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

PROJECT STREE MANORAKSHA

"INTEGRATING TRAINING AND SUPERVISION IN PSYCHOSOCIAL AND MENTAL HEALTH CARE FOR ONE STOP CENTRE (OSC) STAFF TO SUPPORT WOMEN FACING VIOLENCE"

RESOURCE BOOK

SUPPORTED BY THE MINISTRY OF WOMEN AND CHILD DEVELOPMENT, GOVERNMENT OF INDIA

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National Institute of Mental Health and Neuro Sciences, (NIMHANS), Bangalore

"Integrating Training and Supervision in Psychosocial and Mental Health Care for One Stop Center (OSC) Staff to Support Women Facing Violence"

Funded and Supported by Ministry of Women and Child Development, Government of India

RESOURCE BOOK

2022

Director's Message

Project Stree Manoraksha, an initiative by NIMHANS supported by the Ministry of Women and Child Development, Government of India, focuses on Training in Psychosocial issues and Mental Health Care to Support Women Facing Gender-Based Violence.

Women may face violence in several contexts- at home, in the workplace and in communities. Violence can take many forms- physical, psychological and sexual. Such violence is a core human rights violation and makes the women vulnerable to experiencing debilitating consequences to her mental, physical health, and reproductive health. Witnessing violence at home in childhood may also lead to adverse effects later in life. Women who face sexual assault or domestic violence often find it difficult to ask for help and reaching an OSC or a helpline requires a great deal of effort. They need to overcome their own shame and fear in addition to finding ways of doing this without the violence escalating. All these issues can take an immense toll on a woman's mental state. Therefore, mental health support is vital and must be tailored to the individual woman and her unique needs. It should also help the woman in navigating her path through the police and justice systems.

This resource material by the Project Stree Manoraksha team has been developed for training of OSC Counsellors and Staff in a modular format. The modules address different psychological problems, provide simple yet useful psychological interventions, reflective exercises, discuss ethical issues and also focus on self-care of the counsellors themselves.

This Resource Book will help counsellors and staff as well as facilitators to ensure that the training and supervision is sustained in the long term.

I congratulate the team on taking up this important project and bringing out the resource book.

Dr. Pratima Murthy
Director & Senior Professor of Psychiatry
NIMHANS

About Stree Manoraksha Project

'STREE MANORAKSHA'– an initiative aimed at "Integrating Training and Supervision in Psychosocial and Mental Health Care for One Stop Centre (OSC) staff to support Women Facing Violence" is a project started in The National Institute of Mental Health and Neurosciences (NIMHANS), Bangalore, with support and funding from the Ministry of Women and Child Development, Government of India. The project is headed by Dr. Prabha S. Chandra, Professor of Psychiatry and Associate Dean, NIMHANS. The co-principal investigators of the project are Dr. Veena Satyanarayana, Additional Professor of Clinical Psychology, and Dr. Elizabeth Kimneihat Vaiphei, Assistant Professor of Psychiatric Social Work. The project aims to provide training and supervision in psychosocial and mental health care for staff and counsellors of all One Stop Centres (OSCs) across the country to support women facing various forms of gender-based violence.

WHY WAS THE PROJECT INITIATED?

India's National Family Health Survey (NFHS-5) in 2019-2021 reported that one in three married women has experienced Intimate Partner Violence (IPV). However, around 9 in 10 women have never sought help when they faced violence. IPV and abuse is not only a core human rights violation but also makes the women vulnerable to experiencing debilitating consequences to their mental and physical health. Gender-based violence is prevalent across the lifespan and occurs in various contexts. The Covid-19 pandemic has exacerbated the rate of gender-based violence manifold. Therefore, mental health support is highly imperative and needs to be tailored to the individual woman and her unique needs.

WHAT IS AVAILABLE?

The Government of India over the years has taken several steps to make help accessible to women facing violence. As an outcome of these initiatives, various One Stop Centers (OSCs) and women helplines have been established and made functional in the country. At present, 688 OSCs have been made operational in the country, out of the total 733 OSCs that have been approved. According to the Ministry of Women and Child Development statistics (updated in June, 2020), the OSCs across the country have helped over 3, 05,896 women.

Project Stree Manoraksha aims to train around 1400 counsellors and more than 2000 other OSC staff to provide Trauma-Informed Care for women facing violence and abuse. The training is conducted online synchronously and asynchronously comprising of Basic Training for the OSC staff across the country focusing on mental health and psycho-social care and an Advanced Course for the OSC counsellors and center administrators focusing on Trauma-Focused Approaches. At the end of each training module, the participants are given certificates and study materials.

The training curriculum includes Violence against Women and its Multigenerational and Lifetime implications, Guiding Principles of Providing Psychosocial Support to Women facing Sexual Violence, Mental Health Impact of Violence against Women and its Assessment, Suicide risk Assessment and Primary Interventions, Violence between Couples and in Family Context, and ways to intervene, Psychological First Aid and various Psychological Interventions and Referral Pathways for Women facing Violence. It also covers Ethical and Professional Principles in Counselling and Tele-counselling for Women facing Violence. Lastly, it covers the need for Self-care for OSC Counsellors and Staff and ways to manage burnout and compassion fatigue. The Resource Book is a compilation of all the topics in a modular format to help counsellors and staff as well as facilitators to work in the field of gender based violence against women.

Team Stree Manoraksha, NIMHANS

Foreword

The experience of violence is against all human rights. Each person in this world has the right to live in a safe space free from psychological, physical, and sexual violence and also from coercive experiences. A woman facing violence deals with huge emotional challenges in addition to physical and reproductive challenges. She may often not seek help, may not know where to seek help, and may feel the dual stigma of a mental health problem and that of facing gender-based violence. Those of us working in the field know the impact that long-term trauma can have on one's self-confidence, ability to manage emotions, trust in others, and ability to manage relationships.

Women facing violence may often be given advice, solutions, or nudged to make changes in themselves or asked to leave the abusive situation without understanding their lived realities. A woman facing partner violence from the very person who is supposed to comfort and support her, is often confused, ashamed and angry and with it is the added helplessness of not being able to seek help. Gender-based violence can take many forms and any such violence can have a huge mental health impact.

The levels of violence against women in a society increase with patriarchy, low education of women, ineffective legal systems, and the societal acceptance of male violence. Most women seek help from informal systems like peers, family, and neighbours and help-seeking from systems is often poor. For women to seek help from legal and health systems there has to be confident and trust in these. The One Stop Centers and Women's Helplines by the Ministry of Women and Child Development, Government of India have been set up with the aim of supporting women and helping them access these government systems in as seamless a way as possible. A woman facing violence cannot be expected to knock at different doors for different forms of help and advice, of which mental health support is one of the most important.

Through Project Stree Manoraksha, we aim to develop and strengthen trauma-informed mental health care in One Stop Centers (OSCs) by training counselors and other staff, including

caseworkers, center administrators, paralegal, paramedical staff, multi-purpose workers, security guards, and other team members.

This initiative will enable every woman facing gender-based violence who approaches the OSCs to receive empathetic, supportive, and evidence-based primary mental health care and counseling services. So far we have been overwhelmed with the enthusiasm of the trainees from across the country's 704 OSCs and impressed by their dedication to the cause. We aim to provide comprehensive emotional support to every woman and girl who seeks help from these OSCs. We aim to create safe spaces for emotional sharing and expression of fears, alongside being supported legally and through other systems. Our training for OSC staff focuses on reflection, understanding intersectionality, and enhancing the autonomy and agency of all women facing violence regardless of class, education, caste, sexuality, religion, and disabilities.

We know that being a Front line Worker in the field of 'violence against women' is a difficult and emotionally taxing task and we are full of appreciation for all the work that OSC staff do. The Stree Manoraksha Training in addition to providing skills for supporting women also focuses on caring for the self. We hope that the resource book will connect different OSCs and help them learn from the modules as well as provide support to each other.

Let's make mental health of women and girls our priority.

Dr. Prabha S Chandra
Senior Professor of Psychiatry
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NIMHANS

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Contents

1. Violence Against Women: Basic Concepts

LEARNING OBJECTIVES

1. **Understanding Violence**

- What is violence?
- Different types of violence
- Violence occurring in different contexts & situations

2. **Broad ethical and feminist principles to be used in assessment and intervention for women facing violence**

What is Violence?

- It is intentional.
- It includes neglect and deprivation

It often has lifetime consequences in areas of:

1. Physical and mental health

2. Socio-occupational functioning

3. Economic and social development

Typology of Violence

Physical Violence-

- The intentional use of physical force with the potential for causing harm, death, disability, injury or harm.
- It can be done with the use of an object or a weapon; and/or use of restraints or one's body, size, or strength against another person.

Sexual Violence-

- Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances
- By any person, regardless of their relationship to the victim
- In any setting, including home and work

Psychological & Emotional Violence-

- Trauma caused by deliberate acts, threats of acts, or coercive tactics

Can include:

1. Humiliating the victim
2. Controlling the victim's actions
3. Isolating the victim
4. Denying the victim access to basic resources

Stalking-

- Harassing/threatening behavior, such as:

1. Following a person
2. Appearing at a person's home or place of business
3. Making harassing phone calls
4. Leaving written messages or objects
5. Destroying a person's property

6. **Cyber-stalking**

Cyber stalking as a form of violence involves the use of the internet or other electronic means to stalk or harass a woman. It may include false accusations, defamation, slander, monitoring, identity theft, threats, and solicitation for sex or blackmail.

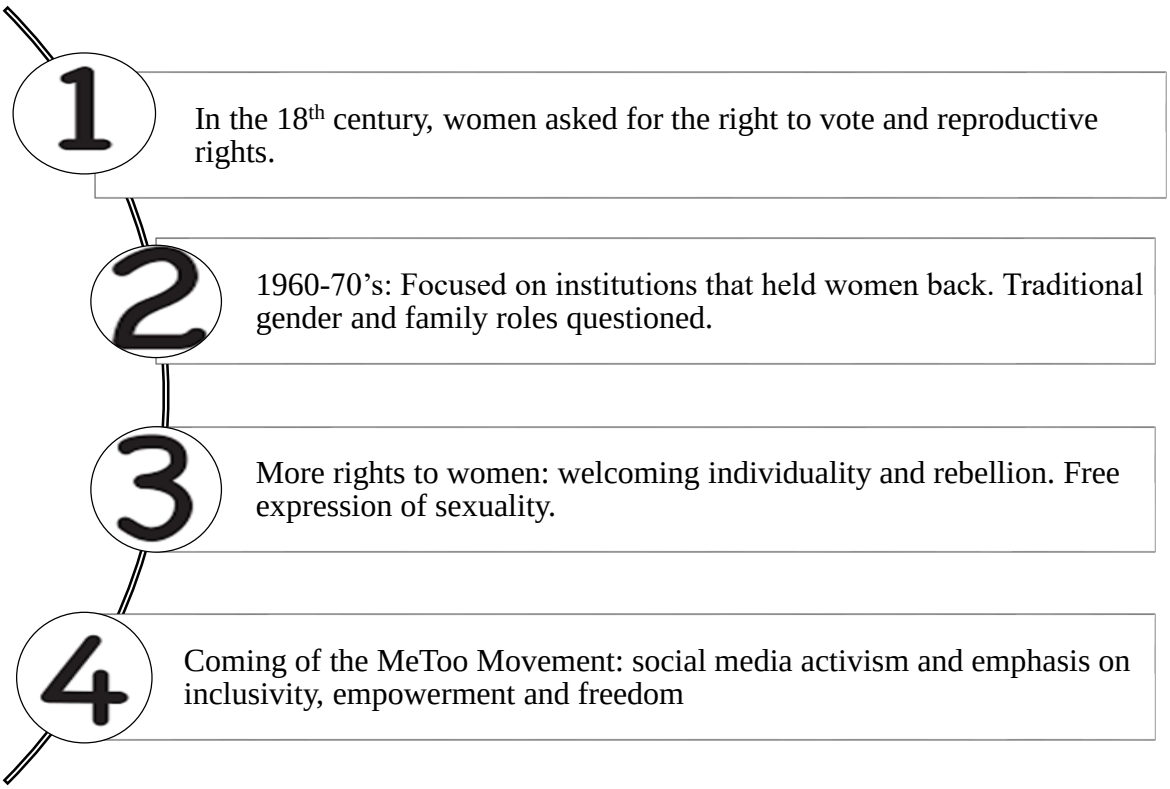
FEMINIST PRINCIPLES OF ASSESSMENT AND INTERVENTION

What is Feminist Psychology?

