparable and that despite Jeff's hurting him, he has come a long way. Furthermore, according to her, suspending Michael from school would be the same as punishing him for Jeff's abuse of him. "I STAY" is how Michael also declares his intention to stay there. A detective is sent to the school after Jeff is arrested and questions Michael about the abuse. Believing Michael to be reliable, the detective remarks to Terry about how great this method of communication is before departing.

But things aren't going well for Karen. Karen abruptly cuts off all communication, refusing to answer calls or show up for visits, and isolating herself in the house. Karen feels offended that Michael trusted Terry more than his own mother, while Roger is thankful that Michael reported the molestation. At last, Terry pays her a visit and tells her that even with everything the school has taught Michael, he still needs Karen in his life and that their collaboration is crucial. This turns her around, and as they get ready for trial (a difficult task made worse by the court's unwillingness to allow facilitated communication in testimony and Jeff's retraction of his confession), Karen emphasises to Terry how crucial it is that she assist Michael in "finding his voice" in court.

Once he has been shown to be a reliable witness, Michael breezes through the district attorney's questions; then, under Jeff's attorney's cross-examination, he has a meltdown on the witness stand that compels the court to order a break. A solution is reached despite the defense's request for a mistrial: Jeff will not be present during another cross-examination that will take place in a different location and be broadcast back to the courtroom via closed-circuit television.

Michael types "I CAN DO IT MOM" in response to Karen's question about trying again, and the trial continues. This time, things proceed more smoothly, and Jeff is ultimately found guilty of having a sexual act on a minor. Michael writes "WE WON" after receiving Karen's excellent news, to which Karen joyfully responds, "Yes, we did." Michael gives Karen a hug and a kiss while he plays on the swing. With Terry and Karen watching Michael play on the swing as the movie comes to a close, Karen remarks, "He is a tough little kid." Terry laughs and says, "I wonder where he got that." Karen responds, "We'll go together," to Terry's statement that "We have a long way to go with him. Our crew works well together."

Discussion

What was the most unforgettable moment in the film for you?

- Was there anything about the child’s personality that stood out to you? Does the behaviour of a child have any impact on the credibility of their communication?

- What are your thoughts on facilitated communication, as depicted in the movie? Is it a legitimate and accurate method of eliciting evidence?
- What are the various ways in which Terry deals with Karen’s overprotective instincts towards Micheal?
- What are the CSA processes through which Jeff sexually abuses Micheal?
- What can be other methods of eliciting evidence from children who suffer from disabilities such as autism spectrum disorder or speech and learning disability?

18. Court Preparation Interventions for Child Witnesses

Learning Objectives

- Develop and implement court preparation interventions in accordance with the specific needs and vulnerabilities of child witnesses.
- Enable children to be competent witnesses and provide accurate testimony in court.
- Help children to feel empowered and confident, and minimize impact of re-traumatization experienced in recounting their abuse experiences;

Time

3.5 Hours

Concept

Activity: Do you understand me?
Method: Discussion
Materials: None.
Process:

- Address the participants in a language which is not known to them, by:
    - Give them a brief account on anything...also asking them questions, in the unknown language.
    - Request them to respond to your questions...continue to engage in this unknown language for about five minutes.

Note: This activity may be done by the facilitator if he/she speaks a language not known to the participants—for example: one may speak in Tamil/Kannada (or any South Indian dialect) if one is addressing a group from the northern part of the country.
Or, you may ask one of the participants to volunteers to do this activity for you. For example, when the room is filled with participants from across the country, a participant who speaks a dialect that is highly specific to a state/region (such as Nagamese or Khasi, for instance) may be called upon.
In case there is no such possibility of using a language which is unknown to majority of the participants, you can use gibberish.
Discussion:

- Were you able to understand what was being said earlier? Why not?
- How did you feel when you were unable to understand what was being said?
- Do you think a child is able to understand the language of the law and what is said inside a courtroom? Why not?
- How do you think a child feels when they are unable to understand the language of the law and what is expected of them inside the courtroom?
- Discuss how the adversarial justice system is heavily reliant on oral testimony...that language is the currency of the court...and what this means for children and their lack of knowledge of 'legalese'.

Why court preparation for child witnesses?

Given the nature and realities of the adversarial criminal justice system, the reasons for why child witnesses require preparation for court is described below.

Secondary Victimization in Criminal Proceedings

- Legal proceedings can be extremely emotionally stressful for child witnesses--this negative experience within the justice system, that contributes to the trauma of victims, is described as 'secondary victimization'.

- Secondary victimization occurs due to factors such as: victims' lack of information and knowledge about their legal rights and criminal processes, which may increase their fears and anxieties, also making them feel disempowered since they feel that they have no influence on decisions affecting their lives; the insensitivity of the court and its procedures, due to lack of training, time and personnel, and which results in disregard of victims' needs during court processes.

- Children are required to provide a crime narrative multiple times, leading them to repeatedly experience feelings of fear, guilt and anxiety—and exacerbating the shame and stigma experienced.

- Lack of familiarity with court procedures, the formality of the court room, long waiting times, and frequent adjournments cause stress and trauma.

- Children are at higher risk of secondary victimization than adults, given their developmental stage; and more so if they have to see the alleged perpetrator in court—children are afraid of being attacked during testimony, by the accused, of being blamed or even arrested for 'making a mistake', and of not being believed.

- The experience of cross-examination wherein attempts are made to discredit the child's testimony, can be very difficult.

- Such experiences of secondary victimization, resulting from judicial proceedings that are not appropriately designed and conducted for children, tends to lead to re-traumatization.

- Thus, preparing children for court, so that they know what to expect in the court room, and of court processes, would help address many of the stresses and anxieties that they would otherwise have—and that would hinder accurate provision of testimony as well as negatively affect their mental health and psychosocial well-being.

The Impact of CSA Trauma on Children's Testimony in the Court Room

- Given CSA, child witnesses may already be experiencing symptoms of post-traumatic stress disorder (PTSD). PTSD symptoms such as recurrent, distressing memories of the event, prolonged psychological distress at exposure to cues that symbolize or resemble aspect of the traumatic events, and dissociative reactions are likely, to be worsened by children's engagement in legal processes.

- They are also likely to negatively impact their abilities to provide testimony--avoidance of efforts to avoid distressing memories, thoughts and feelings and external reminders associated with the event, and negative alterations in cognitions and mood, may also manifest in the inability to remember an important aspect of the traumatic event.

- PTSD is linked to alterations in brain structures and possibly involved in attention, encoding and consolidation of memory. During a traumatic event, the attention remains focused on the main stressor and therefore it is remembered particularly well. Thus, while some children with severe trauma, remembering the core features of the event quite well, others retrieve information in a generic form (without remembering the specifics) - as a means of controlling negative affect associated with the memory.
- Thus, (unresolved) trauma can also impact survivor testimony and, thus, the efficiency and credibility of the judicial proceedings. There is, consequently a need to assist children with their trauma issue, of course first and foremost with the objective of ensuring their healing and recovery, but also as part of court preparation—so that children are better able to regulate their emotions whilst in court and providing distressing abuse narratives.

Children's Competence for Providing Reliable Testimony

- The adversarial system requires children to provide court testimony in ways that need for them to convert their memories into words and sentences. This communication is to be made within the limitations of a question-answer structure i.e. the child witness must respond precisely to the each of the questions put by the court, in whatever manner or sequence the court decides to put them.

- Given the court's use of 'legalese' and their tendency to ask semantically and syntactically complex questions, phrased in ways that are beyond children's levels of understanding, the latter are often unable to comprehend and communicate with the court. This leads to unreliable reports from children.

- There is the particular concern of cross-examination—wherein children's developmental abilities, and how they are pitted, in what is a completely unequal playing field, against a lawyer who is attempting to discredit their narrative. Court preparation helps children to understand (at least to some extent), the ways of cross-examination, and the use of certain skills and techniques to be able to respond to cross-examination. For example, children may be prepared for some questions may be a deliberate attempt by the defence lawyers, to provoke an angry or agitated reaction and that remaining composed is critical to providing accurate responses.

- Thus, the limitations of children's communication abilities, which hinder the obtaining reliable testimony, may be minimized by instructions or preparation of child witnesses.

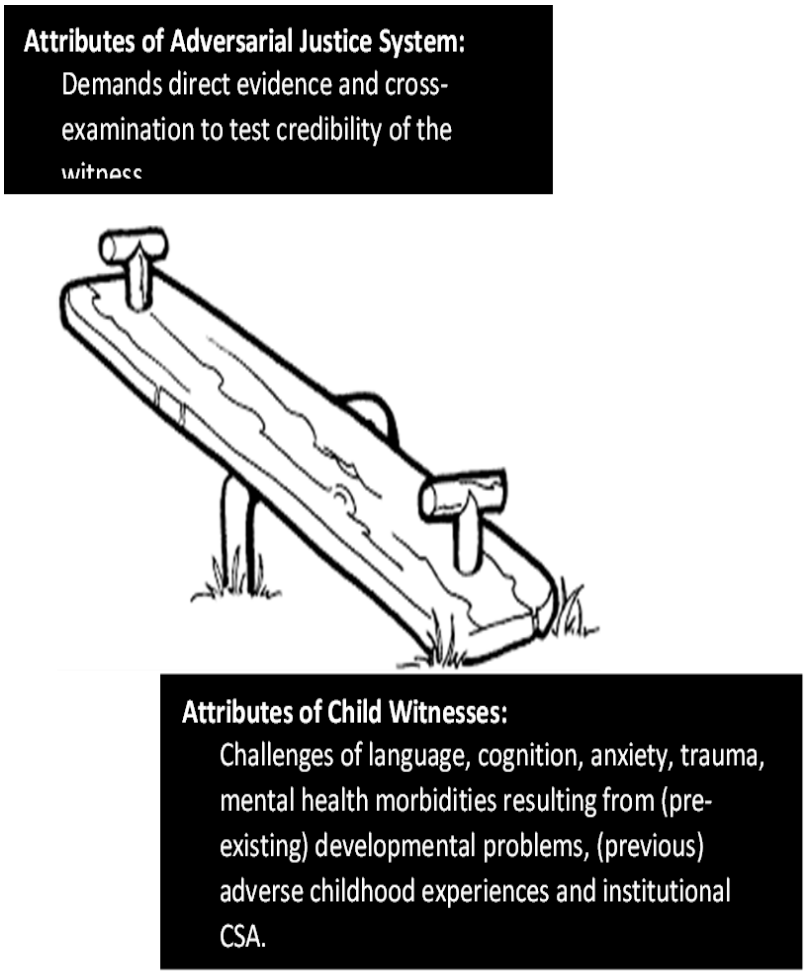


Figure 1: Challenges and Tensions…the Adversarial Justice System versus Child Witnesses

In summary, it is evident that children in general are vulnerable due to their age and developmental capacities; that they are rendered further vulnerable by CSA experiences, due to the ensuing trauma and other mental health issues—which may for certain sub-groups also be compounded by pre-existing adverse childhood experiences and risks i.e. psychosocial and mental health difficulties even prior to the CSA experiences. Children are placed in a situation of testifying in court, wherein they are required to recount their traumatic experiences in an adversarial criminal justice system that is essentially not geared to their developmental capacities and psychological needs. The question therefore is how to equip and enable already vulnerable children to contend with such a system, and respond to processes that are not inherently designed to cater to their needs and capacities, in ways that: (a) avoid secondary victimization and re-traumatization; and (b) assist children to 'tell the truth', and so provide accurate evidence. It is in this context that we address the issue of child witness preparation for court procedures—and child service providers and mental health professionals have a critical role in this. So, in essence, we are dealing with the tensions arising from children having to contend with the adversarial justice system (as shown in Figure 1).

Before Implementing Court Preparation Interventions…

Remember our discussions under assessment of child witness competencies! Those assessments require to be conducted prior to implementing court preparation interventions with a given child witness. In sum,

- Ensure that developmental assessment of child is complete:
    - To understand child's developmental abilities and skills.
    - To be aware of any disabilities and deficits child may have—and how these might hinder child's ability to provide testimony.
- Conduct mental health assessment so as to:
    - Initiate treatment (pharmacotherapy and counselling).

- Identify how a given mental health issue may impact child's ability to provide testimony in court.

Refer to Table 1 for an example of how competency assessments may be analysed to provide the requisite court preparation interventions to a given child. The example provided in the table is drawn from SAMVAD's experience of preparing a group of children who were sexually abused in the child care institution where they were residing for some years. Multiple numbers of children (ranging between ages 11 and 18 years) were abused, and since the children shared a space, they had knowledge of not only their own experiences but also of others as they had witnessed incidents of abuse. Each child had suffered multiple episodes of abuse, by multiple abusers (by known persons such as the staff and also unknown persons from outside the institution), over relatively long time-frames (about 2 to 4 years).

While the institutional context was the same for all children, they each had varying experiences of complex and chronic deprivation, abuse and trauma, both within and prior to their entering the institution. Their life experiences, due to CSA as well as other traumatic events, manifested in various emotional and behaviour problems and mental health problems ranging from post-traumatic stress disorder (PTSD), mood disorders, anxiety, self-harm, withdrawal and other forms of emotional dysregulation to aggression and oppositional behaviour. The children also had varying levels limitations in their cognitive capacities, either due to developmental disabilities, and/or due to lack of stimulation and developmental opportunities and the impact of trauma. In this backdrop, they were therefore were expected to recount multiple experiences of abuse as part of the testimony—and according to which the SAMVAD team had devised court preparation interventions, some universal, and others individually geared to cater to specific child witness needs and abilities.

Court Preparation Programs in Other Countries, for Child Witnesses

In recognition of the challenges child witnesses have in providing testimony, countries such as Canada and the United Kingdom developed some of the earliest programs and packages available for preparation of the child witness.
For more information on child witness preparation and training programs, you may refer to the following programs and websites:

- Child Witness Project, Canada

https://www.lfcc.on.ca/services/adolescent-services-2/child-witness-project/

- Canadian Child Abuse Association

https://www.childcourtprep.com/training_courtprep.html

- Kids and Teens in Court (KTIC): A Model for Preparing Child Witnesses for Court

https://www.chadwickcenter.org/kids-and-teens-in-court/

- Child Witness Institute, South Africa

https://childwitness.net/the-child-witness-institute/

- Child Witness Pack

https://www.ojp.gov/ncjrs/virtual-library/abstracts/child-witness-pack-evaluation

Innovative ways to prepare children for court…

The use of videos and cartoons to help children understand the geographies and processes in court, and to alleviate their fears and anxieties about going to court…

- 'Kids in Court'

https://www.youtube.com/watch?v=EswF5p41Sfs

- 'Radiant Goes to Court'

https://www.youtube.com/watch?v=xcJKOiGmKQY

Role of Support Persons…Assisting Child Witnesses in Court

Finally, based on our understanding of child witnesses' challenges with regard to testifying in court, here are some recommendations on what support persons accompanying children to court need to be doing:

- Accompany the child (and family) to court…help them navigate the system.
- Talk to public prosecutor…inform him/her what child may need in terms of breaks etc depending on age and ability.
- Ensure child gets water, food…breaks during the session.
- Be alert to the child's emotional states…and request court for break accordingly.
- Remind child to use relaxation and self-soothing exercises if she feels distressed…and to think of the objects of courage/comfort.
- Validate child's emotions of anger and distress after the hearing i.e. do a de-briefing session.
- Tell child she did exceedingly well…that she was very brave.
- Never criticize child for not providing (adequate) testimony!