Feminist psychology is a subfield of psychology concerned with gender, sex categories, and sexualities.

Feminist psychology critiques historical psychological research as done from a male perspective with the view that males are the norm.

Waves of Feminism



Feminist Principles of Assessment

1. During the 2nd wave of feminism, violence against women was understood as a condition existing only in the family
2. Later, the effect of patriarchy and its role in violence against women was understood
3. During the third wave, violence against women was understood not just a condition in family but a problem in the society
4. Based on this, emphasis was placed on assessment and understanding each offender to determine appropriate interventions
5. Also the historical roots and cultural underpinnings were noted to understand, assess and intervene on violence against women
6. Evidence based interventions were developed with to help the women facing violence and trauma
7. The aim is to create an anti-oppressive, power balanced and socially just environment to properly tackle violence against women

Feminist Principles of Intervention

1. **Need for critical consciousness:** Understanding the idea that woman's individual problems originate in a socio-political context of patriarchy and gender inequality
2. **Commitment to Social Change:** The goal of intervention is not only to help the individual by addressing their problems, but to make a positive impact on society
3. **The counselling relationship should be egalitarian:** The relationship is based on authenticity, mutuality and respect
4. **Emphasis on Strength based Approach:** Reframing trauma symptoms as survival strategies and coping with mental health issues rather than pathologizing the individual (Trauma-informed Care)

Assessment of violence helps counsellors understand

- Depth of problem
- Identifying risk factors
- Develop realistic safety plans
- Formulate appropriate counselling plans
- Reduce risk
- Provide tools for educating service providers

Basic feminist principles to keep in mind while counselling:

- Trust a woman's experience.
- Women victims are not guilty for violence they experience
- Counselling means not giving advices but trusting women's self determination

2. Multigenerational Implications and Lifetime Trauma of Violence against Women

LEARNING OBJECTIVES

1. **Multi – Generational Trauma**

- Implications and effects

2. **Life-time trauma**
3. **Life Chart of Trauma experience and its impact**

- How to prepare a life chart?
- How to use it to understand the experience of violence in various stages of life?

The Concept of Multi-Generational Trauma

- Trauma that gets passed down to subsequent generations, from those who directly experience trauma
- Begins with a traumatic event affecting individual, multiple family members, or collective trauma affecting larger community, e.g. war

Multi-Generational Trauma Implications and Effects

- **Individuals:**

1. Frequent feelings of anger, fear, anxiety, and low mood

2. Reduced self-esteem and efficacy

3. Social isolation and withdrawal

4. Reduced efficiency in socio-occupational functioning

- **Families:**

1. Continued financial constraints

2. Reduced investment in education, health and other basic necessities

3. High noise levels in the family

4. Poor cohesiveness among family members

- **Communities:**

1. Restricted economic growth

2. Pervasive violence and deprivation

- **Societies:**

1. Failure to meet costs of health

2. Criminal justice and social welfare compromised

- **Countries:**

1. Economic growth slowed

2. Security compromised

3. Social development slowed down

4. Socio-economic inequality

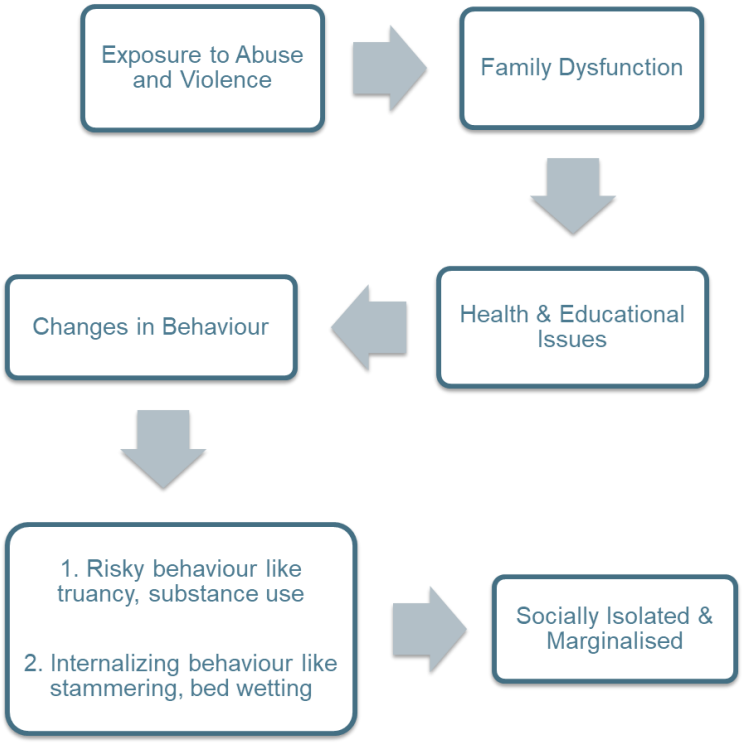
Connection between Traumatic Events and Poor Childhood Development

There is high risk of:

Behavioural problems- lying, truancy, problems in relationships, physical aggression

Emotional problems- isolation, sadness, helplessness, anxiety and hopelessness

Self-injurious behaviour



The Concept of Life-Time Trauma

- Traumatic events are differentiated from stressful life events by their imputed seriousness
- Traumatic events:

➢ Sexual and physical abuse

➢ Witnessing a violent crime

➢ Premature loss of a parent

➢ Participation in combat

- Emotional support offsets the effects of trauma (Krauss, 2004)

Life-Time Trauma Experiences

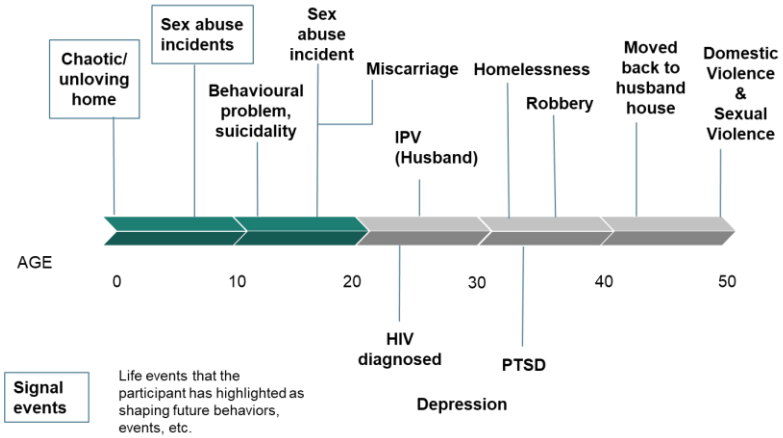
- Severe trauma effects, such as flashbacks
- Misdiagnosis for severe mental disorders
- Poor life satisfaction
- Overlooking underlying issues of abuse
- Risky coping strategies, such as substance use
- Greater vulnerability to experience further trauma

Factors affecting the Trauma Cycle

- Unresolved conflicts, unprocessed emotions and thoughts about a traumatic event
- Negative repeated patterns of behavior like continued violence
- Poor parent-child relations and emotional attachment
- Untreated or poorly treated substance abuse or severe mental illnesses
- Complicated personality traits or personality disorders

Life-Chart for Violence

- Build understanding of tool to assess life chart of violence.
- Assess violence experienced during various stages of life.



Reflective Exercise:

Sudha, a 38-year-old, working as a domestic help, has been married for almost 15 years, to Arun (41 years), a security guard. They live with Arun's parents and have two children, a daughter (13 years) and a son (10 years). Arun grew up in extreme poverty and witnessed his father being emotionally and physically abusive towards his mother. Father was a very authoritative figure. Arun and his siblings grew up in an unprotected environment. After marriage, Arun was absent as a father and would not help with child-care. He made no effort with household chores, he would consume alcohol even at home, after returning home from work would scold Sudha over minor issues- like not cooking properly, many a times would hit her under alcohol intoxication. Arun would scold Sudha during her both pregnancies. He did not help her in any hospital visits during pregnancy. The son started getting into physical fights with his classmates and regularly returned with bruises. The daughter, despite being a bright student in the beginning, started scoring poorly in exams and isolated herself from her peers. Her teacher also reported of her having frequent crying spells at school, without reason.

Questions:

- What are the different forms of violence discussed in the case?
- Identify the types of traumas given in the case.
- Discuss the multigenerational implications of the violence in this case.
- What can be the preventive measures taken up for dealing with the issues of violence?
- Prepare a life chart for the case discussed

3. Guiding Principles and Challenges in Managing Trauma in Women facing Sexual Violence

LEARNING OBJECTIVES

1. **Understanding Trauma Reactions**

- Immediate Psychological reactions related to trauma
- Secondary trauma from police and court procedures
- Long term psychological issues related to trauma
- Psychological reactions related to marital rape
- Factors that increase or decrease trauma

2. **Child Sexual Abuse (CSA)**

- Nature and Types of CSA
- Warning signs to look for in children
- Primary Guidance for handling CSA

3. **Providing Psychological support**

- Educating the woman about possible reactions to trauma
- Managing Reaction to triggers

4. **Referral to a mental health professional**

- When to Refer
- To Whom
- How to Refer
- How will treatment help

What is Sexual Violence?

Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances by any person, regardless of their relationship to the victim in any setting, including home and work.

Types of Sexual Violence

- Coercive penetration of vagina, anus, mouth
- Attempted penetration
- Drug facilitated sexual violence
- Threats of sexual violence
- Unwanted sexual advances
- Sexual harassment
- Incest
- Sexual intercourse without the spouse's consent
- Child sexual abuse

Rape Myths

- Women or children wearing short dresses, sleeveless or no *dupatta* provoke men to behave badly.
- Why did she not scream and shout for help when she was being sexually assaulted?
- She was raped because she went out alone at night- it was her fault!
- Children can forget about the assault and can get over it with time.
- Once a woman gives consent for kissing or touching her breast, she cannot object if the man does more.
- 'If he did not touch you and he only said sexual things' it is not actually abuse.
- Married woman can never say that their husband raped them.
- An adult can show their love by kissing or touching a child's genitals.
- Sex workers cannot complain of being raped- it's their job.

Psychological Responses to Trauma

Now Let's Understand Psychological Responses to Trauma with the help of the case of Ms. S

1. **Immediate response**

Ms S, 27, works in a bank. She came early in the morning to work, and a co-worker had tried to kiss her and touch her when they were alone, without her consent.

She was shocked and felt dirty. When others came at 9 am, she could not greet anyone or smile, and she didn't feel like speaking to anyone. She quietly walked to her desk, and kept staring at her desktop, and she couldn't even work.

She told a female colleague about what happened, who made a statement – but you looked so calm this morning, and it doesn't look like you would have gone through such a terrible and scary experience.

2. **Secondary Victimization Response**

Ms S, with a lot of difficulties, finally managed to discuss with her colleague and elder sister about the incident in detail. They suggested that they should complain to the official authority and the police.

The next day, while reporting to the HR and manager and then to the police, Ms S burst out crying. She was shaking and was very anxious.

The more questions were asked, the more she became uncomfortable and quiet, she started breathing heavily, and started feeling dizzy. After some time she fainted, and this happened every time she spoke to the office lawyer and at the medical examination.

3. **PTSD Response**

Ms S, now 31 years old, housewife, has difficulty feeling happy or excited. She tries hard to forget the incident that happened 4 years ago but fails, as the memories keep flashing in front of her.

Whenever she sees a man in a blue shirt, or standing close to her and talking she freezes and starts sweating. She gets so frightened that she keeps her doors and windows locked.

At night she wakes up trembling; she dreams of her being attacked. She avoids watching crimes scenes or fights on TV. When her husband tries to be intimate with her, she freezes and feels like a stone with no feelings.

Marital Rape

- The act of sexual intercourse with one's spouse without the spouse's consent.
- An act of marital rape is not considered as a criminal act in India.
- Women suffering from marital rape often report of being beaten or abused by her husband.
- Marital rape often goes underreported and unreported

Marital Rape Implications

- Most women fail to report marital rape as it is socially tolerated. People do not believe the experience of the woman.
- Some abused women are afraid to report the violence because they rely financially on their husbands for their upkeep and children's maintenance.
- Others feel unable to speak out due to fear and humiliation.
- Most women continues to experience marital rape with the belief that it's their 'wifely duty'.

Case Vignette

Sunita, 26 years old, married for last 3 years. Soon after a year of her marriage, Sunita got pregnant, but she was not happy about it. Sunita tells her mother that, "I get angry, when I see him"..."he used to force me"…"I shouldn't have married him, he has made my life miserable". Mother tells Sunita that "He is your husband, it's your wifely duty to satisfy him and you cannot leave him". Sunita feels devastated.

Sunita has been visiting a gynaecologist for her pregnancy. The gynaecologist notices that she is not happy with the pregnancy and she tells Sunita, “If you want to share anything, please feel comfortable and say, it will remain confidential.”

Sunita felt little hopeful, and shares that her husband used to beat her and abuse her. He used to force for sexual relations every night. Even though she would say no repeatedly and report pain, he would not listen.

Dissociation as a response to Sexual Assault and Trauma

- Experiencing flashbacks of traumatic events.
- Inability to remember things for some time.
- Losing memories about specific people, places, information, events, or specific periods.
- A blurred or distorted sense of reality.
- A feeling of numbness and disconnection towards one's environment.
- A distorted sense of place and time.
- A feeling of detachment from one's emotions.

Flashback as a response to Sexual Assault and Trauma

- Distressing memory of the trauma.
- Unwanted & intrusive in nature.
- Reliving the trauma as if it were happening now.
- It takes over all the senses.

Child Sexual Abuse

- Any sexual activity with a child (under age 18) by an adult or adolescent.
- An interaction between a child and an adult where the child is used for sexual stimulation.
- These acts can include sexual touching or non-genital forms of touching behaviours,

Types of Child Sexual Abuse

- Contact Abuse: touching of the intimate parts

- Non-contact Abuse: Offensive sexual remarks, observing child while undressing
- Genital Abuse: Touching and fondling of genitals
- Non-genital Abuse: Touching and fondling parts other than genitals
- Penetrative Abuse: Using the penis/other objects to penetrate any orifice of the child's body
- Grooming: method of manipulation that entails a process of engaging the child/adolescent in sexual acts

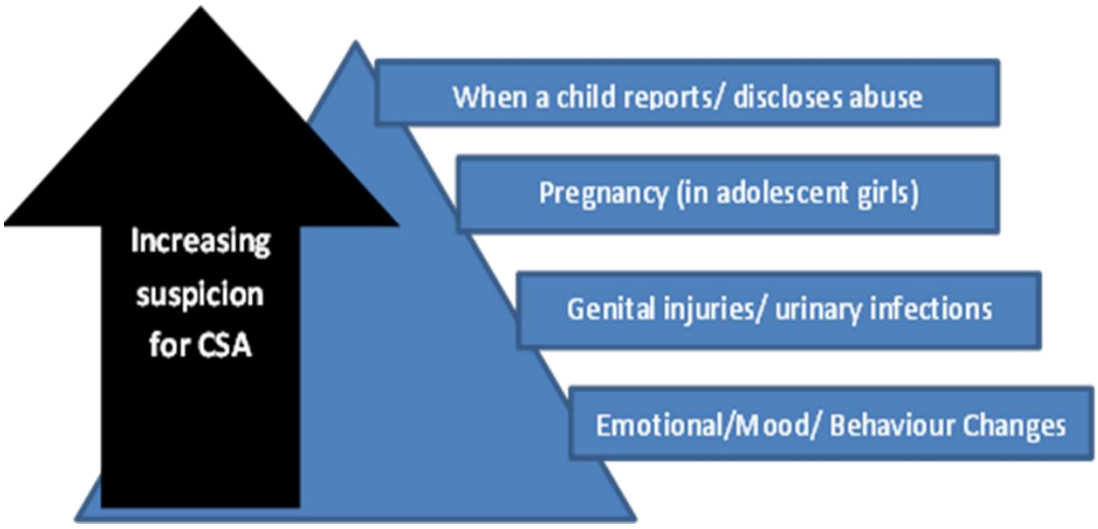
Warning signs to look for in children

In Younger Children…

- 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

In Older Children/ Adolescents…

- 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



Primary response after finding out about CSA

- Reporting to CWC/Police (Mandatory Reporting).
- Guiding/Supporting family through Medical & Legal Processes.
- First-Level/ Emergency Response with Child
- Necessary referrals to be made
- Ensure child's safety
- Respond to children's queries and confusions
- To discuss with child's parents in a sensitive and gentle manner

Factors that Influence Psychological Distress related to Sexual Assault

Nature of Assault

- With Physical Violence
- Threat to Life
- Woman was drugged
- A person with her threatened or harmed
- Raped by more than one person
- Assaulted by known person (like husband)

Response of Family and Friends

•Supportive Responses

•School, College or Work Place giving time off

•Counselling

•Not being blamed

•Not being discriminated

Perpetrator issues – being out on bail, being in the same place

Media trial - Media becoming the judge

Sensitivity within the system– Health system, Police system, Legal system, Counsellor Sensitivity

- Past experience of traumatic events
- Childhood sexual abuse
- History of psychological problem
- Abused by relatives or known person
- Abusive family
- Homelessness
- Physical or Sensory disabilities
- Intellectual Disability

Counselling after Sexual Assault

L – Listen patiently, without interrupting, understand her silences, don't push her to give all details

I – Inquire about her physical and emotional health

V – Validate her responses, her decisions, believe what she says

E – Ensure her safety and confidentiality

S – Support her throughout the procedure, provide links to support systems

Counselling to Reduce Secondary Victimization

- Assuring the survivor that the assault was not her fault
- Giving her a sense of control and agency, e.g. she decides whether she wants to file a case or whom to inform
- Providing her with the freedom to step out of the procedures anytime she wants to.
- Assuring that consent would be sought before introducing any therapeutic technique and proceeding with mutual agreement.
- Get permission before providing information to friends or family unless she cannot give consent.

Counselling to Reduce Flashbacks and Reactions to Triggers

Identify internal or external stimuli that is a trigger – could be an event, situation or memory

- What were the time and day?
- What was happening around you?
- Where were you at that time?
- What were you doing at that time?
- Any particular thing that you noticed? Any person, colour, place, smell, words, images?

Referral to Mental Health Services

When to Refer?

- Risk of self-harm
- Depression that interferes with day–to–day activities
- Severe flashbacks, nightmares, anxiety or other symptoms of PTSD
- Psychological distress persists despite counselling
- Psychosis or severe mental illness
- Survivor is pregnant or has gone through an MTP
- Persons with intellectual disability

To Whom?

- Psychiatrist / Child psychiatrist

- Clinical Psychologist / Child psychologist
- Occupational therapist
- Special educators
- Speech therapist
- Psychiatric Social Worker
- Counsellors
- District Mental Health Program
- Primary Care Doctor

How to Refer?

- Set up an appointment
- Call the mental health professional and brief them about the case
- Make a referral letter
- Follow up after the referral
- Give feedback to the survivor
- Ensure careful documentation

How will Treatment help?

- Managing the symptoms
- Improving mental health status
- Improving the day-to-day functioning
- Improving relationships among couples or family members
- Helping in reducing secondary trauma and anxiety related to evidence and procedures

Creating Inclusive Services and Tailoring it for persons with specific needs

Special Population

- Sex workers
- LGBTQI+ Communities
- Persons with Disability
- People facing caste, class or religion based discrimination

Some Guiding Principles

- We must not make assumptions and look at our own biases carefully.
- We must show cultural sensitivity & enable survivors to feel at ease
- We must acknowledge challenges and provide an enabling environment
- We must not show disbelief, ridicule, bias, judgemental and discriminatory behaviour (explicit/implicit comments)
- Confidentiality of their orientation, identity, the occupation must always be maintained.

Reflective Exercise:

Jyoti, a 19 year old girl was raped by a relative. Jyoti notices that she missed her period for two months, and has severe abdominal pain. In the hospital her mother was told that Jyoti is pregnant. Mother and the Doctor start asking questions - who is the father? Did she had a boyfriend? Jyoti starts shivering and loses consciousness for 5 minutes. She tells them it was the uncle. "Uncle ji used to touch me and I didn't know what he was doing". The doctor and nurse say- "you could have stopped him. You are 19 year old, you should know what is wrong or right." Jyoti appears to be in a daze for some time and again starts trembling and falls down. Jyoti and her mother decides to file an FIR. The police asks – Were you both involved with each other? Why did you let him touch you? Why were you alone with him? And then you did not tell your mother- were you hiding something? Feeling humiliated - Jyoti decides not to talk to the police. She agrees to a medical examination but when the doctor tries to examine her she starts shivering and is unable to allow medical examination. She however, terminates the pregnancy. Following this, Jyothi goes into a shell. She stops college and refuses to meet her friends. She feels very scared about staying alone. Often her mother finds that she looks lost as if in a daze. She gets startled easily and stops talking to men including her own father and brother. She often gets into a rage at small things and shouts and at times like this cuts herself.

Questions:

- Identify the symptoms of distress in Jyoti
- How will you help her? What are the counselling techniques?
- Will you refer her to a Mental Health Service? Why?

4. Violence in Family Context and Ways to Intervene

Learning Objectives.

- To understand the basic concepts of violence between couple.
- To understand the causes of violence between couple (from the perpetrator standpoint).
- To understand ways to intervene when violence occurs in the context of family and couple.
- To understand the impact of violence on children and safeguarding them.

Understanding Violence between Couples

- **Disagreement:** To have a different opinion about something.
- **Conflicts:** Any argument between two people caused by differences in their opinion.
- **Abuse:** Physical, sexual, emotional, economic or psychological actions or threats of actions that influence another person. Any behaviors that frighten, intimidate, terrorize, manipulate, hurt, humiliate, blame, injure, or wound someone.

What is Violence?