Table: An Example of Children's Developmental and Mental Health Concerns: Implications for Capacity to Provide Testimony and Preparation for Court (as implemented by the SAMVAD team in the context of sexually abused children in a child care institution)

Category of Children	Developmental and Mental Health Concerns	Implications for Capacity to Provide Testimony	Implications for Court Preparations
Children with socio-emotional skill deficits:	• Drawn from backgrounds of chronic neglect, without adequate nurturance and developmental opportunities at home and subsequently, at the institution. • Institutionalized at relatively young ages, when identities were at a formative stage. • Consequently, did not develop age-appropriate socio-emotional skills, despite having average age-appropriate intellectual/ cognitive capacities. • Significant socio-emotional communication difficulties either due to social skills deficits and disorders of social anxiety, causing reluctance to engage with new persons.	• High ability to provide valid and reliable (abuse) narratives and evidence but with a focus on external events and occurrences rather than linked to self. • Ability to provide adequate amounts of information regarding events /occurrences in the institution, and on physical abuse, but reluctant to provide information regarding (traumatic) experiences of the self, particularly of sexual abuse.	• Eliciting children's fears and confusions about court testimony and related issues including abuse experiences. • Introducing ideas of courage and determination to encourage overcoming of fears. • Discussion on the benefits of providing accurate testimony • Universalization of their abuse experiences to 'normalize' them and thus enable them to provide details about the self.

Children with near-normal socio-emotional skills:	• Drawn from backgrounds of chronic neglect but had near-normal social and emotional development (possibly explained by resilience). • Institutionalized at a relatively older age, i.e.mid-late adolescence, when identities were better developed. • Developed mental health issues such as PTSD, depression, adjustment disorder and emotional regulation issues in the institution, due to experiences of abuse and trauma.	• High ability to provide valid and reliable (abuse) narratives and evidence both about external events/ occurrences as well as experiences of the self, pertaining to sexual abuse. • Ability to engage socially, and provide details about difficult experiences. • Presence of risk/ tendency to be overwhelmed by PTSD symptoms interrupt the abuse narrative.	• Acknowledgement of anxiety and PTSD-related emotions that arise while talking about traumatic experiences. • Highlighting their courage to talk about difficult experiences. • Enhancing emotional-regulation abilities, through training in anger and anxiety management techniques.
Children with Below Average Intelligence—Mild Intellectual Disability:	• Cognitive capacities below age-appropriate levels. • Independent in day-to-day functioning and self-help skills. • Speech and communication abilities present but more complex physical aspects of sexual experiences hard for them to explain. • Difficulty with memory, sequencing and details of events.	• Ability to provide valid and reliable (abuse) narratives and evidence both about external events/ occurrences as well as experiences of the self. • Difficulty with advanced reasoning and higher-order perspective, leading them to be less inhibited; therefore, less likely to withhold information—consequently able to share narratives more openly.	• Encouragement to provide abuse narratives through appreciation of their courage in the wake of difficult experiences. • Use of communication aids (anatomical dolls) to facilitate communication. • Greater need to refresh memory, and for rehearsal of narrative, to maintain some consistency in sequence and detail.

Activity: Implementing Court Preparation Interventions for Child Witnesses

Method: Analysis and discussion

Materials:
Court preparation interventions hand-outs (developed by SAMVAD in the above discussed example). Hand-outs for this activity are provided as 'Additional Material' at the end of this module.

Process:

- Divide the participants into 4 sub-groups (if is a large group, you may divide them into 8 sub-groups, with two sub-groups working on the same hand-out).
- Provide each sub-group with a hand-out and explain the following:
    - Each hand-out (as you see), has a table, with a column that is titled 'Interventions' and one that is titled 'Descriptions'. The 'Interventions' are the broad processes of what is done with the child; and the descriptions provide details of these processes.
    - Read the descriptions and provide a sub-head for each group of descriptions in the table.
    - Finally, provide an overall title for the three to 4 descriptions/ interventions laid out in the table.
- When all sub-groups have done the exercise, have each of them present their sub-titles/ titles in plenary.

Discussion:

- What do you think is the overall objective of a given group of interventions?
- What are the objectives of each sub-group of intervention?
- What court-related challenges are they addressing?
- Do you see any suggestibility or tutoring in them?
- From a legal perspective: do they infringe upon the rights of the accused?

*After the participants have had a chance to respond, share possible sub-heads and overall titles as below.

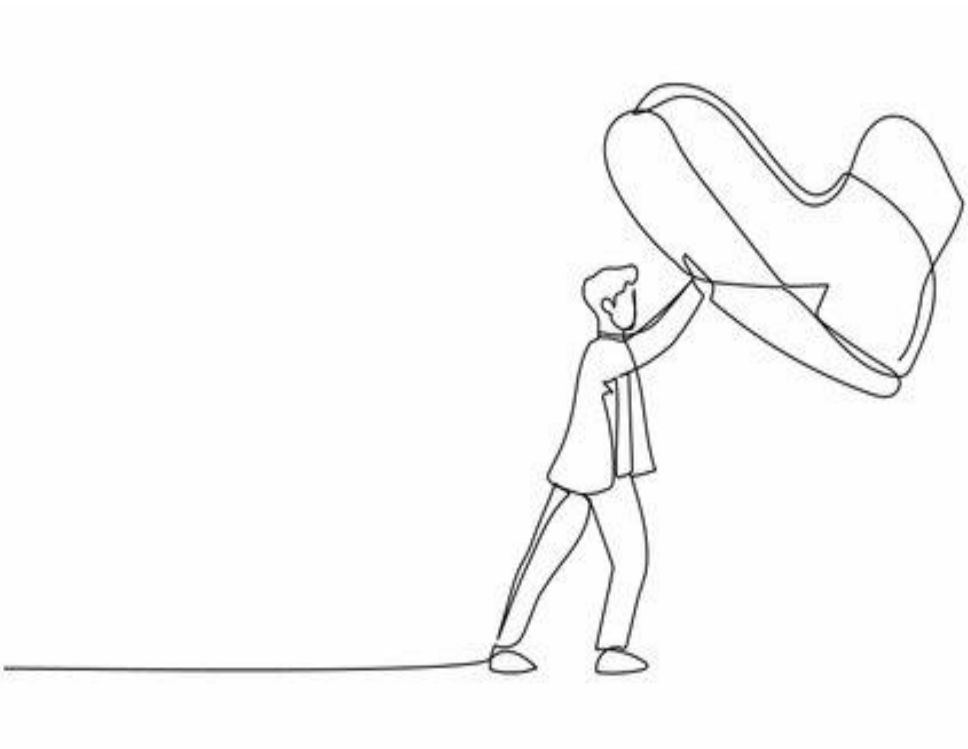
Possible Responses to Activity on Implementing Court Preparation Interventions for Child Witnesses

1. Mental Health & Trauma-Focussed Interventions

Interventions	Description
Treatment of mental health disorders	▪ (Re)assessment of children's mental health status ▪ (Re) Calibration of psychiatric medication adjusted to balance side effects that might influence the child's capacity/ability to provide testimony. ▪ Persuasion of children to adhere to medication regimes. ▪ Teaching of emotional regulation techniques, namely for self-soothing and relaxation, in accordance with individual child needs. ▪ Reminders to use emotional regulation techniques before and during the court deposition processes in case children felt overwhelmed by resurgence of traumatic memories.
Psychological empowerment—Building children's courage and confidence	▪ Helping children internalize ideas of the notion of justice, and the nature of injustice; this was done through group discussions, using simple daily life examples and situations such as, "It is fair if a big strong adult hits and badly injures a small child—is that fair? Or if a person breaks into someone's house and steals their valuable stuff, is it fair to the person who lost everything?" ▪ Film screening (of children's films) and perspective-taking methods implemented to reiterate ideas of courage, motivation and problem-solving in the wake of individual fears and difficulties.
Empowering children to face hostility of defence	▪ Children told that sometimes the defence lawyers might suggest that the child witness is 'telling lies' or 'saying things that never happened'. ▪ As the children were observed to be angry even as they were made aware of this possibility: ○ Their anger was validated--by acknowledging that everyone feels angry when they have suffered abuse or injustice and when are not believed. ○ How it might be more useful to respond calmly and strongly in court, to say, for example, 'I am not lying. It really happened.'
Addressing children's fears about consequences of testifying in court	▪ Provision of information to children about the child sexual abuse law and its provisions on confidentiality i.e. that no child's identity could be disclosed and that the media was not permitted to print or disclose in any manner the child's name, address, family details or photographs. ▪ Children reassured that: ○ There would be police (and others) in court for children's protection. ○ they would not meet the perpetrators in person (only identify them on a TV screen) because the perpetrators, accompanied by the police, would use a separate entrance to the court.
Countering gender stereotypes and stigma	▪ Discussions with children, particularly adolescents, on their right to (reclamation of) personhood and affirmative sexuality. ▪ Enabling children to understand (child) sexual abuse as a criminal issue, not a matter of honour: "When people hurt and injure us, it is a criminal act…against the law. How can the person who got hurt (i.e. the victim) become the bad person…why should she lose respect…?" ▪ Helping children develop a viewpoint that 'honour' and 'self-respect' are intangibles that 'lie in our hearts and minds' and so, 'how no one can touch or take those away from us'.

2. Information on court geography, facilities and personnel

Areas of Knowledge	Description of information provided
Geography & Facilities	▪ Pictures of the court were shown and the set-up of the court was explained, i.e., location of the vulnerable witness deposition room vis à vis the court room for the judge and the lawyers ▪ The process of communication via the court appointed support person and the video cameras in the deposition room was explained. ▪ The process of identification of the accused via TV screens in the deposition room was explained. ▪ They were informed about the availability of toys, refreshments, bathroom breaks and water breaks.
Court Personnel	▪ The concept of two legal parties (prosecution and defence) and the order of questioning was explained to the children. Developmentally appropriate terminologies were used for 'prosecution' and 'defence', to avoid confusion. ▪ The role of the judge was explained. ▪ The role of the court (appointed) support person (to convey the questions to the children and convey their answers to the judge & the lawyers via the use of earphones) was explained. ▪ The role of the counsellor (accompanying the children to and from the court, sitting with them in the waiting and deposition room, and provide them support) was explained.



3. Techniques for Refreshing Children's Memory

Technique	Description
Cues for memory retrieval	▪ Children were reminded about the time period when evidence was gathered and the need to provide those narratives in court was explained to them. ▪ Evidence recorded for each child was read to her. This was done twice – a few weeks before the trial and a day before the child had to depose in court. ▪ Child was asked whether she remembered any new information in relation to the already provided narrative. ▪ Non-leading memory retrieval cues were provided to recall key aspects of their narratives. ▪ Open-ended questions were posed about details given in the statements (related to people who perpetrated, other people present who possible aided and abetted, time of day, location where the abuse took place, details of the acts of abuse). ▪ Children were also asked to recall topographical memories of the institution (layout of the building, rooms and their purposes) as this knowledge was key to providing details on the whereabouts of the abuse within the institution.
Memory rehearsal	▪ Purpose of the rehearsal was to familiarise the children with the statements they had earlier provided to the investigative officers & to be able to provide a narrative based on the same, in court. ▪ Children rehearsed what they were going to say in court using the memory retrieval cues, once in the weeks leading up to the trial and then on the day before the deposition. ▪ Rehearsal of general information for the group was implemented through quiz games and rehearsals of individual testimony were tailored to each child's competency. ▪ Means of assisted communication, i.e., dolls were provided to children with intellectual disabilities and children with (social) anxiety as they felt uncomfortable in speaking about body parts and abuse.
Identification of the accused	▪ Identification of individuals who allegedly perpetrated using the same photographs which were used at the time of eliciting of evidence was done. ▪ Based on the information provided by the public prosecutor about the changed appearance of some of the individuals who allegedly perpetrated, the children were prepared for the same. ▪ To ensure that the preparation was not tantamount to tutoring, games were used to do the same wherein the children had to recognise famous film actors and TV personalities from pictures in which the appearances of these persons were changed through addition or removal of facial hair, or of spectacles. This helped children understand how people could still be identified, through careful observation, even if their physical appearance was altered.

4. Techniques for Skilling Children to Respond to Court Interrogation

Areas & Techniques	Description
Response to Questions on 'What happened…'	▪ Discussion on how children would respond to possible questions put by court, such as 'what happened in the child care institution?' ▪ Suggestions provided to children that they: ○ Respond through eye witness accounts (for example, of witnessing another child being abused); ○ Respond through accounts of personal experience (acts done to them by the perpetrators). ○ Avoid stating things they had heard since hearsay can be inaccurate (the judge might say 'how do you know it actually happened if you did not see or experience it?') and not make for as strong evidence.
Helping children to describe the sexual offence	▪ Explanation to children about how 'bad and dirty' may refer to a range of acts such as stealing, breaking into homes, hitting someone…and that the judge would not know what exactly 'bad and dirty' meant to them individually—unless he/she was given specific details of the act by the perpetrator. ▪ A process of desensitization was introduced through a game that involved naming and pointing of body parts, since children were embarrassed and reluctant to use words to describe private parts and related acts of sexual abuse. ▪ Once the children established a vocabulary to name body-parts, by processes of gentle, non-leading facilitation (i.e. mainly asking them to use the body part vocabulary to construct sentences on what was done to them) they were enabled to describe 'bad and dirty things' done to them. ▪ For children with mild intellectual disability and/or extreme social anxiety, a doll was used to allow them to develop communication on acts of sexual abuse.
Response to Difficult or Confusing Ways of Questioning	▪ Examples of how questions may not be asked in a logically sequential manner, and how there may be frequent interruptions by the lawyers (with sub-questions and clarifications) discussed with children. ▪ It was suggested that at times of confusion, children do one of the following: ○ Say 'I don't understand' and ask for the question to be repeated. ○ Say 'I don't know' or 'I don't remember' (whichever is true, if either is). ○ Avoid guessing at possible responses. ▪ Given the complexity of the context, i.e., multiple perpetrators, multiple episodes of abuse over a relatively long period of time, children were encouraged to: ○ start going down the list of perpetrators, stating their experience of abuse with each one of them—as this would also serve the purpose of specificity of incidents and perpetrator identities. ○ go closer to the screen or inform the support person about of lack of clarity of image (to enable the camera to re-focus) in case they had trouble with the identification of the perpetrators.