- It is intentional
- It includes neglect and deprivation
- A way to exert power and control over others.
- It often has lifetime consequences in:

1. Physical and mental health

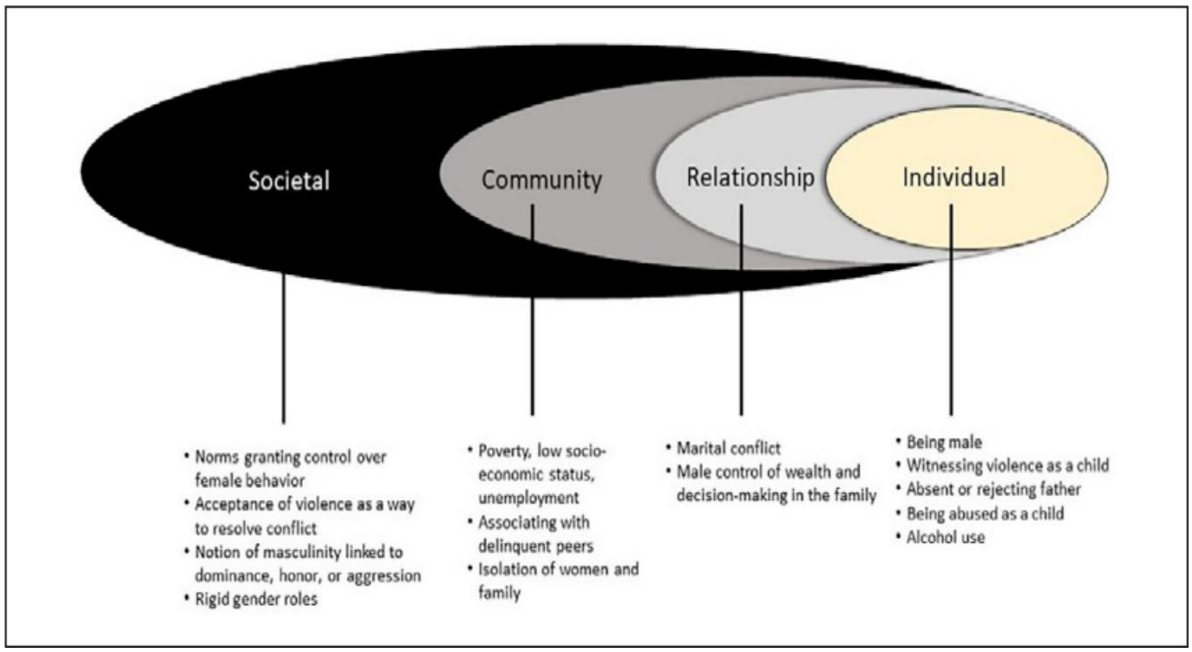
2. Socio-occupational functioning

3. Economic and social development

Types of violence between couples

- Physical Violence
- Emotional violence
- Sexual Violence
- Controlling behaviours

Causes of violence among couple



Ecological Model of Intimate Partner Violence (Heise, 1998)

Social Causes

- **Patriarchy:**

➢ Belief system of the society, focused on gender

➢ Men have more power than women.

➢ Specific gender roles are assigned by the society.

➢ Families passing the assigned gender roles to the next generations.

- **Gender Roles:**

- Women should do all household chores and take care of children.
- Women should not step out of house without the permission from the men in the house.
- Women should be soft spoken, forgiving and do everything in the best interest of other members in the family.
- Women should not share their opinion in public.
- Women should not oppose men in anything.
- Women should not be the decision makers in the family.
- Financial aspects in the family should be dealt by men.

- **Power Imbalance:**

- Unequal distribution of control and power between partners.
- Men dominates women in families.
- Takes decision and exert power that can cause disadvantages to the partner as well as for their relationship.

- **Toxic Masculinity:**

- Harmful concept of masculinity that gives significant importance on ‘manliness’ based on:
- Strength
- Lack of emotion
- Self-sufficiency
- Dominance
- Sexual virility

Individual Causes of Violence between Couple (Related to Mental Health of the Perpetrator)

Mental health of the perpetrator:

- Presence of mental disorders (Depression, Anxiety, Severe Mental Illnesses).
- Substance use (Alcohol, other drugs).
- Personality disorders (definite tendency to act impulsively and without consideration of the consequences; the mood is unpredictable and capricious).

Personality disorders seen in perpetrators- Antisocial Personality Disorder

- Disregard for others' needs or feelings.
- Persistent lying, stealing, etc.
- Recurring problems with the law.
- Repeated violation of the rights of others.
- Aggressive, often violent behavior.
- Impulsive behavior.
- Consistently irresponsible.
- Lack of remorse for behavior.

Personality disorders seen in perpetrators- Paranoid Personality Disorder

- Pervasive distrust and suspicion of others and their motives.
- Hesitancy to confide in others due to unreasonable fear that others will use the information against you.
- Perception of innocent remarks or nonthreatening situations as personal insults or attacks.
- Angry or hostile reaction to perceived slights or insults.
- Tendency to hold grudges.

- Unjustified, recurrent suspicion that spouse or sexual partner is unfaithful.

Personality disorders seen in perpetrators- Borderline Personality Disorder

- Impulsive and risky behavior, such as having unsafe sex, gambling or binge eating.
- Unstable and intense relationships.
- Mood swings, often as a reaction to interpersonal stress.
- Suicidal behavior or threats of self-injury.
- Intense fear of being alone or abandoned.
- Ongoing feelings of emptiness.
- Frequent, intense displays of anger.

Personality disorders seen in perpetrators- Narcissistic Personality Disorder

- Belief that one is special and more important than others.
- Fantasies about power, success and attractiveness.
- Failure to recognize others' needs and feelings.
- Exaggeration of achievements or talents.
- Expectation of constant praise and admiration.
- Arrogance.
- Unreasonable expectations of favors and advantages, often taking advantage of others.
- Envy of others or belief that others envy you.

Substance Use

- Has a bidirectional relationship with Intimate Partner Violence.
- The most common substance used is Alcohol.
- Alcohol compromises the thinking, reasoning and causes disinhibition in an individual, causing them to react impulsively.

- IPV can happen under intoxication as well as during withdrawal.
- The frequency and intensity of violence increases with substance use.
- Also happens because of social perceptions that a man should consume substances to be 'manly'.
- Often substance use by men and resulting violence is culturally and socially accepted.

Feminist principles of violence against women

Shepard, M. (1991). Feminist practice principles for social work intervention in wife

Sl. No	Principles	Description
1.	Tactics of Control	Violence as a tactic to control the woman by: • Emotional abuse • Isolation • Intimidation • Threats • Economic abuse • Sexual abuse • Physical abuse • Using cultural norms to dominate.
2.	Intent	Abusive behaviours are intentional, not a result of uncontrolled anger or of impulsivity.
3.	Emotions	Feelings of anger, frustration, hostility, and insecurity do not cause a person to be violent.

4.	Minimization, Denial, and Blame	Minimizing, denying, and blaming others for one's acts of violence is an attempt to avoid taking responsibility for one's behaviours.
5.	Negative Effects	The use of abusive tactics often gets the abuser what he wants, it has negative effects on him, the woman he abuses, his children, and his relationship with family and friends.
6.	Non-violent Relationships	It is possible to achieve nonviolent relationships that are based on equality.

Working with the perpetrator

- Individual sessions are advised.
- Check for the reason of violence towards his partner.
- Refer for mental health support, if violence is a result of mental health issues.
- Educate about legal complications, if violence is a result of social causes.

Managing Disagreements and Conflicts between Couple

What is Couple Counselling?

Couple counselling (CC) is provided to people who are in a relationship (married or unmarried). The same is called as Marital Counselling if the couple are married. It addresses various issues like resolution of conflicts, feelings of disconnection, extra marital affairs etc. Couple counselling is effective to any couple regardless of the age, gender, religion or marital status.

Goals of Couple Counselling

Couple counselling is basically for people who wants to work on their relationship. The major goal is to make the relationship between the couple fruitful, and to rediscover, love and to respect each other.

- To improve the relationship of the couple.
- To improve communication patterns.
- To enhance problem solving.
- To encourage effective conflict resolution.

For whom?

Couple counselling can be provided to a wide range of populations. It can be provided to couple who are in any forms of romantic relationship. It can be provided to any two individuals who share a romantic bond and identifies themselves as a couple, irrespective of age, gender and marital status.

- Unmarried couples
- Married couples
- Live in partners
- Older couples
- LGBTQI+ Couples.

Why?

As the CC is focused on improving the relationship of the couple, it will enable the couple to identify the patterns they follow in communication, the methods they resolve the conflicts, and solve the problems.

- To improve relationship among the couple by learning more mature and better methods for resolving the conflicts between them.
- To learn more effective ways of solving their problems.
- To provide support for safe separation if needed.

When?

Couple counselling cannot be done always. There are certain indicators that are suggestive of a CC.

- If the couple has consented to a joint session after discussing the process in detail.
- If both partners want to learn new methods to resolve their conflicts.
- When there is situational physical violence (when the violence is situational or contextual).
- The couple can commit to improve relationship.

When not to?

There are instances when the CC cannot be provided.

- If any of the partner is not consenting for a joint session.
- When the woman or her partner lacks capacity (in case of an acute psychotic illness or dementia).
- Substance use disorder (like severe alcohol use disorder) in partner may be one of the contributing factors for violence: - Evaluation on treatment for substance use is required.
- If the partner has personality disorder- Anti Social Personality Disorder/Narcissistic personality/ Paranoid personality: - Evaluation and referral for individual therapy is required

What to do?

- Couple counselling is not applicable for all the issues between the couple.
- For couple having ongoing physical violence, couple counselling should NOT be initiated.
- If the couple has problems such as conflict resolution, anger management or problem solving, Couple counselling can be provided.

Anger Management

STOP skills:

S – Stop for that moment. Do not react to the situation.

T – Take a step back from that situation.

O – Observe your body and thoughts.

P – Proceed carefully.

Write about your anger.

Mention date and time.

A- Antecedents (Situation that caused anger in the individual)

B- Behaviour (What did you do when you got angry)

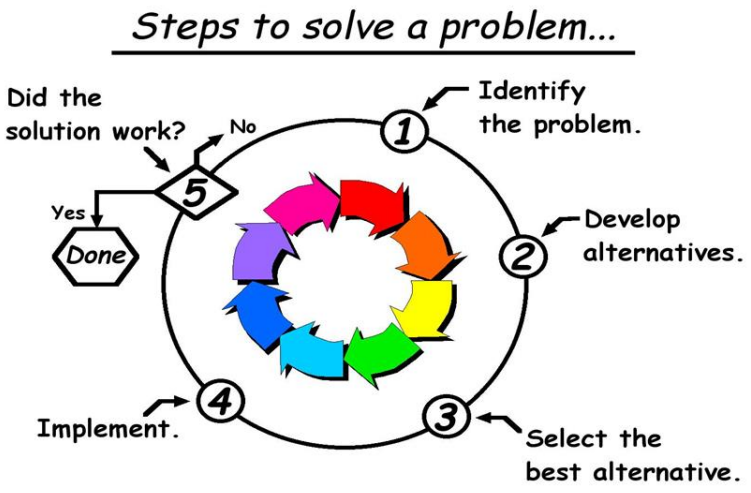
C- Consequences (What were the after effects)

ANTECEDENT	BEHAVIOR	CONSEQUENCE
What happens directly before that "triggers" the behavior	What the person does (defined in measurable, observable terms)	What happens directly after the behavior, from student's perspective. What does the student GET or AVOID?

Examples:

ANTECEDENT	BEHAVIOR	CONSEQUENCE
Teacher hands out a math worksheet with word problems	Student says he won't do the work and calls the teacher a name	Teacher sends student out to buddy classroom (AVOID Math Worksheet/ Classroom activities)
Peers refuse to let the student join in their game	Student cries and yells	Teacher comes over, problem solves a solution (GET adult attention in the form of help)

Problem Solving Strategies



Identify what the problem actually is.

Brainstorm all available solutions for the problem.

Select the best solution after assessing pros and cons of solutions.

Implement the selected solution.

Check if the picked solution is working out in resolving the problem.

If it is not working or not giving the desired results, pick another solution from what has been brainstormed, implement it. Check for the result.

This process can be continued until the problem is solved completely.

Conflict Resolution- Healthy methods

Reasoning	Using rational arguments	Checking alternatives, finding solutions for the problem.
Assertion	Expressing views and wants directly and respectfully	Clearly stating one's position, respectfully redirecting the conversation to the issue, emphasizing points.
Partner Support	Acknowledging partners view	Actively listening or questioning, expressing clear agreement with the partner, making compromises or concessions (middle ground)

Conflict Resolution- Unhealthy methods

Coercion	Taking control using force	Blame, threats, sarcasm, physical or verbal aggression.
Manipulation	Attempting to gain compliance by false means.	Providing misleading information, attempting to make the partner feel guilty or defensive, feigning sincerity or various mood states.
Avoidance	Physical and/or emotional withdrawal from the situation.	Changing or avoiding the topic, avoiding eye contact, minimizing the situation by joking.

Attitude of families towards women facing violence

- Families tend to blame the woman for bringing out the issue of violence outside the family.
- Family not intervening because the woman should be patient and it's okay for the husband to physically hurt the woman if she is wrong.
- Belief that divorced woman bring disgrace to the family.

How to provide family support to women facing violence

- Involve the family in healing process if the client consents.
- Discuss with the family about the importance of support from the near and dear ones.
- Believe the woman when she shares the problem.

How to provide family support to women facing violence

- Educate about being emotionally supportive and not to blame the woman.
- Assuring the woman and promising support from the family.
- Provide instrumental and monetary support for the woman.

SAFEGUARDING CHILDREN

Symptoms and Warning Signs in Children for Witnessing Violence

Internalising Symptoms	Externalising Symptoms
• Fearfulness • Social Withdrawal • Anxiety • Depression • Somatic Complaints • Bedwetting • Poor academic performance	• Substance Use • Anger outbursts • Anti-social behaviours • Bullying • Poor Self-esteem • Difficulty in peer relationships • Temper tantrums • Sibling rivalry

- Children from violent households are at the risk of developing mental health problems. They are likely to adapt to negative coping to solve their problems also, they can be perpetrators in the future as they have learnt violence as a method of problem solving.
- Discuss about safety planning with the mother.
- The child should be taught about the safety behaviours and safety places in case of any violent behaviour occur from the perpetrator. The child has to be taught who is the person he/she can go to if in danger, and what things to do from the child's side. Child line numbers can be shared with the child so that the child can also contact child line services if there is nobody else to help.
- Separation of child to be considered when all other means of safety have been considered.
- Separation of child from the parents is the last resort. Institutionalizing the child because of the violent environment at home should be considered only after trying other options. These options can be shifting the child to the other family member's house or others depending on the available resources for the family. Separation should be considered only if:
    - ❖ When all other means of safety have been considered and offered.
    - ❖ Child is at imminent risk and there is no other way to protect the child from this situation.
    - ❖ When victim is unable to protect the child.
- Contact Child line/ Child Welfare Committee if you are concerned about the child's safety.

Reflective Exercise:

Maria (40), is married for past 9 years. She has completed her graduation before marriage, but is a housewife, comes to the center and reports of physical violence directed towards her as well as to her children occasionally. She was unable to take the children when she came to shelter. She reports that she has two children, a boy (7 years) and a girl (5 years) and that they are also being

beaten badly by her husband sometimes when they are in the room. She expresses her concern that the children might be abused when the husband realizes that she has reached outside for help. She fears that the husband might direct his anger to her children.

Questions:

- What is the concern of the client and is it needed to address it?
- What are the indicators for providing protection for the children?
- What should be the primary response of the counsellor?
- What can be done to protect the child in this situation?
- Is Couple and relationship counselling required to the couple for discussing about protection of the children from violence?

5. Psychological Impact of Trauma, Abuse and Violence

Learning Objectives

- Understanding Violence, Abuse and Trauma.
- Understanding Psychological impact of violence.
- Understanding the state of Mind
    - Cognition
    - Behaviour
    - Emotion
- Coping mechanisms to reduce stress resulting from trauma.

Violence

World Health Organisation has defined Violence as:

- the intentional use of physical force or power, threatened or actual,
- against oneself, another person, or against a group or community,
- which either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation."

Abuse

American Psychological Association defines Abuse as:

- Interactions in which one person behaves in a cruel, violent, demeaning, or invasive manner toward another person or an animal.

- Abuse can come in various forms, such as

- Pattern of harmful behaviour
- Verbal or physical
- Assault, violation
- Rape
- Unjust practises,
- Crimes and other types of aggression.

Trauma

American Psychological Association has defined trauma as

- Any disturbing experience
- that results in significant fear, helplessness, dissociation, confusion or other disruptive feelings,
- Intense enough to have a long lasting negative effect on a person's attitudes, behaviour, and other aspects of functioning".

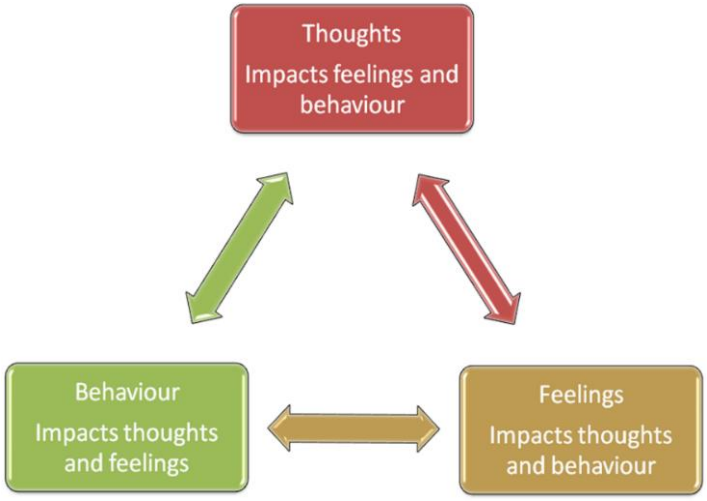
Why it is important to learn about psychological impact?

- People are not aware that they are being abused.
- Lack of self- awareness about their own mental health
- Identify vulnerable people and situation ,who are at high risk of violence, abuse and trauma
- Early prevention

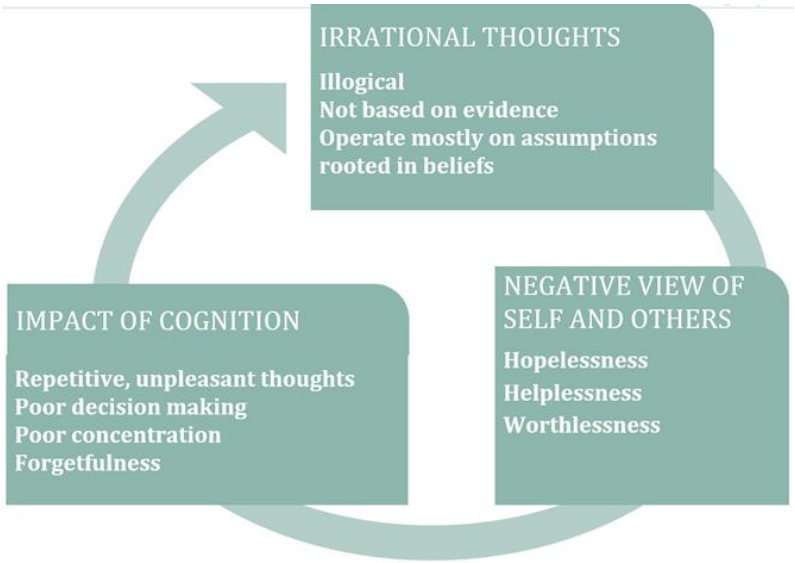
Let's understand: The State of Mind

Mind comprises of three main components:

- Thoughts (Cognition)
- Emotions (Affect)
- Behaviours (Conation)



Cognition



What does irrational thoughts look like?

“It was all my fault”

"I cannot share my problems with anyone”

"Whole world is like this, I cannot trust anyone anymore”

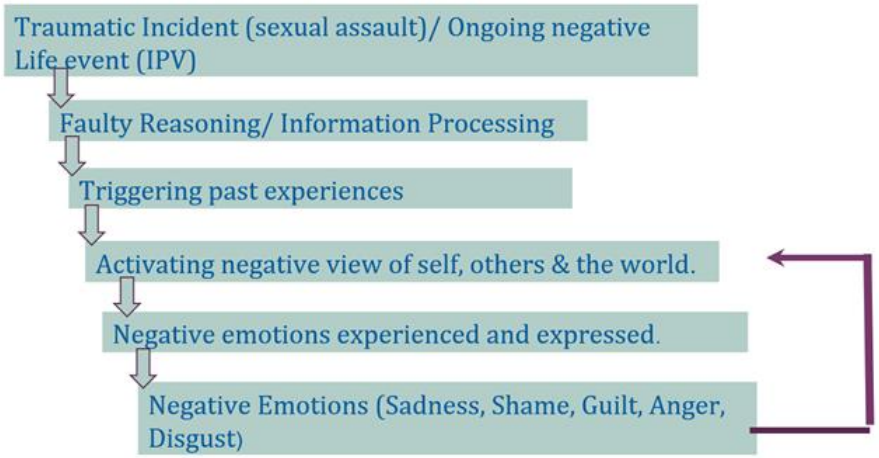
“I deserved to be punished, I cannot go against him “

“There is no point of living anymore”

“This is my fate; I have to accept it”

What are maladaptive emotions?

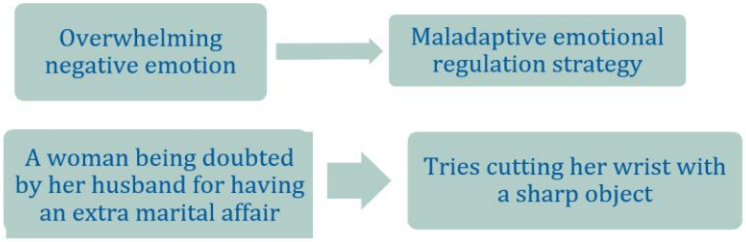
Maladaptive emotions are direct reactions to past situations that no longer help the person cope constructively with situations that elicit them in the present.



Some of the maladaptive emotions are as follows:

Emotional Dysregulation

Emotional dysregulation is the use of maladaptive emotion regulation strategies in the face of overwhelming negative emotions. Such strategies include self-harm, attempting suicide, or attempting to inhibit affect, excessive substance abuse.



Emotional suppression

Emotional suppression are the feelings consciously avoided because the person doesn't know exactly how to deal with it.

A woman constantly faces psychological abuse from her husband. He would regularly scream at her and demand her to do things that she does not like to do. She tries not to think about whatever he does as those feelings make her feel uncomfortable. With time, it is noticed that she has been experiencing pains in different parts of the body and mostly has a very low mood for weeks together.

Emotional repression

Emotional repression happens when uncomfortable emotions such as anger, frustration, sadness, fear are unconsciously avoided. This also leads to mental health conditions such as anxiety and depression.

A child who has abused by a parent, represses the memories and becomes completely unaware of them as an adult. These repressed memories of abuse may still affect this person's behaviour by causing difficulty in forming relationships.