Suggested Readings

- Ramaswamy, S., Devgun, M., Seshadri, S., & Bunders-Aelen, J. (2023). "When an Elephant has its foot on the tail of a mouse…" Trauma-Focused Court Preparation Interventions for Sexually Abused Child Witnesses. *Journal of Indian Association for Child and Adolescent Mental Health*, *31*(2), 403-443.
- Ramaswamy, S., Devgun, M., Seshadri, S., & Bunders-Aelen, J. (2023). "The Child Needs to Tell it to Me in Words": Barriers and Facilitators to Witness Competencies in Child Sexual Abuse Trials. *The International Journal of Children's Rights*, *31*(2), 403-443.
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- Nathanson, R., & Saywitz, K. J. (2015). Preparing children for court: Effects of a model court education program on children's anticipatory anxiety. *Behavioural Sciences & the Law*, *33*(4), 459-475.
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- Crawford, E., & Bull, R. (2006). Teenagers' difficulties with key words regarding the criminal court process. *Psychology, Crime & Law*, *12*(6), 653-667.
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- Nathanson, R., & Saywitz, K. J. (2003). The effects of the courtroom context on children's memory and anxiety. *The Journal of Psychiatry & Law*, *31*(1), 67-98.
- Claasen, L. T., & Spies, G. M. (2017). The voice of the child: experiences of children, in middle childhood, regarding children's court procedures. *Social Work*, *53*(1), 74-95.

Additional Material

Videos for viewing and discussion during the session on 'Innovative ways to prepare children for court…'

Radiant Goes to Court

https://www.youtube.com/watch?v=xcJKOiGmKQY

Kids go to Court

https://www.youtube.com/watch?v=EswF5p41Sfs

Court preparation intervention hand-outs for the **Activity: 'Implementing Court Preparation Interventions for Child Witnesses'** is provided on the next page in a printable format for your use.

Materials for the activity on 'Implementing Court Preparation Interventions for Child Witnesses'

Group 1 (Interventions): (TITLE?)

Interventions	Description
(SUB-TITLE?)	▪ (Re)assessment of children's mental health status ▪ (Re) Calibration of psychiatric medication adjusted to balance side effects that might influence the child's capacity/ability to provide testimony. ▪ Persuasion of children to adhere to medication regimes ▪ Teaching of emotional regulation techniques, namely for self-soothing and relaxation, in accordance with individual child needs. ▪ Reminders to use emotional regulation techniques before and during the court deposition processes in case children felt overwhelmed by resurgence of traumatic memories.
(SUB-TITLE?)	▪ Helping children internalize ideas of the notion of justice, and the nature of injustice; this was done through group discussions, using simple daily life examples and situations such as, "It is fair if a big strong adult hits and badly injures a small child—is that fair? Or if a person breaks into someone's house and steals their valuable stuff, is it fair to the person who lost everything?" ▪ Film screening (of children's films) and perspective-taking methods implemented to reiterate ideas of courage, motivation and problem-solving in the wake of individual fears and difficulties.
(SUB-TITLE?)	▪ Children told that sometimes the defence lawyers might suggest that the child witness is 'telling lies' or 'saying things that never happened'. ▪ As the children were observed to be angry even as they were made aware of this possibility: o Their anger was validated--by acknowledging that everyone feels angry when they have suffered abuse or injustice and when are not believed. o How it might be more useful to respond calmly and strongly in court, to say, for example, 'I am not lying. It really happened.'
(SUB-TITLE?)	▪ Provision of information to children about the child sexual abuse law and its provisions on confidentiality i.e. that no child's identity could be disclosed and that the media was not permitted to print or disclose in any manner the child's name, address, family details or photographs. ▪ Children reassured that: o There would be police (and others) in court for children's protection. o they would not meet the perpetrators in person (only identify them on a TV screen) because the perpetrators, accompanied by the police, would use a separate entrance to the court.
(SUB-TITLE?)	▪ Discussions with children, particularly adolescents, on their right to (reclamation of) personhood and affirmative sexuality. ▪ Enabling children to understand (child) sexual abuse as a criminal issue, not a matter of honour: "When people hurt and injure us, it is a criminal act…against the law. How can the person who got hurt (i.e. the victim) become the bad person…why should she

	lose respect…?" ▪ Helping children develop a viewpoint that 'honour' and 'self-respect' are intangibles that 'lie in our hearts and minds' and so, 'how no one can touch or take those away from us'.

Group 2 (Interventions): (TITLE?)

Intervention	Description of information provided
(SUB-TITLE?)	▪ Pictures of the court were shown and the set-up of the court was explained, i.e., location of the vulnerable witness deposition room vis à vis the court room for the judge and the lawyers ▪ The process of communication via the court appointed support person and the video cameras in the deposition room was explained. ▪ The process of identification of the accused via TV screens in the deposition room was explained. ▪ They were informed about the availability of toys, refreshments, bathroom breaks and water breaks.
(SUB-TITLE?)	▪ The concept of two legal parties (prosecution and defence) and the order of questioning was explained to the children. Developmentally appropriate terminologies were used for 'prosecution' and 'defence', to avoid confusion. ▪ The role of the judge was explained. ▪ The role of the court (appointed) support person (to convey the questions to the children and convey their answers to the judge & the lawyers via the use of earphones) was explained. ▪ The role of the counsellor (accompanying the children to and from the court, sitting with them in the waiting and deposition room, and provide them support) was explained.

Group 3: (Interventions): (TITLE?)

	Description
(SUB-TITLE?)	▪ Children were reminded about the time period when evidence was gathered and the need to provide those narratives in court was explained to them. ▪ Evidence recorded for each child was read to her. This was done twice – a few weeks before the trial and a day before the child had to depose in court. ▪ Child was asked whether she remembered any new information in relation to the already provided narrative. ▪ Non-leading memory retrieval cues were provided to recall key aspects of their narratives. ▪ Open-ended questions were posed about details given in the statements (related to people who perpetrated, other people present who possible aided and abetted, time of day, location where the abuse took place, details of the acts of abuse).

	▪ Children were also asked to recall topographical memories of the institution (layout of the building, rooms and their purposes) as this knowledge was key to providing details on the whereabouts of the abuse within the institution.
(SUB-TITLE?)	▪ Purpose of the rehearsal was to familiarise the children with the statements they had earlier provided to the investigative officers & to be able to provide a narrative based on the same, in court. ▪ Children rehearsed what they were going to say in court using the memory retrieval cues, once in the weeks leading up to the trial and then on the day before the deposition. ▪ Rehearsal of general information for the group was implemented through quiz games and rehearsals of individual testimony were tailored to each child's competency. ▪ Means of assisted communication, i.e., dolls were provided to children with intellectual disabilities and children with (social) anxiety as they felt uncomfortable in speaking about body parts and abuse.
(SUB-TITLE?)	▪ Identification of individuals who allegedly perpetrated using the same photographs which were used at the time of eliciting of evidence was done. ▪ Based on the information provided by the public prosecutor about the changed appearance of some of the individuals who allegedly perpetrated, the children were prepared for the same. ▪ To ensure that the preparation was not tantamount to tutoring, games were used to do the same wherein the children had to recognise famous film actors and TV personalities from pictures in which the appearances of these persons were changed through addition or removal of facial hair, or of spectacles. This helped children understand how people could still be identified, through careful observation, even if their physical appearance was altered.

Group 4 (Interventions): (TITLE?)

	Description
(SUB-TITLE?)	▪ Discussion on how children would respond to possible questions put by court, such as 'what happened in the child care institution?' ▪ Suggestions provided to children that they: ○ Respond through eye witness accounts (for example, of witnessing another child being abused); ○ Respond through accounts of personal experience (acts done to them by the perpetrators). ○ Avoid stating things they had heard since hearsay can be inaccurate (the judge might say 'how do you know it actually happened if you did not see or experience it?') and not make for as strong evidence.
(SUB-TITLE?)	▪ Examples of how questions may not be asked in a logically sequential manner, and how there may be frequent interruptions by the lawyers (with sub-questions and clarifications) discussed with children.

	▪ It was suggested that at times of confusion, children do one of the following: o Say 'I don't understand' and ask for the question to be repeated. o Say 'I don't know' or 'I don't remember' (whichever is true) o Avoid guessing at possible responses. ▪ Given the complexity of the context, i.e., multiple perpetrators, multiple episodes of abuse over a relatively long period of time, children were encouraged to: o start going down the list of perpetrators, stating their experience of abuse with each one of them—as this would also serve the purpose of specificity of incidents and perpetrator identities. o go closer to the screen or inform the support person about of lack of clarity of image (to enable the camera to re-focus) in case they had trouble with the identification of the perpetrators.
(SUB-TITLE?)	▪ Explanation to children about how 'bad and dirty' may refer to a range of acts such as stealing, breaking into homes, hitting someone…and that the judge would not know what exactly 'bad and dirty' meant to them individually—unless he/she was given specific details of the act by the perpetrator. ▪ A process of desensitization was introduced through a game that involved naming and pointing of body parts, since children were embarrassed and reluctant to use words to describe private parts and related acts of sexual abuse. ▪ Once the children established a vocabulary to name body-parts, by processes of gentle, non-leading facilitation (i.e. mainly asking them to use the body part vocabulary to construct sentences on what was done to them) they were enabled to describe 'bad and dirty things' done to them. ▪ For children with mild intellectual disability and/or extreme social anxiety, a doll was used to allow them to develop communication on acts of sexual abuse.

19. Appreciation of Evidence (A): Understanding Legal Principles

Learning Objectives

- To get an overview of the different types of evidence and their meanings in the context of the Indian Evidence Act, 1872.
- To understand the concepts of relevance and admissibility of evidence.
- To develop an understanding of the significance of relaxing evidentiary rules in CSA cases.
- To contextualize cross-examination of a child within the adversarial system of justice.

Time

2 Hours

Concept

As medical and mental health professionals providing assistance in child sexual cases, key areas of work relate to:

- Providing the court with reports on the child's capacity for testimony.
- Recording information keeping in mind their evidentiary value in court
- Supporting the child witnesses through court processes.

Therefore, the need to understand what evidence is, what types of evidence are admissible in court & how children may be assisted is central to facilitating greater convergence between the mental health and legal domains in cases of child sexual abuse.

Understanding Evidence

So, how do we ordinarily define 'evidence'?

Broadly speaking, in general parlance, anything that supports a claim or proposition may be considered to be **evidence** of that claim. Consequently, "**proof**" is a body of evidence that conclusively proves something is true, and typically, includes different kinds of evidence.

Understanding Evidence under the law

The Law of Evidence in India is governed by the Indian Evidence Act, 1872. These evidence rules provide a framework to identify and prove certain facts through different pieces of information, in order to sufficiently prove/disprove a claim in courts of justice. This is the adversarial system of Justice.

From an evidentiary standpoint, a preliminary question that needs to be answered prior to the judicial process of evaluating and 'appreciating' the quality of evidence presented in Court, is that of 'admissibility' of evidence. In accordance with the law, there are stipulations as to what kind of evidence is "admissible" i.e., whether it can be

presented to the Court as legal evidence. Following a judicial determination of whether the concerned evidence is admissible, the court can proceed with appreciation of evidence i.e., the judicial process of analysing and evaluating the value, quality and worth of evidence.

Basics of Admissibility: Facts and Relevant Facts

"Fact" refers to anything (incl. the state/relation of things) which can be perceived by the senses. It may also refer to any state of mind that a person is aware of. For example: you are currently looking at a screen and hearing me say this sentence. This is a fact.

Facts in issue: Any 'fact' which by itself, or in connection with other facts shows the existence or non-existence, the nature or extent of any matter which is asserted or denied in the proceedings before the Court. Let's consider the following example:

Amit is accused of stealing Brijesh's bag. At the trial, the facts which are in issue can include:

i) That the bag belonged to Brijesh;

ii) That Amit took away the bag without Brijesh's knowledge or consent;

iii) That Amit intended to take Brijesh's bag for himself, knowing that it belonged to Brijesh;

iv) That Amit mistakenly believed that the bag was his own.

Relevant facts are those which are connected to each other i.e., they support or influence other facts. Proving a relevant fact may be relevant to answering the main issue in question. Typically, evidence relating to a series of relevant facts ultimately paint a story that is sufficient to prove the main disputed issue i.e., the fact in issue. In the above example, consider that Amit was in a different city on the day that Brijesh's bag was stolen. Therefore, while Amit's location in a different city is not in and of itself the disputed issue in the case, it nonetheless is critical information since it proves a relevant fact: Amit was not present at the location where Brijesh's bag was stolen at the time of the offence.

In light of the above, there are broadly two types of evidence that are admissible in court: a) evidence of facts in issue and relevant facts; b) facts which form part of the same transaction.

- Let's take an example of a fact that 'forms part of the same transaction': Amit is accused of murdering Brijesh in the course of a fight. Whatever Amit and Brijesh said before the fight began, or during the fight, form part of the same transaction.

- Let's consider another example: Aisha sues Brijesh for sexual harassing her through emails. Prior emails exchanged between them, which form part of their communication, even though not directly related to the sexual harassment allegations, are relevant facts.

What are some common kinds of relevant facts that are admissible?

1. Facts which are the occasion, cause or effect of facts in issue, or facts which afforded an opportunity for their occurrence, are relevant as evidence.

Examples:

a) It is alleged that A sexually abused B. The fact that A was aware of B's schedule and when B was alone, that B had marks on their body or was distressed in the days following the incident, are all relevant facts.

b) The case is that A robbed B with the use of a knife. The fact that A had bought a knife that day, and was spotted following B a few days earlier, are relevant facts.

2. Facts which are indicative of motive, preparation and previous or subsequent conduct

Any fact which shows or constitutes a motive or preparation for any fact in issue or relevant fact. The conduct of any party is relevant if it influences or is influenced by other relevant facts. It is irrelevant if the relevant fact took place before or after.

Example

a) Brijesh says that he saw Amit buying sedatives from a medical store, before the alleged rape occurred, wherein it was reported that the child was drugged prior to the assault. This is relevant as it shows preparation and Brijesh's conduct prior to the incident.

Note: In CSA cases, evidence about grooming can be brought as evidence to indicate preparation for the abuse incident/s. These processes will have to be brought to the notice of the police and to the Court.

3. Facts showing *existence of state of mind, or of body feeling*

Any fact which shows the existence of a state of mind, intention, knowledge, good faith, ill will towards a particular person, or the existence of any state of body or bodily feeling are relevant as evidence. **Behaviour of the abuser, grooming processes used with the child, can all indicate the existence of the intention and ill will of the accused.** Further, evidence about fear, confusion, hesitancy, can be brought to the notice of the Court to explain delayed disclosures by the child.