Rumination

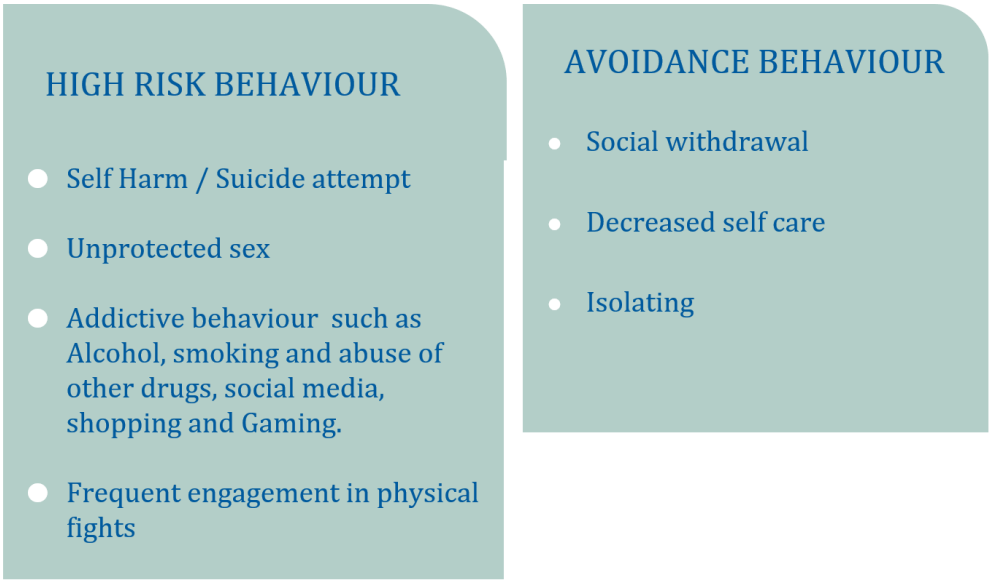
Rumination is defined as thinking repetitively and passively about negative mood states or about the causes and consequences of negative mood. Prolonged rumination is associated with Depression.

A woman was beaten by her husband a month back, she finds it difficult to forget because of the intensity of pain and shame that she had to go through in front of people. She would keep thinking about what happened whenever she is doing any work. The quality of household work and other chores get affected and she feels that she has not been able to concentrate well to complete the task, since all that she thinks about is how her husband had beaten her up in front of everyone a month ago.

What are maladaptive Behaviours?

- Behaviours that help in temporary relief from the intense emotions.
- Poor coping mechanism
- Behaviours that adapts, modifies, or adjusts poorly.
- Not able to cope in healthy, productive ways.
- When the behaviour is used to continuously avoid the perceived negative situation, maladaptation occurs.

Maladaptive Behaviour



What are Coping Mechanisms?

- Coping is defined as the thoughts and behaviours that people use consciously or unconsciously as a strategy while facing stressful situations. All individuals have basic needs to feel competent, to relate and to be connected to others, when there is a challenge or a threat to these needs coping strategies are used.

Types of Coping Mechanisms

- One way of classifying coping behaviours is having either emotion focused coping or problem focused coping.

- ✔ Emotion focused coping refers to people's efforts to manage their emotional responses to stress. For example venting, distracting oneself, denial.
- ✔ Problem focused coping strategies include thinking about solutions, taking direct actions to solve the problem, seeking help from others etc.

Healthy and Unhealthy Coping Mechanisms

Reflective Exercise:

Varsha, 17 years old had a boyfriend living few kilometres away from her house. One day her boyfriend on the pretext of taking her out, had kidnapped her and kept her in isolation for 4 days. He raped her along with some of his friends.

After 4 days he dropped her back in the place where she lives. Varsha's mother had filed a police complaint, but withdrew the complaint as she started receiving threats from the man who raped her.

People in the neighbourhood came to know about what had happened and had stopped other girls from talking to Varsha as they all blamed Varsha for what had happened. Varsha was very angry with herself and sad for having trusted a man.

In School some of her friends wanted to talk to her and make her feel better, but since she felt that everyone has been blaming her she withdrew herself from everyone.

She would always be alone, even at home, and wouldn't talk to anyone. She stopped playing, and doing other activities which she would earlier enjoy. She would constantly think of what had happened to her because of her boyfriend.

She would tell herself that "Now there is no point of living" and had made plans to jump off a building. Meanwhile when Varsha's mother asked her to be more active and help out in the house, she would mention about having constant body pain. She often gets angry at her mother and in several occasions have thrown objects out of anger.

Varsha's mother came to know about OSC and brought her to the counsellor. Varsha met the counsellor but mentioned about not wanting to talk about anything today as her head is hurting, the counsellor after doing a brief risk assessment gave some of the important helplines to call in times of emergency and asked her to come back whenever she feels like talking.

Varsha started coming for counselling sessions and only in the third follow up session mentioned about having been assaulted and spoke about how she doesn't feel like doing any work and wants to end her life as she feels that "Everything has come to an end because people know that she has been raped by her boyfriend".

She reported of feeling guilty and angry with herself, as others were blaming her for having a boyfriend. She reported of having frequent thoughts of ending her life. The counsellor noticed multiple slash (cut) marks on her left hand.

The counsellor told Varsha, that she has been going through a very difficult situation and that anyone in such a situation would feel the way she does and that it is not right how you got treated by your neighbours. The counsellor made a safety plan on suicide along with Varsha and other plans for the session were laid out.

Questions

- Identify the maladaptive emotions.
- Identify maladaptive behaviour and coping styles.
- Identify the maladaptive thoughts.

6. Mental Health Impact of Violence against Women

LEARNING OBJECTIVES

1. To understand the mental health impact among women facing gender based violence

2. To understand the identification and assessment of mental health among women facing gender based violence among women

Consequences of Intimate Partner Violence (IPV)

- Physical
- Mental
- Reproductive/ sexual
- Disorders

Physical Health Consequences

- Bruises, abrasions
- Abdominal injury
- Head injury
- Thoracic injury
- Sight and hearing damage
- Back and neck injury
- Broken bones or teeth

- Functional disorders or stress related conditions - irritable bowel syndrome, gastrointestinal symptoms, fibromyalgia, chronic pain symptoms, exacerbation of asthma

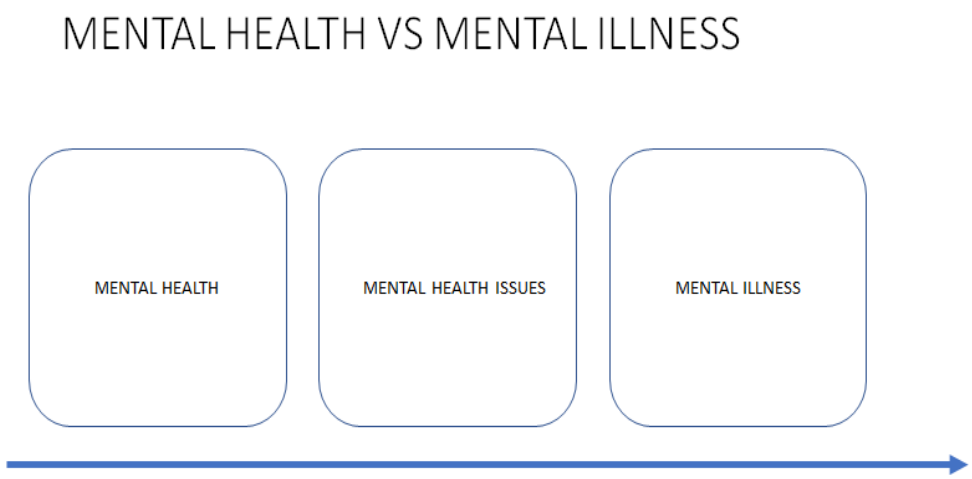
Mental Health Consequences

- Depression
- Anxiety
- Phobias
- Emotional distress
- Thoughts of suicide
- Attempted suicide
- Eating and sleep disorder
- Poor self-esteem and confidence
- Self-harm
- Post-traumatic stress disorder/ complex PTSD
- Psychosis
- Risky behaviours - substance abuse, smoking, unsafe sexual behaviours

Reproductive/Sexual Health -

- Unintended and unwanted or unplanned pregnancy
- abortion/unsafe abortion
- STDs - HIV
- Pregnancy complications
- Pelvic inflammatory disease
- UTI
- Sexual dysfunction
- Miscarriage
- Still birth
- Premature labour and birth

Understanding difference between mental health, mental health issues and mental illness



- MENTAL HEALTH - According to the World Health Organization (WHO), mental health is "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community"
- Mental illnesses are health conditions involving changes in emotion, thinking or behavior (or a combination of these). Mental illnesses are associated with distress and/or problems functioning in social, work or family activities. (APA)

Common versus Severe Mental Disorders

Common Mental Disorders

- Includes symptoms that everyone experiences sometime or the other in life
- They can be impairing everyday functioning and, in some cases, along with sometimes a person could be functioning well
- Anxiety,
- Depression

Severe Mental Disorders

- Often difficult for lay person to understand
- Impaired functionality
- Require immediate attention of mental health professionals
- Requires long term treatment and management
- Schizophrenia, Bipolar disorder, Psychosis

Ground Rules for assessment

- Sit in a quiet place
- Ensure privacy and confidentiality
- Make the client comfortable
- Keep all necessary things such as pencil, eraser, pen, paper with you
- Don't give assessment tools or performa to clients to take with them
- Keep the notes of your assessment out of reach of client
- There should be no interruptions from surroundings
- Build rapport before assessing for mental health concerns
- Behavioral observations must be noted
- Explain about the assessment – Why, What, When, How
- Listen actively and attentively
- Be empathetic
- Make sure to take Consent
- Non judgmental
- Clarification – if there is any confusion
- Don't generalize personal experiences

When not to do assessment

- When client refuses to talk or reports they are feeling tired, sleepy or lack of interest
- When client is angry, agitated, aggressive, violent
- When client cannot comprehend your questions or instructions
- When intoxicated – alcohol or other substances

- Immediate traumatic response, client is not speaking
- When the client is having severe symptoms – suspiciousness, personality issues
- In severe distress
- Not to do assessment in the first session itself
- Don't do assessment in tele counselling session

Steps to do assessment

- **Socio demographics** –name, age, marital status, socio economic status, domicile, educational qualification, occupation, religion
- **Main concerns of the client visiting**
- **Details of the main concerns** – When, What, Why, Whom and How
- **Mood -** how is your mood, how do you feel? How are you feeling?
- **Behavior** – observation (grooming, kempt, dressing, involuntary movements, eye contact, hygiene, is she able to concentrate, is she able to comprehend or follow the instructions)
- **Body language** – posture, relaxed, tense or restless, slow, hesitant, cooperative?
- **Biological functions** – sleep, appetite, menstrual cycle, bladder bowel movement
- **Socio – occupational functioning** – involvement in daily activities, involvement in work (if employed), social interactions – family, children, friends, neighbors, attending social gatherings etc.

What are the symptoms to look for to identify common mental disorders?

Anxiety

What symptoms to look for?

Physical symptoms

- Excessive sweating
- Palpitations
- Breathing difficulties
- Fatigue

- Sleep problems
- Muscle tension & pain
- Nausea, gastric problems

Thought & Feeling symptoms

- Apprehension
- Worry, fear of future
- Difficulty in concentration
- Racing thoughts
- Mental restlessness
- Irritability
- Feeling lost

Behavioral symptoms

- Inability to sit still
- Difficulty in focusing on tasks
- Difficulty in completing tasks
- Irritability
- Social withdrawal

How to assess Anxiety?

Questions to Assess Cognition (Thoughts)

- Do you worry a lot about things?
- Do you worry a lot about your future?