Other classificatory types of evidence

1. Oral and Documentary Evidence

One particularly significant classification here, is with respect to oral and documentary evidence. Oral evidence is accorded primary significance under the law, in terms of evidentiary value, making it imperative that all witnesses are assisted sufficiently in order to be able to provide testimony where possible. Broadly, they can be defined as follows:

- **Documentary evidence** – All documents which are brought before the Court, including electronic documents. Documentary evidence may be primary - showing original documents, or secondary, which is producing copies of documents (permitted under certain circumstances).

- **Oral Evidence** - Statements which are made before the Court by witnesses in relation to the facts in dispute. In most cases, oral evidence must be primary or direct, which means that the witness who has personally seen, heard or perceived the fact must give their evidence before the Court. Oral evidence is collected primarily during:

a) examination-in-chief
b) cross examination &
c) re-examination.

Table: Process of recording witness testimony (oral evidence) in Court through examination-in-chief, cross-examination and re-examination.

Examination-in-chief	Cross-Examination	Re-examination
The examination of witness by the party who calls him	The examination of a witness by the adverse party	The examination of a witness, after the cross-examination, by the party who initially called him
To provide material facts supporting the party's narrative.	To cross-question the witness on statements made during chief examination.	To clarify any ambiguity or discrepancy after the cross-examination; to explain any point referred to in cross; elicit new information if relevant (with permission of the Court)
First in the order of witness examination	Second in the order of witness examination	Last in the order of witness examination
No leading questions	Leading questions can be freely asked	No leading questions

2. Direct and Indirect Evidence

- ***Direct Evidence*** directly proves or disproves a fact. Direct evidence relates to the very issue in question, and can prove the fact in question without any corroboration. (for e.g.: **Eyewitness Testimony**)

- ***Indirect Evidence*** proves facts in question by proving other facts which are related to the main issue in dispute. A deduction must be drawn from the evidence by linking it with the claims/allegations made. Indirect Evidence includes: a) **hearsay evidence**; and b) **circumstantial evidence**

So, what constitutes circumstantial and hearsay evidence?

Circumstantial evidence does not prove the issue in question but it establishes the point through inference or reasoning. When there is insufficient direct evidence to prove any fact in issue then the court evaluates the availability of existing evidence and construct a link between the existing evidence and inference to be drawn from the same. Typically, circumstantial evidence requires a chain of circumstances to establish a clear line of events which may 'reasonably' point to a factual conclusion. If there are serious breaks in the chain, circumstantial evidence will not be able to satisfy the court's evidentiary requirement. For example: At the time of the rape, the

accused was seen going to the victim's house, and shortly afterwards, screams were heard from the victim's house. This is circumstantial evidence.

Hearsay Evidence refers to when a person narrates facts which were told to them by the actual witness of the incident. The witness before the Court is reporting **not** what they themselves saw or heard, but facts which relayed to them. It is typically considered weak evidence, or no evidence at all (in most instances).

3. Substantive and Corroborative Evidence

Substantive evidence is the evidence on the basis of which a fact is proved and which requires no corroboration. (E.g.: **Eyewitness Testimony**) Corroborative evidence is the evidence used to support substantive evidence, and therefore, cannot in and of itself prove a fact. If there is no substantive evidence, corroborative evidence loses its significance. (E.g.: **Medical Evidence**) Both these evidences are either direct or circumstantial or both i.e., these concepts are fundamentally interrelated but distinct.

Activity: Identification of different types of evidence.

Method: Case Discussion

Material:

Illustration: - Amit is charged under POCSO for the penetrative sexual assault of Brijesh (a 9 year-old boy). Chetan, Dinesh, Ehsaan, and Farooq are witnesses called by the prosecution.

1. Chetan says that he saw Amit forcibly remove Brijesh's shorts in his shop, which is near Brijesh's school. (His evidence is purely direct and substantive since he is an eye witness.)
2. Dinesh says that he heard Brijesh cry out that Amit was hurting him. (His evidence is direct and corroborative, as he did not actually witness the incident of assault, but heard Amit's cries for help. His evidence, in and of itself might raise more questions than answers. However, Dinesh's testimony could be vital corroborative evidence to Brijesh's testimony.)
3. Ehsaan says that he saw Amit running away from the shop, with his pants unzipped and shirt untucked, after people started gathering outside his shop. (His evidence is circumstantial as he did not witness the events leading to state of A's clothes & physical appearance.)
4. Farooq says that he saw Amit burning his clothes shortly after running away. (Evidence of Farooq is essentially circumstantial.)

Process: To identify the interplay of direct/circumstantial & substantive/corroborative evidence in each illustration.

Discussion: This activity requires that all participants evaluate the different examples provided below and identify which type of evidence these examples may constitute and provide reasons for the same. Each example may also include more than one type of evidence. For example, a piece of evidence may be direct, but also corroborative evidence. The remarks within brackets are for the reference of the facilitator and may be shared with the group during discussion of the examples.

Imperatives & Issues in Children's testimony

In a national study of CSA reports made in Israel in 2014, the child and event characteristics that determined whether child reports were evaluated as credible were analysed, and certain important findings were recorded:

Only 57.9% of cases were evaluated as credible, and the most powerful predictors of credibility were determined to be older age and absence of cognitive delay. The remaining 42.1% cases did not just consist of cases wherein the truthfulness of the reports was doubted, but also cases wherein the evidence was found to be insufficient. Given the small proportion of suspected false reports, it was concluded that the justice system was likely to dispose of nearly a third of truthful cases. These realities raise certain important questions in regards to the methods of collection of evidence during child sexual abuse trials. While there have been no studies with a similarly large sample in the Indian context, the low conviction rates and challenges faced in trials of POCSO cases make it increasingly likely that many genuine reports of CSA are incorrectly disposed of. Given the adverse consequences of ineffective mechanisms for evidence collection on child protection in the country, there is a pressing need for greater reflection on issues affecting the prosecution of CSA cases in India despite the existence of the POCSO Act.

Indeed, while there are developmental differences between adults' and children's memory, it is to be noted that children also have the ability to provide accurate and meaningful information. For example, the ability to narrate past events, may be loosely organized according to children's developmentally immature views of the world. This does not imply that the child cannot sequence and describe abuse events. Instead, it emphasises the role of the forensic interviewer in using child-sensitive methods of forensic interviewing, which may utilise the child's sense of time and sequence in order to optimise the information collected from the child. For example, the interviewer may not get very far if they ask a young child about what happened at 9:00 am on the day of the incident. Nonetheless, the interviewer is likely to be more successful if they enquire from the child what happened after the school bus dropped the child off at school. This is a technique often used in child forensic interviews, and establishes the importance of questioning methods on the quality of the child's testimony.

Additionally, in the context of legalese in the court context, common courtroom questions may be misunderstood by children, especially given their developmental immaturity. When children are asked questions they cannot understand, miscommunication is inevitable. Therefore, there is an imperative to relax some of the strict rules of admissibility and appreciation of evidence of child witnesses, given that these rules have been developed in the context of the 'reasonable adult' standard, and are required to accommodate the child's characteristics in order to facilitate the creation of a more just 'reasonable child standard'.

Activity: Judge's role during POCSO Trials

Method: Case Discussion

Material:
Rinku v. State (NCT of Delhi) 2019 (Transcript of the child victim's cross-examination)
Q. You had earlier told your mother it was a tall boy who lives in your area?
Ans. Yes.
Q. Did you tell mummy that Jaanu's uncle took you to the forest?
Ans. Yes. I told her.
Q. Beta, did the police come to meet you in the hospital?
Ans. Yes.
Q. When did they come to meet you…same day or next day?
(*Question disallowed considering the age of victim*)
Q. Was mummy in the hospital with you all night that day?
Ans. Yes.
Q. Do you know any girl by the name N?

Ans. No.
Q. Do you know any girl by the name Z?
Ans. No.
Q. Beta, did your mummy ask you to say what you said in court today?
Ans. Yes.
Court question: Beta, whatever you have said today happened to you or are you saying it at the behest of your mother?
Ans. It happened to me."

Process: To provide this excerpt from a POCSO Trial and discuss the role played by the Judge in ensuring a child-oriented approach to cross-examination and how the Judge tackles the issue of tutoring.

Discussion:
- What was the role of the Presiding Officer/Judge in this cross-examination? Were the Judge's interventions in line with their role under the POCSO Act?
- How did the Judge's interventions affect the nature of questioning? Were these interventions restricted to relaying questions from the defence?
- Did the Judge's questions affect the perceived credibility of the child witness?
- In the absence of the judge's interventions, what do you think would be the impact of this cross-examination on the appreciation of evidence?

Appreciating Child Witness Testimony: Revisiting the Precautionary Approach

In a multitude of cases, judicial interpretations have generally prescribed caution while evaluating the competence of a child witness, and subsequently, while evaluating the credibility/veracity of the child's testimony. Sec.118 of the Evidence Act states that a child is also competent to give evidence and the evidence of a child is admissible. Therefore, a young child can be allowed to testify if he or she has the capacity to understand questions and give rational answers thereto. *The only caution to the court is that the evidence of a child must be scrutinized with care and caution, **and where possible**, be supported by corroboratory evidence*. Therefore, while case law has established that even the sole testimony of a child witness can be the basis of conviction, in the absence of any corroborative evidence, the child's testimony is legally viewed with circumspection (due to concerns of suggestibility or tutoring). Therefore, in actual practice, children's statements are viewed with a great degree of uncertainty, especially in the absence of corroborative evidence, owing to the innate developmental limitations of child witnesses.

Relaxing Rules of Admissibility: Scope of the hearsay exception in India

In CSA Cases, there are typically two witnesses…the perpetrator & the victim. Given the many rules on admissibility of evidence, proving CSA becomes difficult. Given the above-mentioned dilemmas in regards to evaluating competence and credibility of child-witness testimony, there is a need to also address concerns of procedural justice from a child-centric point of view. In this context, the statutory understanding of admissibility of evidence has been reoriented in cases of sexual offences to address the peculiarities of sexual offences, particularly when these offences are committed against children. Therefore, in light of the unique context of CSA, there are certain relaxations that may be availed of under the law.

Hearsay exception in CSA

Section 6 read with Section 157 of the Evidence Act allows for admission of ***hearsay evidence,*** as corroborative evidence, subject to certain conditions of **contemporaneity** and **spontaneity of disclosure.** Certain kinds of statements may be made naturally, spontaneously, and without deliberation soon after an incident. They typically do not leave much room for misunderstanding or misinterpretation, when someone else hears them, and hence carry a high degree of credibility. **Hearsay** evidence includes:

1. Words or phrases that either form part of, or explain, a physical act,
2. Exclamations that are so spontaneous as to belie concoction, and
3. Statements that are evidence of someone's state of mind.

The hearsay exception is of special significance in child sexual abuse cases as the child victim-witness, in many cases, discloses abuse to the parent/caregiver after the incident. The testimony of the parents or caregivers is hence vital corroborative evidence, especially in the absence of physical or medical evidence.

There are, however, certain issues with the exception in regards to its implementation in different contexts. Multiple decisions of various courts have held that the disclosure must be "contemporaneous" with the offence committed for it to be considered valid *res gestae* evidence. The logic behind this requirement is that the hearsay exception must only extend to those disclosures that are "spontaneous utterances" and not statements made after there is an opportunity to reflect and fabricate. When seen in the context of sexual offences committed against children, this logic is not commensurate with the available research on child development. (Jee, 1997) (Raeder, 2007) Depending on the stage of the child's sexual development, the child may have vastly different responses to an incident of abuse. Unlike an adult, a child cannot be "reasonably" expected to react to the incident with comparable indignation. If the attendant circumstances of the abuse involve sustained CSA by a known individual, disclosure is further complicated. Therefore, the hearsay exception in cases of CSA will need to adopt a more comprehensive understanding of "contemporaneity" to adequately include instances of res gestae evidence that are not marred by "reasoned reflection".

The case of *State of T.N v. Suresh and Anr.* is interesting in this context. In this case, the test of contemporaneity was broadly applied. The Court noted that there was no hard and fast rule in regards to spontaneity of disclosure. The only requirement stipulated in the aforementioned case is in regards to whether or not the victim had the opportunity to concoct or be tutored.

Activity: Let's analyse a few cases

Method: Case Discussion

Material: Excerpts from High Court and Supreme Court judgments (provided in 'Additional Materials at the end of this module).

Discussion:

- What are the requirements for the Hearsay exception to apply? What do these requirements mean?
- What evidentiary value does hearsay have in CSA cases? Does the dynamics of disclosure in CSA cases have an impact on application of the hearsay exception?

Sole Testimony of the victim-witness in CSA

In cases where the child's testimony is the only available evidence (with no corroborative evidence), a conviction may nonetheless be entered into, provided that the following conditions are met...This critical aspect of appreciation was discussed in the Supreme Court case of ***State of Maharashtra v. Babu Meenu*** (2013). Let's look at another case below:

"In cases of this nature, we cannot expect any eye witness or independent witness... It is settled proposition of law that when the evidence of prosecutrix (child) is cogent, consistent and trustworthy and inspires confidence of the Court, conviction can be recorded solely based on the evidence of the victim, unless there is a reason to discard or disbelieve the evidence of the sole witness" - ***K Ruban v. State*** (Madras HC 2021).

Children's testimony: What kind of 'consistency' are we talking about?

"**Consistency**" of statements and evidence is one of the primary requirements for a conviction in a criminal trial. However, in light of their developmental limitations, children may be inconsistent, which is usually not because of any 'deliberate falsehood' or attempt to mislead the court. Inconsistency may be caused by numerous factors, including:

1) The nature of disclosure among abused children,

2) developmental immaturity.

Inconsistencies in child witness testimony call into question the reliability of the testimony, and in some cases, the credibility of the witness itself. Typically, inconsistencies in the child's testimony may be an indicator of the possibility of tutoring, thereby requiring the Court to consider further evidence, or in some cases, acquit the accused altogether.

Let's look at what the Bombay High Court said in the case of ***Ali Mohammed Shaikh v. State of Maharashtra*** *(Bombay HC 2020)*:

"The testimony of the victim so far as the identity of the accused is concerned, appears to be inconsistent. When the evidence of the Prosecution Witness — 5 was recorded in the Chamber of the learned Judge, the appellant (accused) was shown to her and she identified him in the Court saying that he is a friend of her father. The victim then deposed that she did not see the person prior to the date of offence committed on her, but then goes on to say that he used to meet her father and that she knew him well. It is in her evidence that she had an occasion to see the appellant again since the day she was assaulted. Considering these inconsistencies in her evidence, the version of the victim has to be scrutinized carefully."

As child was the sole witness in this case, the accused was acquitted by the High Court. If we analyse this case, it is evident that the accused was acquitted not simply by virtue of the inconsistency, but rather, owing to the nature of the inconsistency. The identity of the perpetrator in any case of sexual abuse is a fact in issue. Therefore, inconsistency on this point will typically be fatal to the prosecution of the case.