Questions to Assess Autonomic Symptoms

- Do you have increased heartbeat and sweating?
- Do you feel restless when you worry a lot?
- Do you find it difficult to focus on work and completing it?

Questions to Assess Emotion

- Do you feel fearful without any reasons?
- Do you feel more irritable then usual?

Severity of Anxiety

MILD - worries about future, native thoughts, able to do work, not significant physical symptoms

MODERATE – unable to focus on task, feeling restless, distressed, having racing thoughts

SEVERE – Severe physical symptoms (increased heartbeat, sweating etc), not able to do routine activities, difficulty in concentration and not able to complete tasks, fearful, on the edge, breathing difficulties

Depression

What symptoms to look for?

Physical Symptoms

- Fatigue
- Exhaustion
- Reduced appetite
- Increased/reduced sleep (early wakefulness)
- Weight loss
- Headaches
- Body pain
- Sensation of increased heart rate

Thought & Feeling symptoms

- Low mood
- Irritability
- Negative thoughts about self, future and others
- Difficulty in concentration
- Forgetfulness, indecisiveness

- Low self-esteem, guilt
- Decreased confidence
- Thoughts of death or suicide

Behavioral symptoms

- Frequent weeping
- Decreased interaction
- Poor self-care and grooming
- Lack of interest
- Long hours of inactivity
- Anger outbursts
- Self-harm

How to assess Depression?

Questions to Assess Cognition (Thoughts)

- Do you feel that there is no hope for the future and it is not worth living?
- Do you feel helpless at times?
- Do you feel that it is better to die rather than continuing this life?
- Have you lost interest in pleasurable activities?

Questions to Assess Behaviour

- Do you have sleep disturbances very frequently?
- Do you think you have lost weight in the last few weeks because of less or no eating?
- Have you lost interest in activities that interested you earlier?
- Are you able to do your daily chores properly?
- Do you feel tired all day?

Questions to Assess Emotions

- How is your mood for the past two weeks?
- Do you feel excessively sad?
- Do you feel like crying often?

Severity of depression

MILD – Mild changes in mood, feeling low or sad, not feel like talking to people, but able to do all household chores and other activities

MODERATE – low and sad mood, getting tired easily, decreased social interactions, mood and thoughts create difficulty in daily activities (Important to refer to MHP)

SEVERE – Suicidal thoughts, unable to do daily activities, poor self-hygiene, death wishes, social withdrawal, negative thoughts of self, others and future, feelings of guilt (Important to refer to MHP)

NOTE – Important to assess for suicide in depression

Somatization Disorder

- Causes one or more bodily symptoms e.g. Pain
- Unexplained medical symptoms
- These symptoms cause significant emotional distress
- These symptoms are multiple and recurrent in nature
- The distressed experienced from pain and other problems is real regardless of whether or not there is medical explanation to the symptoms
- There is a constant worry about potential illness
- There is a feeling that medical evaluation and treatment have not been adequate
- There is frequent and repeated checking body for abnormalities

Symptoms

- **Pain** is the most commonly reported symptom. Areas of reported pain can include chest, arms, legs, joints, back, abdomen, and other areas.
- **Neurological symptoms** such as headaches, movement disorders, weakness, dizziness, fainting
- **Digestive symptoms** such as abdominal pain or bowel problems, diarrhea, constipation
- **Sexual symptoms** such as pain during sexual activity or severe pain during periods

How to assess Somatization?

- Do you frequently have aches and pains all over your body?
- Do you frequently have aches and pains on specific parts of your body?
- Have you visited many doctors to treat aches and pains?
- Do you take lot of medications or self-medication to get rid of aches and pains?
- Do you also feel sad or stressed out when you have aches and pains?
- Has you sleep and appetite been affected significantly?
- Do these physical complaints affect your daily routine and your social life?
- Do these physical complaints restrict your mobility?

Dissociation

Dissociation is disconnection & lack of continuity between thoughts, memories, surroundings, actions and identity.

An individual experiencing dissociation may feel as though things around them are unreal.

It may occur as a coping mechanism for an individual, to put some distance between themselves and the traumatic situation.

Symptoms

- Experiencing flashbacks of traumatic events
- Inability to remember things for some time

- Losing memories about certain people, places, information, events, or specific periods
- A blurred or distorted sense of reality
- A feeling of numbness and disconnection towards one's environment
- A distorted sense of place and time
- A feeling of detachment from one's emotions

Post-Traumatic Stress Disorder (PTSD)

PTSD is a lasting consequence of traumatic events that cause intense fear, helplessness, or horror.

Complex PTSD: Experienced by people who have repeatedly experienced traumatic events, such as violence, neglect or abuse.

In PTSD, the experience of traumatic event may not be experienced repeatedly

Symptoms

- Night terrors
- Nightmares
- Fearfulness
- Flashbacks
- Disturbed sleep
- Avoidance of situations and triggers related to violence
- Negative beliefs about oneself
- Hyper vigilance

What is Flashback?

- Distressing memory of the trauma
- Unwanted & intrusive in nature
- Reliving the trauma as if it was happening now
- Takes over all the senses

What is Hyper vigilance?

- It a state of heightened alertness accompanied by behavior that aims to prevent danger
- Person is extremely sensitive to environment
- Physical symptoms –breathing very quickly, restlessness, increased heart rate
- Behavioral symptoms – jumpy reflexes
- Emotional symptoms – fear, panic, worry

What are Night terrors?

- Also known as sleep terrors
- During a night terror, a person appears to awaken and scream or shout in terror
- The content is not remembered
- They cause increased heart rate, flushed skin, sweating and kicking and thrashing in bed

What is Nightmare?

- Unpleasant dreams that are usually remembered upon waking
- Start after traumatic event
- Follow the experience of trauma and often involve the same elements that were in the trauma
- Signs – sweating, increased heart rate, fearful

How to assess PTSD?

- Do you get scary dreams which bother you a lot?
- Do you have flashbacks of past painful events?
- Does anything remind you of your past painful events such as any program on the TV or newspaper? Do you avoid them?

- Do you become vigilant or alert on listening to some sudden sound or something which makes you fearful?
- Do you feel fearful sometimes?
- Do you have disturbed sleep?
- Do memories of your past painful event keep intruding in your thoughts which you are not able to control?
- Do you try to avoid thinking of past painful experiences?

What are the symptoms of severe mental disorders?

Behavioural Symptoms

- Aggressive behavior
- Disorganized behavior such as eating dirt/mud
- Talking to self
- Poor self-hygiene
- Loss of social skills
- Withdrawal from friends and activities (Isolation)

Emotional Symptoms

- Extreme mood changes of highs and lows
- Difficulty in understanding & handling emotional experiences
- Laughing and smiling inappropriately without any reason
- Making big and unrealistic plans

Thought related symptoms

- False beliefs e.g. – People are plotting against me; I am God's messenger and I have powers to save the world
- Inability to think rationally (lack of logic)
- Suspiciousness (having, fixed and rigid beliefs about things that are not true)
- Disorganized thinking leading to disorganized speech

- Inability to concentrate
- Hearing voices

Referral Process

When to refer?

- Risk of self- harm or suicide
- Survivor is so depressed, that she cannot do any day-to day activities
- Severe flashbacks, nightmares, anxiety or other symptoms of PTSD
- Psychological distress persists despite counselling
- Psychosis or severe mental illness
- Difficulties in individual, social and occupational level

Whom to refer?

- Psychiatrist
- Clinical Psychologist
- Psychiatric Social Worker
- Counsellors
- District Mental Health Program
- Primary Care Doctor

How to refer?

- Set up an appointment
- Call the mental health professional and brief them about the case
- Make a referral letter
- Follow up after the referral
- Give feedback to the survivor

Reflective Exercise:

Ms. Reena is a 26 years old married female. She has studied B.E. and is a homemaker. She has been married for 1.5 years. Her relationship with her husband was good for the first 2 months of marriage, but later she says her husband started getting angry on trivial things and would shout and yell at her. He would not like her to go to work, would doubt her, argue with her every day, and check her phone, so she decided to leave her job to avoid any such conflicts at home. But it didn't help for long, after some days of nice behaviour, he started physically abusing her- hitting her and punching her in the stomach. He would verbally abuse her, criticize her in front of relatives often. These behaviours of husband have been disturbing her a lot. She says she is having trouble sleeping, and wakes up frightened in the middle of night. Her mood is low most time of the day and she reports that she doesn't feel like talking to anyone. For the past few weeks, she has been often experiencing a recurring nightmare where a woman is being pushed and hit by her partner and finds herself alone crying in a small room. Most mornings she wakes up very early in the morning and isn't able to go back to sleep. However, she finds it difficult to get out of the bed throughout the day and if she is able to push herself out of bed, she reports of feeling low on energy and gets tired quickly. Reena also reports of feeling lost, sitting and staring in one place, feeling uneasiness and restlessness in her body. She tells that her mind is constantly thinking about worse situations that would happen to her and her children. While doing her everyday chores, she experiences flashbacks of being hit by her husband and gets very scared. She is not able to do her routine activities properly as suddenly after the flashbacks her heartbeat increases and she finds herself stuck. Her interaction with her children and family has also reduced significantly

Questions:

What types of violence do you identify in the case?

List the symptoms reported in the case vignette.

When will you refer them to a psychiatrist or a mental health professional?

7. Suicide Risk related to Gender-Based Violence against Women and its Assessment

LEARNING OBJECTIVES

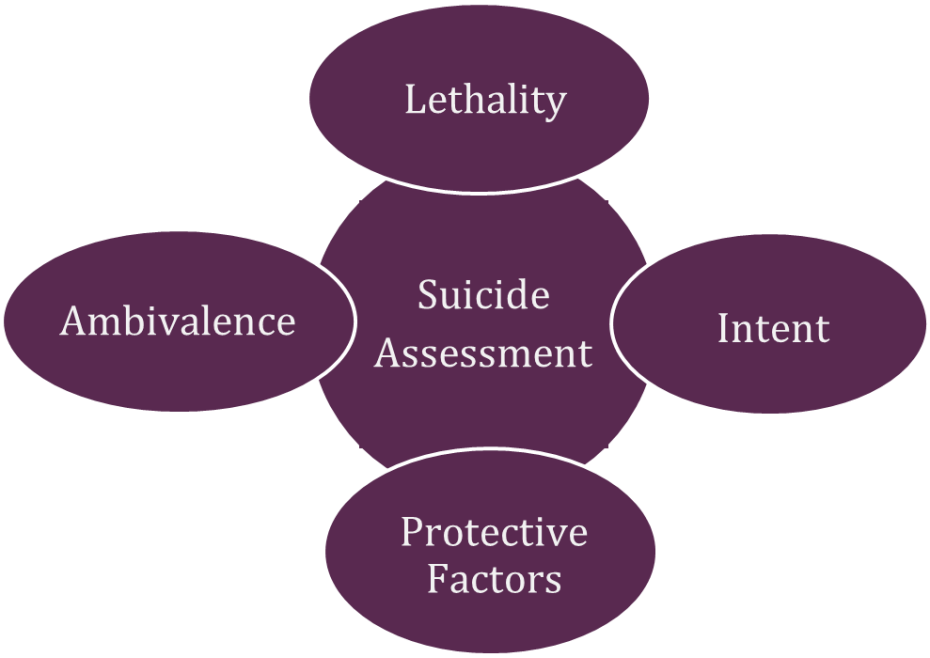
1. To identify risk factors of suicide and assessment of suicide among women facing violence

Suicide and Self harm

Suicide - A process of purposefully ending one's life

Self-harm - Self-inflicted injury such as cutting or burning is described as a way of expressing very deep distress of regaining some control over it.