In light of the above, case law has recognised that inconsistency, in itself, is not sufficient reason to discredit a witness. The question is with regard to the extent of omission/discrepancy in the child's testimony. If it is a minor inconsistency, it does not affect the reliability of the evidence. Only inconsistency in material particulars i.e., key aspects of the testimonial account (as mentioned above), would require greater scrutiny.

Child witness testimony and issue of inconsistency

Narayan Chetanram Chaudhary & Anr. v. State of Maharashtra

"Only such omissions which amount to contradiction in material particulars can be used to discredit the testimony of the witness. The omission in the police statement by itself would not necessarily render the testimony of witness unreliable. **When the version given by the witness in the court is different in material particulars from that disclosed in his earlier statements, the case of the prosecution becomes doubtful and not otherwise**. Minor contradictions are bound to appear in the statements of truthful witnesses as memory sometimes plays false and the sense of observation differ from person to person…**Even if there is contradiction of statement of a witness on any material point, that is no ground to reject the whole of the testimony of such witness.**"

Application of Presumptions and Burden of Proof under POCSO

The basic presumption in criminal law is that a person is innocent until proven guilty i.e., the burden of proof is on the prosecution to prove the accused's guilt beyond reasonable doubt i.e., beyond the possibility of reasonable alternatives. This presumption is reversed in the POCSO Act i.e., there is a presumption of guilt on the accused**.** However, by definition, proving a negative fact is exceedingly difficult. Therefore, there are certain requirements for the 'presumption of guilt' to apply in any POCSO case. Let's take a look at some important cases on this point:

In ***Manirul Islam @ Manirul Zaman Vs. State of Assam***:

"…mere insertion of sections 29 and 30(2) in the POCSO does not altogether relieve the prosecution of the burden of proof … but merely lessen the burden on the prosecution by shifting the onus upon the accused. However, such reverse onus would shift upon the accused only when the prosecution succeeds in prima facie establishing the charge by adhering to the standard of proof of preponderance of probability. It is only then, the accused would have to displace the presumption of guilt."

In ***Babu Vs. State of Kerala*** **(2010 SC)**

Statutes like Negotiable Instruments Act, 1881; Prevention of Corruption Act, 1988; and Terrorist and Disruptive Activities (Prevention) Act, 1987, provide for presumption of guilt if the circumstances provided in those Statutes are found to be fulfilled…However, such a presumption can also be raised only when certain foundational facts are established by the prosecution.

Therefore, the reverse burden of proof is in fact an attempt to lower the burden and vulnerabilities on child witnesses and to ensure effective implementation of the POCSO Act, to achieve its object of protection of children.

Suggested Readings

- *Jitender v. State (NCT of Delhi)* 2017 SCC OnLine Del 8723.
- *Sukhar v. State of Uttar Pradesh* (1999) 9 SCC 507.
- *Manish v. State of Maharashtra* 2019 SCC OnLine Bom 1154.
- *State of T.N v. Suresh and Anr* (1998) 2 SCC 372.
- *Babu Vs. State of Kerala*, (2010) 9 SCC 189.
- *Manirul Islam @ Manirul Zaman Vs. State of Assam*, 2021 (3) GLT 128.
- Lal, B. (2023). The Law of Evidence. 24th edn. Central Law Agency.
- Ratanlal. Dhirajlal. (2019). The Law of Evidence. 27th edn. LexisNexis.

Additional Material

Excerpts from High Court and Supreme Court judgments for the Activity: 'Let's analyse a few cases'.

On the basis of these excerpts from High Court and Supreme Court judgments, the following questions can be put to participants to elicit responses related to their understanding of the case law on hearsay in CSA cases.

Manish v. State of Maharashtra (2019 Bombay HC)

- "The evidence of PW 2 and PW 7 as regards the disclosure made by the child victim though hearsay is admissible in view of the provisions of section 6 of the Indian Evidence Act…"
- "…Section 6 is an exception to the rule of evidence that hearsay evidence is not admissible. The statement must relate to the fact in issue or relevant thereto and must be substantially contemporaneous with the fact. Such statement, though not evidence of the truth of the matters stated, are of corroborative value…provided such evidence is almost contemporaneous with the fact/s excluding the possibility of fabrication."

State of T.N v. Suresh and Anr (1998 SC)

- "We think that the expression "at or about the time when the fact took place" in Section 157 of the Evidence Act should be understood in the context according to the facts and circumstances of each case. The mere fact that there was an intervening period of a few days, in a given case, may not be sufficient to exclude the statement…The test to be adopted, therefore, is this; Did the witness have the opportunity to concoct or to have been tutored?"
- "There can be no hard and fast rule about the 'at or about the' condition in Section 157. The main test is whether the statement was made as early as can reasonably be expected in the circumstances of the case and before there was opportunity for tutoring or concoction".

20. Appreciation of Evidence (A): The Dynamics of Abuse and Medical Evidence

Learning Objectives

- To develop an understanding of the basics of appreciation of medical evidence in CSA cases
- To explore the gaps in the current research on the interpretation of medical findings in CSA medical examinations.
- To develop an understanding of the implications of indeterminacy of medical findings for appreciation of evidence in CSA cases.

Time

3 Hours

Concept

In the realm of child protection and criminal justice, cases involving allegations of child sexual abuse demand a comprehensive and developmentally-sensitive approach. The Protection of Children from Sexual Offences (POCSO) Act, enacted in India to safeguard children from sexual exploitation, emphasizes the significance of medical evidence in establishing the veracity of such allegations. This Chapter delves into the intricate process of appreciating medical evidence within the context of POCSO cases, recognizing the pivotal role it plays in arriving at a scientifically-informed judicial determination.

This chapter will also explore the multifaceted challenges faced by medical professionals, legal practitioners, and judicial authorities when interpreting and evaluating medical evidence. From the delicate task of conducting medical examinations to the meticulous analysis of forensic reports, each step holds the potential to shape the course of justice for both the survivor and the accused.

Against the backdrop of evolving medical knowledge, forensic methodologies, and legal precedents, this chapter delves into the complexities surrounding the interpretation of medical findings. It underscores the importance of multidisciplinary collaboration, where medical experts, psychologists, social workers, and legal experts converge to ensure a holistic understanding of children's experiences and the implications of medical evidence.

Ultimately, the objective of this chapter is to provide insights into the intricacies of appreciating medical evidence in POCSO cases, fostering a nuanced understanding of the interplay between medical expertise and legal proceedings. By examining the dynamics at play, the chapter aims to equip legal professionals, medical practitioners, and stakeholders within the justice system with the knowledge and tools required to ensure that justice is served while prioritizing the physical, emotional, and psychological well-being of child victims and victim-witnesses.

Medical Examination

According to the Handbook on Medical Examination of Survivors of Sexual Violence (and POCSO), the following must be done during medical examination:

- Obtaining informed consent,
- History taking
- Medical examination

- Collection and documentation of evidence and maintaining chain of evidence
- Providing therapeutic care including immediate treatment of physical injuries, mental trauma, provision of emergency contraception, pregnancy advice, STI care, etc.
- Providing psycho-social support including counselling, rehabilitation and follow up care.

While one of the key imperatives for medical examination is to collect and document evidence, this is NOT the only objective…

Informed consent for medical examination and sample collection

Information about the purpose of medical examination and sample collection has to be provided to the child and parent in simple language. Use of easy-to-understand handouts in the local language will be helpful in providing clear information. The medical officer has to answer any questions that the child and/or parent may ask related to medical examination and sample collection. The medical officer has to explicitly mention to the child and parent that even if consent is not provided, the child will be provided the medical and psychological support as per standard protocols.

The consent form has to be signed by the child if the age of the child on the date of examination is 12 years and above. In addition to the child's signature, the medical officer, parent, and a witness have to sign the consent form. In case the child's age on the date of examination is below 12 years, he/she need not sign the consent form. Children diagnosed with neurodevelopmental disorders, especially Intellectual Disability or autism spectrum disorder, may not understand the information provided about medical examination and sample collection. In such cases the consent of parent must be obtained.

A child and/or parent may refuse consent for medical examination and sample collection or specifically for examination of anogenital area or specifically for sample collection. The medical officer has to clearly document the refusal of consent for either of the above-mentioned scenarios. The child should be provided necessary medical and psychological support even if there is a refusal of consent.

History taking

The medical officer has to obtain a detailed history from the child as well as parent prior to medical examination and sample collection. History taking has to be done in a sensitive, non-judgemental manner. It is important to initiate the interview with child and parent using neutral questions to build adequate rapport and explain the purpose of the interview.

The template given herein will be helpful to collect a detailed history:

- Socio-demographic details
- Informants: Whether one parent or both parents or other caregivers
- Referral: Self-referred or referred by other medical specialist or referred by Child Welfare Committee (CWC) or referred by Special Juvenile Police Unit (SJPU) or referred from school or referred from a child care institution
- Reason for consultation: any emotional and/or behavioural symptoms, functional impairment, physical injuries after alleged CSA, physical symptoms after alleged CSA etc.
- Family history: any medical illness, any psychiatric illness, any neurodevelopmental disorder, any substance abuse, family relationships, any family conflict etc.

- Birth and Developmental history
- Schooling history
- Past history of any medical and/or psychiatric illness
- Past professional help-seeking/assessments/treatment
- History of the alleged child sexual abuse
- History of current emotional/behavioural symptoms
- Current functioning - academic/self-care/interpersonal/leisure activities

In addition to obtaining a detailed history using the template mentioned above, the medical officer has to collect and review any reports related to past consultations

Prerequisites for medical examination

All hospitals have to ensure that all the medical officers on out-patient, in-patient and emergency duties are formally trained in conducting medical examination and sample collection for children with history of alleged sexual abuse. It is mandatory to prepare standard operating procedures (SOPs) related to medical examination and sample collection and ensure regular training of all the medical officers using the SOPs.

- The hospitals can empanel subject experts in the area of Paediatrics, Forensic Medicine, and Gynaecology who have experience in the area of child sexual abuse to prepare the above-mentioned SOPs.
- Informed consent has to be obtained from child (12 years and above) and parent prior to medical examination
- All hospitals should ensure spaces with adequate lighting, examination cot and privacy in the out-patient, in-patient and emergency settings for conducting medical examination of the children.
- The presence of the child's parent is mandatory during the medical examination.
- The medical examination for girl children should be carried out by a female medical officer. In case a female medical officer is not available, the medical examination of the girl child should be done in the presence of a female attendant (for example a female staff nurse on duty).
- Police personnel should not be allowed inside the examination room.
- Hospitals should procure adequate number of Sexual Assault Forensic Evidence (SAFE) kits and ensure proper storage of the kits at accessible areas of out-patient, in-patient and emergency settings. Each SAFE kit includes the below mentioned items:

    - Forms for documentation
    - Large sheet of paper to undress over
    - Paper bags for clothing collection
    - Catchment Paper
    - Sterile cotton swabs and swab guards for biological evidence collection
    - Comb
    - Nail Cutter
    - Wooden stick for finger nail scrapings
    - Small scissors
    - Urine sample container
    - Tubes/vials/vaccutainers for blood samples [Ethylenediaminetetraacetic acid
    - (EDTA), Plain, Sodium fluoride]
    - Syringes and needle for drawing blood
    - Distilled water
    - Disposable gloves

- Glass slides
- Envelopes or boxes for individual evidence samples
- Labels
- Lac(sealing wax) Stick for sealing
- Clean clothing, shower/hygiene items for survivors use after the examination

Responsibilities of Hospitals

All hospitals have to ensure that all the medical officers on out-patient, in-patient and emergency duties are formally trained in conducting medical examination and sample collection for children with history of alleged sexual abuse. It is mandatory to prepare standard operating procedures (SOPs) related to medical examination and sample collection and ensure regular training of all the medical officers, nursing staff, and lab staff using the SOPs.

The hospitals can empanel subject experts in the area of Paediatrics Forensic Medicine, and Gynaecology who have experience in the area of child sexual abuse to draft the aforementioned SOPs and to train the hospital staff.

The hospital administration has to ensure timely OP/emergency registration, conduct of medical examination, medical investigations, sample collection, and provision of medical and psychological care to survivors of child sexual abuse.

The OP/Emergency registration, medical examination, sample collection, any investigations, medical treatment and psychological therapy to the child have to be provided free of cost. A copy of all the documents has to be provided to the child's parent free of cost.

Body and genital evidence for both clinical and forensic purposes should be collected simultaneously after explaining the purpose and process to the survivor/victim.

Maintaining the chain of custody of evidence collected is the responsibility of the doctor/ hospital. Every hospital should identify and designate key persons who will maintain the chain of custody till it is handed over to the police, hospital laboratory or the forensic laboratory.

All collected evidence should be packed, labelled and sealed properly ensuring that there is prevention of loss, decay or deterioration of evidence by taking precautions such as adding suitable preservatives or air drying in shade, wherever appropriate.

The medical officer conducting the medical examination has to duly provide Post-exposure Prophylaxis (PEP) for STIs and emergency contraception (in cases of suspected penetrative sexual assault), immediate medical/surgical care and Tetanus prophylaxis for wounds, and immediate psychological support to child as well as parent.

Legal Definitions for Examination & Reporting

There are separate legal provisions for medical examination of the accused and the victim. However, while medical examination of the victim requires informed consent (or the parent's/guardian's assent), medical examination of the accused can be conducted even in the absence of their consent with 'reasonable force'.

Following the examination, the medical report of the victim and the accused require the following details, as per the law:

- *Name and Address of the accused/victim*
- *Age of the accused/victim*

- *Marks of injury (if any)*
- *Description of material taken for DNA profiling*
- *General Mental Condition (ONLY applicable to the Victim)*
- *Other material particulars in reasonable detail.*

Basics of Medical Evidence: Evidentiary Value

Medical evidence does not play a decisive role in the adjudication of a CSA case. It can only support stronger evidence (i.e., more substantive) like witness testimony. Substantive evidence, like witness testimony, is evidence that is capable of proving a fact on its own (without corroboration).

However, evidence obtained from the medical examination of the victim and the accused plays an important *corroborative role*, for two predominant reasons:

- proving the penetrative act and;
- establishing its link with the accused.

It is also important to note that while medical evidence can serve as the basis for a conviction (if reliable), it can never be used to discard an otherwise cogent victim's testimony indicating abuse, as held in numerous judgments by the Supreme Court of India. This is owing to the available scientific evidence indicating the possibility of penetrative assault without injury, and indeed, the poor quality of collection/handling of medical evidence in many cases.

Types of Medical Evidence

In Indian medical jurisprudence, there are various types of medical evidence that are used to a broad or limited extent. Each evidence-type has different implications for appreciation of evidence, and is typically accorded differing evidentiary value. The following is an overview with brief excerpts from Dr Jagadeesh Reddy's article on appreciation of medical evidence in POCSO Cases:

- *Trace Evidence:* "Based on Locard's principle of exchange, the trace evidence (which includes semen, spermatozoa, blood, hair, cells, dust, paint, grass, lubricant, fecal matter, body fluids, or saliva), if detected, (depending on the type of sexual violence), has good corroborative value as it is indicative of contact between the victim and accused. This evidence has several limitations in getting detected, because it depends on the time when the medical examination is carried out after the alleged crime. — with delays accounting for loss of trace evidence; Additionally, post-assault activities like washing, bathing, douching, urination, defecation; affect availability of trace evidence or evidence of semen or spermatozoa."
- *Injuries:* "If injuries are present in a case, and the timing of the injuries is established, this will help in determining the likelihood of the accused's guilt. The 2003 WHO Guidelines for Medico-Legal Care states that in only 33% of cases of sexual violence, (penetrative cases), there are injuries. This means that in two out of three cases of penetrative sexual violence, injuries will not be present. Additionally, the timing of the medical examination will also impact detection of injuries, since healing of such injuries occurs within a short period of time. Typically, injuries are sustained when the victim offers resistance. Absence of injuries could be due to various reasons—the victim being unconscious, either due to trauma, or being drugged / intoxicated, overpowered, or silenced due to fear. The use of a lubricant in sexual violence cases also decreases the chances of infliction of injuries."

- *Sexually Transmitted Infections (STIs)*: Based on Locard's principle of exchange, if either the victim or accused is suffering from a STI at the time of the incident, then there is a possibility of transfer of microorganisms (causing that STI), through body contact, from one person to another. Thus, properly conducting and interpreting the tests to detect the transmission of STIs, as a result of the abusive sexual contact, could help in corroborating the offence.

  However, this evidence is often not collected properly, as at least two medical examinations are warranted to detect these infections, —one as early as possible and the other, after the lapse of the incubation period, depending on the STIs in question (gonorrhea, syphilis, herpes, HIV, or hepatitis).

- *Pregnancy & its Complications:* The products of conception, in cases of medical termination of pregnancy, (MTP), if carried out, serve as medical evidence. If the baby is already born, then the DNA materials of the foetus, when compared with that of the mother and the alleged father, would help in identifying the biological father of the child.

- *Evidence of Treatment:* This is a new piece of medical evidence available in the form of evidence of treatment and its documentation, in case sheets, discharge summaries, prescription sheets, and pharmacy bills, etc.

  With compulsory treatment in every case of rape/sexual assault, this evidence will be available in all cases in which the victim has visited a hospital and consulted a doctor, post sexual violence. If there is proof in the form of medical prescriptions /case sheets / discharge summaries / pharmacy bills / analgesic drugs/ antidepressant drugs consumed post-assault, then these could act as indirect evidence of the pain sustained by the victim after the assault. Finally, even proof of the psychological counselling sessions undergone could act as proof of psychological disturbances, post-assault, that warranted the need for counselling, post-assault.

Interpretation of Genital Findings: Guidelines for Practise

To begin with, the Adams Guidelines reflect our current understanding of how genital trauma may (or may not) be sustained in the context of child sexual abuse, the timing and sequelae of healing of genital trauma and the dynamics of child sexual abuse. Significantly, the Adams Guidelines describe how these factors influence the interpretation of genital findings in children. There are 5 main categories of genital findings under these guidelines:

- **Normal anatomical variants (category A)**
  The guidelines recognise a wide range of normal genital variants in the non-abused child. These include variations in hymenal shape (e.g. annular, crescentic, septet, redundant), findings such as hymenal tags and bumps, any notch or cleft of the anterior or lateral hymen (i.e. on or above the 3 or 9 o'clock position), partial notch or cleft of the posterior hymen and narrow posterior rim, as well as periurethral bands, intravaginal ridges, external hymenal ridges, dilatation of urethral opening, normal midline features and hyperpigmentation of the labial skin.
- **Findings caused by other conditions (category B and C)**
  Some genital findings are caused by conditions other than trauma or abuse. Findings such as generalised erythema and increased vascularity of the genital tissues, labial adhesions and friability of the posterior fourchette can be caused by medical conditions such as urethral prolapse, lichen sclerosus, vulval ulcers and non-sexually transmitted genital infections, which should be considered in the differential diagnosis.
- **Findings with no expert consensus (category D)**

- Several genital findings remain in the 'indeterminate' category due to insufficient evidence and lack of expert consensus. These include:
    (a) notch or cleft at or below the 3–9 o'clock position that extends 'nearly to the base of the hymen' but is not a complete transection;
    (b) complete transection at the 3 or 9 o'clock position.

Findings diagnostic of acute or past injury (category E)

Acute injuries to the genital tissues, including the hymen, for example, acute lacerations, bruising, petechiae or abrasions, indicate recent trauma. In the absence of an adequate explanation, for example, an accidental straddle injury, these findings are highly suggestive of abuse. The only two non-acute hymenal findings that provide clear evidence of past trauma are:

(a) a complete transection of the hymen below the 3 to 9 o'clock position (defined as a hymenal defect that extends to or through the base of the hymen, with no residual hymenal tissue seen at that location); and
(b) a scar of the posterior fourchette or fossa.

Documentation of findings from Medical Evidence

Documents including out-patient or emergency case registration document, case history, prior consultation reports, consent form, medical examination findings, sample collection documents All documentation should be done in a legible manner . The consent process has to be documented in detail and signatures of the child, parent, witness, medical officer has to be obtained. The names of all the persons who have signed on the consent form has to written in capital letters in a legible manner.

The date and time of medical examination has to be mentioned on the document. The medical officer's official seal along with the hospital seal has to be affixed wherever the medical officer signs on the documents.

Two identifying marks of the child preferably from the exposed body parts such as face, upper limbs or lower limbs have to be documented.

Documentation of findings should be done using a standard proforma prescribed in the Guidelines and protocols for the Medico-legal care of survivors of sexual violence drafted by the MoH&FW, Government of India. The findings of general physical examination, examination for external injuries, and examination of anogenital area must be documented. The medical officer who conducts the examination has to include his/her opinion on the findings.

Collection of Samples

The medical officer has to duly collect the samples mentioned below :

- Samples for evaluation in hospital laboratory - blood sample for screening for sexually transmitted infections (HIV, HbsAg, Syphilis, Gonorrhea, HPV), blood sample for any medical investigations if there is a clinical suspicion of underlying medical disorders, urine sample for urine pregnancy test.

- Samples for Forensic Science Laboratory (FSL)
    - Debris;
    - Clothing;
    - Swabs from oral cavity, anal area and genital area;
    - Blood for grouping, drug screen, and DNA analysis;
    - Hair and Nail clippings; and any other objects.

Suggested Reading

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- *State of Rajasthan vs. Noore Khan* (2000 (3) SCC 70)
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21. Role of Mental Health Service Providers in Provision of Expert Testimony

Learning Objectives

- To orient mental health and other child care professionals about their role in supporting children through the court processes.
- To gain an understanding of legal provisions and judicial decisions on the importance, evidentiary value, and expectations from expert witnesses.
- To develop the skills to document and render expert opinions and testimony in a manner which is comprehensible to the Court and is legally sound.

Time

6 Hours

Concept

Expert evidence has increasingly occupied an important role, owed in part to its growing relevance to the field of child sexual abuse prosecutions. Two critical reasons for this judicial phenomenon include: i) judicial perceptions regarding the dearth and unreliability of testimonial evidence in child sexual abuse cases (given the concerns surrounding child witness competency and suggestibility/tutoring); ii) the lack of judicial familiarity with a burgeoning system of knowledge in the domains of mental health and child/adolescent development.

In light of this reality, there has been a growing discourse surrounding the applicable rules of evidence, in child sexual abuse contexts, the role of domain experts from medical/mental health backgrounds, and the suitability of judicial standards in admitting and appreciating expert evidence. This chapter will briefly elucidate some of the basic imperatives in the admissibility and appreciation of expert evidence.

What does the law say about Expert Testimony?

Sec. 45 of Indian Evidence Act:

Opinions of experts. — When the Court has to form an opinion upon a point of foreign law or of science, or art, or as to identity of handwriting, or finger impressions, the opinions upon that point of persons specially skilled in such foreign law, science or art, or in questions as to identity of handwriting or finger impressions are relevant facts. Such persons are called experts.

In essence, the adjudicatory value of expert evidence is that of a *reasoned opinion*. As a result, it is not accorded the same degree of evidentiary value as testimonial evidence (i.e., direct evidence from witnesses), and exists solely to provide the judicial trier of fact with a scientific conclusion, based on commonly recognized principles, and systems of reasoning, from domains such as mental health and medical science. As a result, an expert is typically called upon to provide a conclusion/set of conclusions about a specific relevant fact, or about the fact-in-issue itself. The expert's opinion, however, as reasoned as it may be, remains an opinion till the judge is satisfied with the conclusion and the reasoning provided, at which point the court is inclined to adopt the reasoning of the expert. This opinion thus becomes an opinion of the court and may assist in a judicial finding of guilt.

Consequently, the judge is also liable to dismiss an expert's opinion if these basic imperatives are not satisfied.

Basics of Admissibility: Facts and Relevant Facts

What are the two types of facts for which evidence is admissible? (Refer to the Chapter on Appreciation of Evidence for a detailed explanation of these concepts.)

- Facts in Issue
- Relevant Facts

So, what is expert evidence?

Usually, under the law of Evidence, third parties, that is, persons who are unacquainted with the facts and circumstances of the case are not called upon to give their testimony, opinion or witness in any criminal trial.

As discussed above, expert evidence is a limited exception to this. The question then is, what are the limits to this exception?

Experts are only to testify about facts within their exclusive knowledge i.e.: drawing inferences from factual evidence (on the basis of their expert knowledge); and providing an opinion on the causal relationship between an act and consequence for the victim, on one hand, and the link between the act and offender (where available).

Illustrations of Expert of Evidence

- Suppose, the question is, whether the death of A was caused by poison. The opinions of experts as to the symptoms produced by the poison by which A is supposed to have died, are relevant.

- Suppose, the question is, whether A, at the time of doing a certain act, was, by reason of unsoundness of mind, incapable of knowing the nature of the act, or that he was doing what was either wrong or contrary to law. The opinions of experts upon the question: i) whether the symptoms exhibited by A commonly show unsoundness of mind, and ii) whether such unsoundness of mind usually renders persons incapable of knowing the nature of the acts which they do, or of knowing that what they do is either wrong or contrary to law, are relevant.

What are the different kinds of expert evidence in POCSO Cases?

- For Mental Health:
  - Psychiatrists, psychologists, or social workers,
- Medical Issues:
  - Gynaecologists and other medical professionals treating the child.
- Other Experts (in domains of forensic examination like DNA evidence.

Why have Expert witnesses in CSA cases?

As highlighted above, corroborative evidence often is lacking. Victims are less than ideal witnesses, both developmentally and psychologically, as they may be unable to provide detailed and spontaneous reports of the abuse, be confused about dates and frequencies of events, or fail to understand questions unless phrased in age-appropriate language. Additionally, there is also the possibility that they may retract earlier accusations if proceedings are protracted.

In this context, expert evidence can help the court understand and evaluate the child victim-witness, provide a scientific proposition (generally accepted by the expert's professional community) and elucidate the characteristics of child sexual abuse victims. Experts may also assist the court in evaluating the veracity of child victims and the particular child's statement, elicit the typical effects and symptoms of victimization, and provide information on the characteristics of typical perpetrators and modes of perpetration, thus helping to identify the defendant.

Mental health professionals may also specifically testify as to whether the child's symptoms are consistent with the behaviour of sexually abused children.

So, when is expert evidence particularly important?

There are two common scenarios where such evidence is critical to an accurate judicial determination:

- When the case depends on circumstantial evidence, expert evidence is particularly important in establishing causality and inferences from relevant circumstantial evidence.
- Expert evidence adds to the tipping scale of presumptions in favour of or against the accused. Let's revise these presumptions again…

Application of Presumptions and Burden of Proof

The basic presumption in criminal law is that a person is innocent until proven guilty i.e., the burden of proof is on the prosecution to prove the accused's guilt beyond reasonable doubt i.e., beyond the possibility of reasonable alternatives. For the accused, on the other hand, the standard of proof is *'preponderance of probabilities'* i.e., a likelihood of other reasonable explanations for the occurrence of the offence. This presumption is reversed under the POCSO Act i.e., there is a presumption of guilt on the accused. However, by definition, proving a negative fact is exceedingly difficult. Therefore, there are certain requirements for the 'presumption of guilt' to apply in any POCSO case, which basically require the prosecution to discharge an initial burden of proof by establishing *prima facie* evidence. Such evidence is also evaluated from a 'preponderance of possibilities' standard.

Key Imperatives in Expert Testimony

Owing to the legal presumptions and standards of proof, it is not just the cross-examination of expert testimony that is significant. Many times, ambiguities in the direct/chief examination weaken the prosecution's case more than the cross-examination. One of the reasons this is so is because the standard of proof applies throughout the hearing. Think of it like a relay race. If the starter is faulty, the whole team's race is in jeopardy! So, if there are ambiguities in the direct examination, the balance is tilted in the accused's favour, even if the defence do not sufficiently exploit those ambiguities during cross-examination.

While the area of expert evidence can seem complex, experts are typically asked two kinds of questions:

a. Questions regarding their credibility: These questions are an important part of the process and are not limited to the 'years of experience' or the 'qualifications of the expert'... Questions can also be asked to verify expertise in a particular subset of cases. For example, an experienced psychiatrist may be argued to not possess sufficient knowledge if they have not previously worked with CSA victims, despite their proven expertise in a different area of specialisation as a psychiatrist.

b. Questions regarding the case & expert's involvement: As mentioned earlier these questions relate to two broad areas within their expert knowledge: practise-informed inferences and opinions regarding causality.

State v. Brajesh Kumar Thakur and others **(Muzaffarpur Shelter Home Child Sexual Abuse Case, 2018)**

Introduction

In this case, following directions of the Supreme Court of India, the CBI was directed to take over the investigation, following which they requested assistance from the NIMHANS team in two broad contexts: i) to ascertain the mental health status and developmental abilities of the child victim-witnesses; ii) assist the CBI in recording the children's police statements.

Following this, a part of the NIMHANS team subsequently provided court preparation interventions for the children, to address serious trauma and other mental health consequences of the abuse, in addition to also assisting the court by providing an expert opinion. The relevant part of the court order is reproduced below:

"In terms of the orders of the Hon'ble Supreme Court of India in M.A. No. 2069/2018 in Writ Petition (C) No. 473/2005, and pursuant to the request of the CBI made to the Director, National Institute of Mental Health and Neuro Sciences (NIMHANS), a team comprising of professionals from NIMHANS interacted with the victim girls and the team assessed the mental health status and developmental ability of the children in the present case and provided first level counselling to address their anxiety and prepared them to address the issues raised by the Investigating Officer of CBI. After counselling of the victims by the NIMHANS team at the respective Children's Homes where such victims were lodged, the statements under section 161 Cr.P.C. of such victim girls were recorded by CBI officials."

Child Context in this case

The child victim-witnesses were child and adolescent girls between the ages of 11 and 18, many of whom hailed from contexts marked by adverse childhood experiences (ACES). These experiences included physical, sexual and emotional abuse & neglect, and socio-economic deprivation, prior to institutionalization at the shelter home. Some children also possessed pre-existing developmental disabilities (with effects exacerbated during institutional stay) and mental health disorders, including anxiety & mood disorders/self-harm/post-traumatic stress disorders

Institution Context

The shelter home was run by a non-government organisation. Children, mostly runaways and rescues, were residing in the child care institution in Muzzafarpur. These children were observed to be deprived of opportunities for education and development, including no facilities for recreational activities. In keeping with the persistent nature of the abuse, these children were also not permitted to maintain contact with their families or anyone else outside the institution.

Nature of Abuse

The abuse included sexualization and grooming (with rewards for compliance & physical abuse/coercion in case of non-compliance), exposure of children to sexual videos, coercion to 'sleep' with women institution staff, forcibly requiring children to wear sexually suggestive and age-inappropriate clothes, and requirements for children to engage in age-inappropriate dance routines. In addition to the above, many children were also subjected to drug-facilitated penetrative sexual intercourse. There was also frequent use of physical abuse and violence to maintain secrecy surrounding the abuse and ensure compliance.

The perpetrators included known & unknown individuals, including, institutional staff (male & female), non-institutional staff (carpenters/plumbers/drivers, Child Welfare Committee members), and other unknown persons (associates of staff). Each child had suffered multiple episodes of abuse, by multiple perpetrators, over relatively long timeframes (ranging from 2 to 4 years).

Objectives of NIMHANS's Support & Intervention to Child Witnesses

- Conduct mental health and developmental assessments for affected children in order to screen for mental health morbidity and ascertain the psychological impact of child sexual abuse (CSA).
- Use the developmental and mental health assessments to ascertain the child's capacity to provide evidence/ testimony as child witness.
- Assist CBI investigative officers to interview and gather evidence from the children, using sensitive and child-friendly methods of interviewing.
- Provide first level responses to trauma and identified mental health issues, and refer for further/intensive treatment.
- Prepare children for court and support them through the in-trial processes.
- Make recommendations for mental health and rehabilitation focussed interventions.

Key Findings of the Court in relation to NIMHANS testimony and its assistance in the case

i. Charge-wise Findings Qua Accused No. 1: Brajesh Kumar Thakur *(State v. Brajesh Kumar Thakur and others* (2019))

- "The next contention of the Ld. Counsel for the accused Brajesh Kumar Thakur and the Ld. Counsel for the other accused persons is that the report submitted by the NIMHANS team (Ex. PW 38/A and Ex. PW 38/B) is inadmissible in evidence." (This was a critical submission of the accused)

What the Court said in relation to this submission:

- "NIMHANS is a premier mental health organization of the country and there is absolutely no reason to doubt the impartiality or independence of the members of the NIMHANS team. I have already held that mere giving of bald suggestions to the witnesses does not establish the plea of the accused persons" (in relation to manipulation of the child witnesses).
- "There is nothing in the cross examination of PW 38, PW 39 and PW 40 (NIMHANS witnesses) which persuades this Court to disbelieve the report of the NIMHANS team or to believe that the same has been manipulated or fabricated."
-

ii. Court findings on evidentiary value of NIMHANS Expert Opinion qua its Report and Oral Testimony

- "It is true that the report of the NIMHANS team cannot be considered as direct evidence with respect to the alleged crimes committed against the victims. However, the report of the NIMHANS team establishes that the victim girls were counselled by the NIMHANS team before recording of their statements by the Investigating Officer(s) of CBI.

- The said report further establishes the factum of interaction between the NIMHANS team and the victims and the factum of the victims disclosing the crimes committed against them to the NIMHANS team members and therefore the said report has corroborative value.

- The said report can definitely be used for appreciating the conclusions with respect to the nature and behaviour of the victims girls drawn by qualified experts of the premier mental health organization of the country on the basis of their interaction with the victim girls. Thus it cannot be said that the report of the NIMHANS team is inadmissible in evidence and cannot be taken into account for any purpose whatsoever."

iii. Court Findings in relation to NIMHANS' Expert Opinion on Mental State of Child Witnesses

- "The reports of the NIMHANS team Ex. PW 38/A and Ex. PW 38/B spell out the miseries and trauma suffered by these victims and when these victims were initially shifted from XYZ CCI it is logical to presume that they must have been under immense trauma. In fact keeping in mind the stature and power wielded by the main accused (which is apparent from his 'political resume' spelt out in his statement under section 313 Cr.P.C.), it is logical to presume that these children must have been under extreme fear and pressure as well."

iv. Court's Findings on Imperative for NIMHANS to assist CBI in recording child witnesses' statements

- "On the other hand it is seen that when the investigation was taken over by CBI, pursuant to the directions of the Hon'ble Supreme Court, the victims were counselled by the NIMHANS team, which assessed their mental health status and developmental ability and provided first-level counseling to address their anxiety and prepared them to address the issues raised by the Investigating Officer. Thereafter the statements of the victims were recorded in terms of section 161 Cr.P.C. by the CBI officials and even the time of recording of such statements the NIMHANS counsellor(s) used to remain present in the same room.

- This is in consonance with the provisions of section 26(1) of the POCSO Act, 2012. Moreover it also appears that the investigation was not being properly conducted by Bihar Police and that is why the investigation was handed over to the CBI."

Court's Findings on Primacy of S.161 Statement (CBI assisted by NIMHANS) over S.164 Magistrate Statement

- "The NIMHANS team has also observed in their reports Ex. PW 38/A and Ex. PW 38/B that V-19 was very shy and she gets anxious when she meets new people. It is further mentioned that she will be able to provide detailed evidence after establishing a good rapport with a female counsellor and given the traumatic nature of her abusive experiences she should be interviewed with reassurance in a sensitive manner. The observations made by the NIMHANS team explain as to why V-19 did not open up and disclose her experiences regarding sexual abuse before the Ld. Magistrate.

- In fact, as per the report she had disclosed regarding commission of sexual abuse by Brajesh Sir to the NIMHANS team in detail. PW 38, the head of the NIMHANS team deposed that the team assessed the mental

health status and developmental ability of the children in the present case and provided first-level counselling to address their anxiety and prepared them to address the issues raised by the Investigating Officer.

- Accordingly, her statement recorded after her counselling by the NIMHASNS team has to be given precedence (over the S.164 Magistrate Statement). Thus, this argument of the Ld. Counsel for the accused is rejected."

Questions to consider…

- What were some of the important Court Findings on Opinions provided by NIMHANS that you identified? Why?
- Which way did you think the expert testimony shifted the balance of the case: accused or victim?
- How did NIMHANS Expert Opinion assist the Court in arriving at its conclusions?

Appreciation of Expert Evidence and judicial requirements

Excerpts from ***Dayal Singh and Ors. Vs. State of Uttaranchal (2012)***

- "The Courts, normally, look at expert evidence with a greater sense of acceptability, but it is equally true that the courts are not absolutely guided by the report of the experts, especially if such reports are perfunctory, unsustainable and are the result of a deliberate attempt to misdirect the prosecution.
- The expert witness is expected to put before the Court all materials inclusive of the data which induced him to come to the conclusion and enlighten the court on the technical aspect of the case by examining the terms of science, so that the court, although not an expert, may form its own judgment on those materials after giving due regard to the expert's opinion, because once the expert opinion is accepted, it is not the opinion of the medical officer but that of the Court.
- The essential principle governing expert evidence is that the expert is not only to provide reasons to support his opinion but the result should be directly demonstrable. The court is not to surrender its own judgment to that of the expert or delegate its authority to a third party, but should assess his evidence like any other evidence. If the report of an expert is slipshod, inadequate or cryptic and the information of similarities or dissimilarities is not available in his report and his evidence in the case, then his opinion is of no use…Indeed the value of the expert evidence consists mainly on the ability of the witness by reason of his special training and experience to point out the court such important facts as it otherwise might fail to observe, and in so doing, the court is enabled to exercise its own view or judgment.
- The opinion is required to be presented in a convenient manner and the reasons for a conclusion based on certain visible evidence, properly placed before the Court. In other words, the value of expert evidence depends largely on the cogency of reasons on which it is based.
- The skill and experience of an expert is the ethos of his opinion, which itself should be reasoned and convincing. Not to say that no other view would be possible, but if the view of the expert has to find due weightage in the mind of the Court, it has to be well authored and convincing."

Activity: Providing Expert Testimony in Court

Method: Mock Trial

Material: Factual Matrix of a case (provided in 'Additional Materials at the end of this module).

Process:

- ***Step 1:***
  Participants may work in groups for this activity. Participants will have to fill out the Psycho-Social Assessment form based on the facts of the case given above.
- ***Step 2:***
  In a separate sheet of paper, participants will have to answer the following:
  1. What are the key facts of the case?
  2. As a Mental Health Professional / Paediatrician (whichever is applicable), provide an overview of what you would testify on.
- ***Step 3:***
  Based on the clinical impressions/medical report and answers provided by the participants a Trial is to be conducted in a moot court setting. The facilitator (s) shall take on the role of a Judge, Public Prosecutor and Defense Counsel. The Trial procedure shall include:
  a. Examination-in-Chief of the Expert
  b. Cross-examination of the Expert
  (Refer to the Chapter on Appreciation of Evidence for a detailed explanation on the above.)
- ***Step 4:***
  Upon completion of the expert's recording of testimony, process the experience with the participant to understand their challenges and appraise their demeanor and content of their answers.

Discussion:

Discuss the challenges and barriers participants face when presented with the requirement of testifying in Court as and identify good practices that will help address these issues.

Note: *This activity is a simulation exercise to empower more medical professionals to provide credible expert testimony in Court. Sample questions that may be used by the facilitator(s) for the chief examination and cross-examination are shared in the corresponding Additional Material.*

Suggested readings

- Section 45, Indian Evidence Act, 1872.
- *Dayal Singh and Ors. Vs. State of Uttaranchal,* MANU/SC/0622/2012.
- *Parhlad v. State of Haryana,* (2015) Supreme Court of India.
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Additional Material

Case Matrix for the Activity on 'Providing Expert Testimony in Court'.

- **Context of the child**

  The child victim 'X' is a 9 year old girl who resides in a village. The girl's parents often left her at home during the day, with her two younger siblings, aged 5 and 2 years respectively, as they had to go to the city to find work as daily wage labourers. As X had to take care of her younger siblings, during the day, she was often absent from school. She stayed at home with her siblings, without any adult supervision.

  X's father used to come home drunk and would often get into physical fights with her mother. The child too faced physical abuse by her father.

- **Details of the incident**

  The accused 'Y' is a 30 year old man, who resided in the same village and was a family friend. He is an influential man who had formerly served as the village Sarpanch. One afternoon, knowing that X was alone with her siblings he went to her house. He asked X to let her siblings play for a bit so that she could come with him to an eatery nearby where they could have some snacks and her favourite cold drink. Excited by the prospect, X went with Y on his bike. Y took X to a nearby abandoned building and proceeded to drug her and commit penetrative sexual assault on her.

- With X not having returned home for over two hours, X's 5-year old sibling informed their neighbour. The neighbour started looking for X and upon being informed by a shopkeeper who had seen X leave with Y on his bike towards the abandoned building, found X unconscious, with her clothes torn, lying on the floor inside the said building.

- **What happened after the incident?**

  The neighbour took X to the PHC. Upon medically examining X, it was found that she had suffered multiple bruises on her cheeks, chest, arms, abdomen and thighs. There were dried blood and faecal stains over her genital and perineal region. X was also suffering from incontinence and complained of a burning sensation while urinating.

  The Medical Officer at the PHC reported the incident to the Police. However, Y's family and associates have been threatening X and her family to withdraw the complaint. Many villagers have also been persuading them to drop the case as it would create unnecessary acrimony in the village and have shunned them. X is also scared to venture out to even go to school.

Examination-in-Chief sample questions:

1. Can you describe your education and training in the medical field?
2. How long have you been practicing medicine?
3. What is your area of specialization?
4. Can you describe the patient's medical history and current condition?
5. Have you ever examined a child victim who had been sexually abused?
6. What examination did you conduct on the child victim, and what were your findings? Did you find any physical evidence of sexual abuse, such as injuries or signs of penetration?

7. Based on your assessment of the child victim, are you able to estimate the general time the sexual assault took place?
8. Can you rule out the chance that something other than sexual abuse, such as a medical condition or an accidental incident, caused the child victim's injuries or medical conditions?
9. Did you consider any prior medical issues or therapies the child victim underwent, and if so, how did these affect your investigation and conclusions?
10. What possible treatment and conditions for recovery and rehabilitation would you recommend?

Cross-Examination sample questions:

1. Can you tell us about your qualifications and experience as a medical professional especially suitable for this kind of a case?
2. Are you a specialist in paediatrics/gynaecology/child psychiatry, which are relevant to this case?
3. How long have you been practicing in your field, and what is your level of experience in dealing with cases involving sexual assault?
4. Have you ever been involved in a case where your testimony was challenged or discredited?
5. Can you describe the medical examination process you followed in this case? Is this the standard procedure followed in these kinds of cases?
6. Were there any discrepancies or inconsistencies in the observations recorded by different doctors?
7. Were you present at the time of the assault, or did you rely on information provided by others?
8. Can you explain how you prepared the medical report?
9. Did you consult with any other medical professionals while preparing the report?
10. Were there any errors or omissions in the report?
11. Are there any limitations or uncertainties associated with your methodology or conclusions that should be taken into account?
12. Were there any inconsistencies or errors in the medical records or test results that you relied upon in your analysis?
13. Can you explain why there is a difference between your findings and those of other medical professionals who have reviewed the same evidence?
14. Can you explain how you arrived at your conclusions regarding the cause of the injuries observed during the medical examination?
15. Did you consider other possible causes of the injuries?
16. Can you provide any alternative explanations for the victim's injuries or medical condition that are consistent with the accused's innocence?
17. Can you confirm that the injuries observed during the medical examination could not have been caused by other factors, such as a pre-existing medical condition, an accident, or self-infliction?
18. Can you confirm that the medical examination was conducted within a reasonable time frame after the alleged assault?
19. Did you consider the possibility that the injuries may have healed or changed since the time of the alleged assault?
20. Can you confirm that you have no personal or professional bias that may have influenced your examination or report?
21. Is it possible that your conclusions were influenced by assumptions or preconceptions about the case or the parties involved?
22. Can you describe any potential alternative diagnoses or explanations for the patient's symptoms?

Annexe 1
Sample Schedule for (In-Person) Training Program

Note 1 : ***In case the training program is being done continuously over the course of several days, it would be critical to give some break days, as feasible i.e. one after each four-day block.***

Note 2: ***The time durations provided for each session may be used to plan stand-alone sessions, including online sessions.***

Day	Timings	Theme
Day 1	9:30 am – 1:00 pm	Introduction to Child Sexual Abuse Legislation
	1:00 pm – 2:00 pm	Lunch
	2:00 pm – 5:30 pm	The Experience and Impact of Childhood Trauma
Day 2	9:00 am – 1:00 pm	The ABCs of Child Sexual Abuse
	1:00 – 2:00 pm	Lunch
	2:00 – 4:15 pm	The Dynamics of Child Sexual Abuse Disclosure
	4:15 – 6:30 pm	Film Screening (A)
Day 3	9:00 – 9:45 am	Discussion on Film Screening (A)
	9:45 am – 1:00 pm	Identifying the Context & Experience of Child Sexual Abuse: Hearing the Child's Inner Voice
	1:00 – 2:00 pm	Lunch
	2:00 – 5:00 pm	Essential Communication and Interviewing Skills with Children Skill 1: Rapport Building Skill 2: Listening
Day 4	9:00 am – 12:30 pm	Skill 3: Recognition & Acknowledgement ofEmotions
	12:30 – 1:30 pm	Lunch
	1:30 – 6:00 pm	Skill 4: Acceptance & Non-JudgmentalAttitude Skill 5: Questioning & Paraphrasing
Day 5	9:00 – 11:00 am	Assessment of Sexually Abused Children
	11:00 am – 1:00 pm	Immediate Family & Systems Responses to Sexually Abused Children
	1:00 – 2:00 pm	Lunch
	2:00 – 5:00 pm	First Level Psychosocial & Mental Health Interventions: Developing Scripts for Responses to Children
	5:00 – 7:00 pm	Other First Level Psychosocial & Mental Health Interventions
Day 6	9:00 am – 1:00 pm	Long Term Interventions in Child Sexual Abuse (A): Towards Healing & Recovery
	1:00 – 2:00 pm	Lunch

	2:00 – 4:30 pm	**Long Term Interventions in Child Sexual Abuse (A): Towards Healing & Recovery (Contd…)**
Day 7	**9:00 am – 1:30 pm**	**Long Term Interventions in Child Sexual Abuse (B): and Personal Safety Awareness and Education**
	1:30 –2:30 pm	**Lunch**
	2:30 – 4:30 pm	**Film Screening (B)**
Day 8	**9:00 – 9:45 am**	**Discussion on Film Screening (B)**
	9:45 am –1:30 pm	**Navigating the Dilemmas of Mandatory Reporting in Child Sexual Abuse: Practice Guidelines for Implementation under POCSO Act**
	1:30 – 2:30 pm	**Lunch**
	2:30 – 4:30 pm	**The Child Witness in the Adversarial Justice System**
Day 9	**9:00 am –1:15 pm**	**Child Witness Competencies to Provide Testimony: Applying the Child Development Lens**
	1:15 – 2:15 pm	**Lunch**
	2:15 – 4:15 pm	**Film screening & Discussion (C)**
Day 10	**9:00 – 9:45 am**	**Discussion on Film (C)**
	9:45 am – 12:00 pm	**Eliciting Evidence from Child Witnesses**
	12:00 –1:00 pm	**Lunch**
	1:00 pm – 3:30 pm	**Cautions in Child Witness Interviewing & Court Preparation: Understanding Issues of Suggestibility & Tutoring**
Day 11	**9:00 am – 12:30 pm**	**Court Preparation Interventions for Child Witnesses**
	12:30 – 1:30 pm	**Lunch**
	1:30 pm – 3:45 pm	**Appreciation of Evidence (A): Understanding Legal Principles**
Day 12	**9:00 am – 12:00 pm**	**Appreciation of Evidence (B): The Dynamics of Abuse and Medical Evidence**
	12:00 –1:00 pm	**Lunch**
	1:00 – 4:30 pm	**Role of Mental Health Service Providers in Provision of Expert Testimony**
Day 13	**9:00 – 11:30 am**	**Role of Mental Health Service Providers in Provision of Expert Testimony (Contd…)**
	11:30 am – 1:00 pm	**Summary & Feedback**

Annexe 2
Power Point Presentations for Modules

All PPTs for teaching are available here	
Module 1: Introduction to Child Sexual Abuse Legislation in India	
Module 2: The Experience and Impact of Childhood Trauma	
Module 3: The ABCs of Child Sexual Abuse	
Module 4: The Dynamics of Child Sexual Abuse Disclosure	
Module 5: Identifying the Context & Experience of Child Sexual Abuse: Hearing the Child's Inner Voice	
Module 6: Essential Communication and Interviewing Skills with Children	

Module 7: Assessment of Sexually Abused Children	
Module 8: Immediate Family and Systems Responses in Child Sexual Abuse	
Module 9 & 10: First Level Psychosocial & Mental Health Interventions: Developing Scripts for Responses to Children	
Module 11: Long Term Interventions in Child Sexual Abuse (A): Towards Healing & Recover	
Module 12: Long Term Interventions in Child Sexual Abuse (B): and Personal Safety Awareness and Education	
Module 13: Navigating the Dilemmas of Mandatory Reporting in Child Sexual Abuse: Practice Guidelines for Implementation under POCSO Act	
Module 14: The Child Witness in the Adversarial Justice System	
Module 15 : Child Witness Competencies to Provide Testimony: Applying the Child Development Lens	

Module 16: Eliciting Evidence from Child Witnesses	
Module 17: Cautions in Child Witness Interviewing & Court Preparation: Understanding Issues of Suggestibility & Tutoring	
Module 18: Court Preparation Interventions for Child Witnesses	
Module 19: Appreciation of Evidence (A): Understanding Legal Principles	
Module 20: Appreciation of Evidence (A): The Dynamics of Abuse and Medical Evidence	
Module 21: Role of Mental Health Service Providers in Provision of Expert Testimony	

Annexe 3
Resources for Working with Child Sexual Abuse

- **Training Manuals**

  - **The Building Blocks- Mental Health Care, Psychosocial Care & Protection for Children & Adolescents**
    https://nimhanschildprotect.in/wp-content/uploads/2023/08/Training-Series-1-Building-Blocks-1.pdf (English)
    https://nimhanschildprotect.in/wp-content/uploads/2023/08/HIndi-Building-Blocks.-PDF-1.pdf (Hindi)

  - **The Trauma of Loss & Abuse- Mental Health Care, Psychosocial Care & Protection for Children & Adolescents**
    https://nimhanschildprotect.in/wp-content/uploads/2023/08/Training-Series-2-Trauma-of-Loss-Abuse-1.pdf (English)
    https://nimhanschildprotect.in/wp-content/uploads/2023/08/Hindi-Document-Series-2-trauma-of-Loss-abuse-2-1.pdf (Hindi)

  - **Children in Conflict with the Law - Mental Health Care, Psychosocial Care & Protection for Children & Adolescents**
    https://nimhanschildprotect.in/wp-content/uploads/2023/08/Training-Series-3-Children-in-Conflict-with-Law.pdf (English)
    https://nimhanschildprotect.in/wp-content/uploads/2023/08/Hindi-Training-Series-3-Children-in-Conflict-with-Law-2-1.pdf (Hindi)

- **Training Curriculums**

  - **Essential Interventions & Skills for Working with Child Sexual Abuse- Introducing Mental Health & Legal dimensions of Forensics**
    https://nimhanschildprotect.in/wp-content/uploads/2023/08/CSA-Forensics-curriculum_Final-1.pdf

  - **Working with Children Affected by Sexual Abuse and Violence – A Training & Capacity Building One Stop Centre Staff, Frontline Functionaries and Primary Care Workers**
    https://nimhanschildprotect.in/wp-content/uploads/2023/08/Primary-Front-Line-workers_CSA-curriculum_4th-Nov-2022.pdf

  - **Essential Child & Adolescent Mental Health Interventions & Psychosocial Care – For Mental Health Service Providers in Secondary & Tertiary Level Facilities**
    https://nimhanschildprotect.in/wp-content /uploads/2023/08/Child-Mental-Health.SAMVAD-NIMHANS-1.pdf

- **Resources for Judicial Officers**

  - **The Child as a Witness: developmental and Mental Health Implications for Eliciting evidence under Protection of Children from Sexual Offences Act, 2012**
    https://nimhanschildprotect.in/wp-content/uploads/2021/04/The-Child-as-a-Witness-Developmental-Mental-Health-Implications-for-Eliciting-Evidence-under-Protection-of-Children-from-Sexual-Offences-Act-2012.pdf

  - **A Decade of POCSO: Re-Thinking Progress & Possibilities**
    A review Consultation on the Protection of Children from Sexual Offences Act 2012
    https://nimhanschildprotect.in/wp-content/uploads/2024/01/POCSO-Consultation-Report-Feb-2023.pdf

- **Life Skills Manuals for Mental Health Professionals and Child Care Service Providers**

  - **Socio Emotional Development Manual for Early Childhood Care & Development**
    https://nimhanschildprotect.in/wp-content/uploads/2021/03/Socio-Emotional-Development-for-Anganwadi-Preschoolers.pdf
  - **Child Sexual Abuse Prevention & Personal Safety : Activity Based Awareness for Pre Schoolers and Children with Developmental Disability**
    https://nimhanschildprotect.in/wp-content/uploads/2021/03/CSA_Prevention-Preschool__Disability_Kids.pdf

  - **Social & Emotional Development: Life Skills for Children Aged 8 to 12 years**
    https://nimhanschildprotect.in/wp-content/uploads/2021/03/Life_Skills_Activities_for_Children_7_to_12_years_.pdf

  - **Child Sexual Abuse Prevention & Personal Safety: Activity Based Awareness and Learning for Children Aged 7 to 12 years**
    https://nimhanschildprotect.in/wp-content/uploads/2021/04/CSA_Prevention_Module_7_12-yrs_Oct_2017.pdf.

  - **Adolescent Life Skills Series I: Social and Emotional Development**
    https://nimhanschildprotect.in/wp-content/uploads/2021/03/Life-Skills-Adolesce-Socio-Emotional.pdf

  - **Adolescent Life Skills Series II: Gender, Sexuality and Relationships**
    https://nimhanschildprotect.in/wp-content/uploads/2021/02/Life-Skills-Adolescence-Gender-Sexuality-Relationships.pdf

- **Relevant Publications**

  - Ramaswamy, S., Devgun, M., Seshadri, S., & Bunders-Aelen, J. (2023). "The Child Needs to Tell it to Me in Words": Barriers and Facilitators to Witness Competencies in Child Sexual Abuse Trials. The International Journal of Children's Rights, 31(2), 403-443.
  - Ramaswamy, S., Devgun, M., Seshadri, S., & Bunders-Aelen, J. (2023). Balancing the law with children's rights to participation and decision-making: Practice guidelines for mandatory reporting processes in child sexual abuse. Asian Journal of Psychiatry, 81, 103464.
  - Ramaswamy, S., Seshadri, S., & Bunders-Aelen, J. (2023). Transdisciplinary training for forensic mental health in child sexual abuse in India. The Lancet Psychiatry, 10(5), 317-318.
  - Ramaswamy, S., Seshadri, S., & Bunders-Aelen, J. (2021). Building a research agenda for mental health assessments in resolving legal dilemmas on adolescent sexual consent. Asian Journal of Psychiatry, 66, 102907.
  - Krishna, C. G., Ramaswamy, S., & Seshadri, S. (2021). Integrating child protection and mental health concerns in the early childhood care and development program in India. Indian pediatrics, 58(6), 576-583.
  - Seshadri S, Ramaswamy S. Clinical Practice Guidelines for Child Sexual Abuse. Indian J Psychiatry. 2019 Jan;61(Suppl 2):317-332.
  - Ramaswamy S, Seshadri S. Our failure to protect sexually abused children: Where is our 'willing suspension of disbelief'? Indian J Psychiatry. 2017 Apr-Jun;59(2):233-235.

- **Relevant YouTube Videos**

How does one respond to children and adolescents who exhibit sexually inappropriate behaviours

https://www.youtube.com/watch?v=njlhYJ0Myzw

How would the law respond to an adolescent with disability who engages in sexual activity with a young child?

https://www.youtube.com/watch?v=_-64K6IFAnY

Narrative Approaches in Child Sexual Abuse Interventions

https://www.youtube.com/watch?v=1oh7aeF_azY

Mandatory Reporting Dilemmas in Child Sexual Abuse

https://www.youtube.com/watch?v=39Y-Qm4QKTs&t=29s

Life Skills (Inventure Academy)

https://www.youtube.com/watch?v=g_eut2PeF_A&t=188s

Life Skills – Therapeutic Contexts and Processes: Categorical Nuances (Thursday Musings)

https://www.youtube.com/watch?v=L5QtHSSixDI&t=1859s

Methodologies of Life Skills Trainings in Adolescence

https://www.youtube.com/watch?v=G_JWjcWU9bk&t=494s

Realities of Child Sexual Abuse in India

https://www.youtube.com/watch?v=b_ft_XVAWf8

Breaking the Myth: The Dynamics of Child Sexual Abuse

https://www.youtube.com/watch?v=4VdKJNT35Tw&t=2536s

Developmental Implications for Evidence Eliciting

https://www.youtube.com/watch?v=vxRcdrQj3sc

10 Things to Tell Your Children Before 2020 Ends

Theme 2: Gender

https://www.youtube.com/watch?v=KadXYgjICJo&list=PL6M-G4mGr43qGgGZvd0YsLEESQAx_8ErA&index=2

10 Things to Tell Your Children Before 2020 Ends

Theme 6: Adolescent Sexuality & Decisions

https://www.youtube.com/watch?v=ODOwqMssDb8&list=PL6M-G4mGr43qGgGZvd0YsLEESQAx_8ErA&index=6

10 Things to Tell Your Children Before 2020 Ends

Theme 6: Adolescents and Romantic Relationships

https://www.youtube.com/watch?v=FydNOpZf0Fg&list=PL6M-G4mGr43qGgGZvd0YsLEESQAx_8ErA&index=7

**Note – These videos/ YouTube resources are in addition to the clips used as part of the various activities.*

- **Relevant Movies/TV Series/Documentaries/Docu-series for training purposes:**
  - Jeffrey Einstein: Filthy Rich (2022, Docu-series)
  - Who is Ghislaine Maxwell? (2022, Docu-series)
  - Siya (2022, Movie)
  - Respect (2021, Documentary)
  - Monsoon Wedding (2001, Movie)
  - Spotlight (2015, Movie)
  - Keep Sweet: Prey and Obey (2022, Docu-series)

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Facebook: https://www.facebook.com/childprotectnimhans

Twitter: https://twitter.com/nimhans_CPC

LinkedIn: https://www.linkedin.com/in/nimhanschildprotection

Instagram: https://www.instagram.com/nimhanschildprotect

Towards a new dawn
Ministry of
Women and Child Development
Government of India