Suicide Assessment



How to assess intent?

- Wish to live
- Wish to die
- Reasons for living – suicide counters
- Reasons for dying
- Desire to make active suicide attempt

How to assess lethality?

- Specificity/planning of contemplated attempt
- Availability/opportunity for contemplated attempt
- Sense of "capability/capacity" to carry out attempt
- Expectancy/anticipation of actual attempt
- Actual preparation for contemplated attempt
- Suicide note
- Deception/concealment of contemplated suicide

Suicide ambivalence

Most people have mixed feelings about dying by suicide/attempting suicide. The wish to live and the wish to die wage a see-saw battle.

There is an urge to get away from the pain of living and an undercurrent of the desire to live.

Many suicidal persons do not really want to die - it is just that they are unhappy with life.

If support is given and the wish to live is increased, the suicidal risk is decreased.

Protective factors

- Support system
- Problem solving skills and coping skills, ability to adapt to change
- Self-esteem and a sense of purpose or meaning in life
- Cultural, religious, or personal beliefs that discourage suicide

Risk factors

- Experience of trauma -violence/major life event (e.g. rape)
- Experience of chronic stress (e.g. domestic violence/IPV)
- Mental disorder (e.g. depression)
- Previous history of suicide attempt
- Lack of support

Warning Signs of Suicide

- Talking about the desire to die or to kill oneself
- Looking for a way to kill oneself such as searching online or storing pills or pesticide
- Talking about feeling of hopelessness or having no reason to live, feeling trapped, burden to others
- Signs of anxiety and agitation and reckless behavior
- Sleeping for too little or too much time
- Withdrawn or isolation
- Showing rage or talking about seeking revenge
- Extreme mood swings

Myths & Facts about Suicide

1. **Myth** – Suicide attempt/thought is a sign of weakness
   Fact – It is a cry for help.

2. **Myth** – Once someone is suicidal, he/she will always remain suicidal
   Fact – Suicidality is not permanent
   Heightened suicide risk is often brief lasting and situation specific

3. **Myth** – A survivor of suicide never makes further attempts
   Fact – Past attempt(s) is/are a strong indicator of increased risk for further attempts, especially after a sudden change in mental state following a suicidal or depressive period

4. **Myth** – Talking about suicide will encourage people to die by suicide

   Fact – Talking about suicide– opportunity for communication

   Asking people about suicidal thoughts helps us to identify people at risk and provide help; suicidal people are often looking for help

5. **Myth** – Only people with mental illness are suicidal

   Fact – 1 in 5 people have thought about suicide at some time in their life.

   Not all people who die by suicide have mental health problems at the time they die. However, many people who kill themselves do suffer with their mental health, typically to a serious degree

6. **Myth** – Suicide is hereditary and runs in families

   Fact – Although persons with family history of suicides/attempted suicide are biologically vulnerable, not all persons who attempt have a family history

7. **Myth** – Individuals with a specific personality attempt/die by suicide

   Fact – Anyone can have thoughts of suicide and act upon it irrespective of their personality style.

   Suicide is a complex behavior that depends on not one but multiple factors, e.g.: social humiliation, financial crisis

8. **Myth** – Most suicides happen suddenly without warning

   Fact – Majority of suicides are preceded by prominent warning signs for days, weeks or months. It is important to identify them

9. **Myth** – People who talk about suicide don't really mean it & just do so to seek attention

   Fact – People who are talking about suicide may be reaching out for help or support.

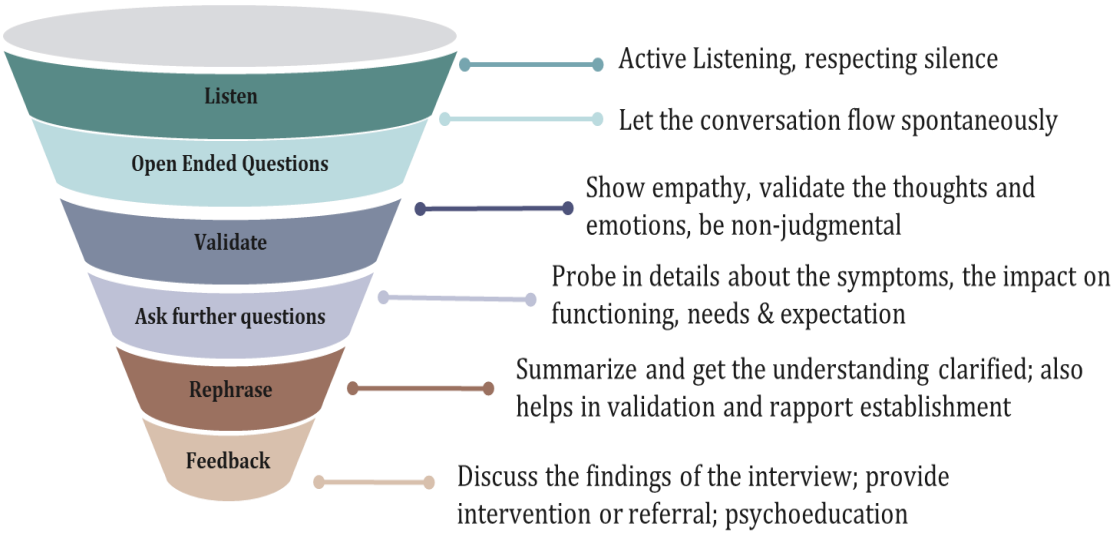
   Do not dismiss a suicide attempt as simply being an attention-seeking behavior

10. **Myth** – Only experts can intervene and prevent suicide. Not all suicides are preventable

    Fact – Anyone who is sensitive to pick up warning signs of suicide can help by emotional support & encouragement.

    Though not all suicides can be prevented but a majority can be predicted and prevented

Suicide Interview & Assessment



Dos of Assessment

- Be empathetic in assessment
- Ask more of open-ended questions
- Show your concern to help while doing the assessment
- Listen to the response; give time and respond gently; validate
- Observe the nonverbal behaviour

Don'ts of Assessment

- Do not be too eager to ask the questions without adequate rapport
- Do not interrogate; interrupt or judge
- Do not trivialize the experiences of problems; do not force positivity
- Do not do assessment as a routine work

8. Psychological First Aid for Women facing Violence

LEARNING OBJECTIVES

To understand:

- What is Psychological First Aid? (PFA)
- Psychological First Aid - When, Where and to Whom?
- Why do we need Psychological First Aid?
- World Health Organization - LIVES Model
- How do we do Psychological First Aid? – Process of PFA
- Dos and Don'ts of Psychological First Aid

Introduction

Psychological First Aid is a humane, supportive & practical assistance to fellow human beings who recently suffered a serious stressor. Example: Disaster, death of a loved one, accident, robbery, assault, abuse, violence, loss and so forth.

Primary Goals of Psychological First-Aid

- Non-intrusive and non-judgmental
- Practical care and support
- Supportive & crisis intervention (comforting people and helping them to feel calm)

Psychological first aid provides practical care and responds to a woman's emotional, physical, safety and support needs without intruding on her privacy. It aims at assessing needs and concerns (helping people to address basic needs (food, water, shelter), helping people connect to information, services and social supports, protecting people from further harm (safety plan) and listening, but not pressuring people to talk.

Principles of Psychological first-aid

- Respect Safety, dignity and rights:
- Adapt to the need and take into account the person's culture
- Be aware of other emergency response measures
- Look after yourself

These principles should be used together irrespective of age, gender or ethnic background. Considering these principles in terms of their cultural context ensure that the women and children you help are safe and protect them from physical or psychological harm. Treat them with respect and according to their cultural and social norms. Make sure they can access help reasonably and without discrimination. Act only in the best interest of any person you encounter and help them claim their rights and access available support.

What is not a Psychological First Aid?

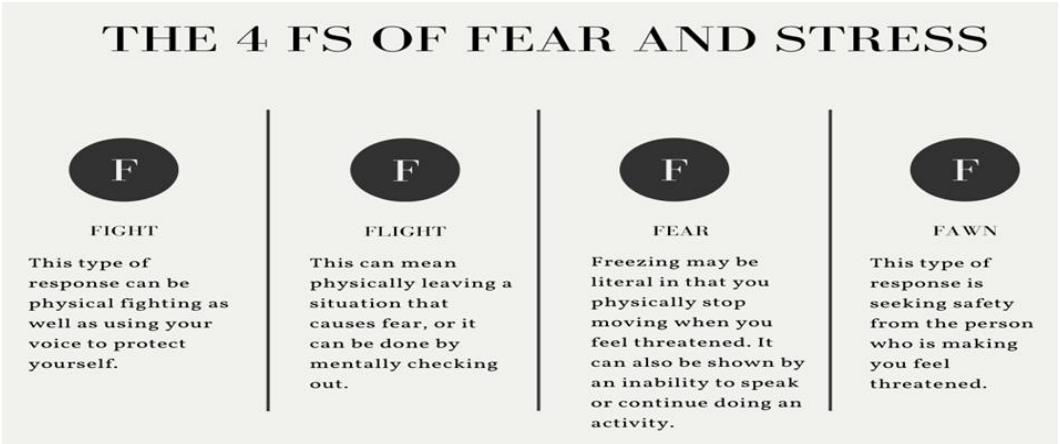
- It is not professional counselling (not something only professionals can do)
- It is not 'psychological debriefing' (not a clinical or psychiatric intervention - although it can be part of good clinical care)
- It is not asking people to analyze what happened or put time and events in order
- It is not pressuring people to tell you their story or asking details about how they feel or what happened

Psychological First Aid: Who? Where? When?

- Psychological First Aid can be provided to an individual who has recently experienced a crisis and is experiencing distress
- Psychological First Aid can be provided anywhere that is safe, ideally with some privacy as appropriate to the situation
- Psychological First Aid can be provided when a person is encountering distress, usually immediately following a crisis event

Why to do Psychological First Aid?

Amygdala is responsible for emotional response and gets activated after a trauma like violence or assault of any kind. It attaches meaning to memories. It activates Fight, Flight, Freeze or Fawn response and HPA – axis (stress response) and activates the Sympathetic nervous system. It often enlarges in people with anxiety or PTSD.



LIVES Model (World Health Organization)

L - Listen: Active listening is the crucial step in providing psychological first aid. Active listening involves:

- Being patient and calm;
- Let her know you are listening; for example, nod your head or say 'hmm'
- Acknowledge how she is feeling;
- Don't look at your watch/computer or speak too rapidly.
- Don't judge what she has or has not done or how she feels. Don't say: "You shouldn't feel that way," or "You should feel lucky you survived," or "Poor you".
- Allow her to say what she wants. Ask, "How can we help you?"
- Encourage her to keep talking if she wishes. Ask, "Would you like to tell me more?"
- Don't assume that you know what is best for her.
- Don't interrupt. Wait until she has finished before asking questions.
- Don't pressurize to speak; allow pauses and silence

I - Inquire about needs & concerns

While listening to the woman, pay special attention to what she says about her needs and concerns – and what she doesn't say but hints at with words or body language. She may let you know about her physical needs, emotional needs, or financial needs, her safety concerns or social support she

needs. You can use the following techniques to help her express her needs and make sure you understand.

- Phrase your questions as invitations to speak:
  "What would you like to talk about?"
  "Would you like to talk about your needs?"
- Ask open-ended questions (Instead of yes/no questions)
  "How do you feel about that?"
- Check your understanding (repeat what she says; rephrase & summarize)
  "You mentioned that you feel very frustrated."
- Validate & reflect her feelings:
  "It sounds as if you are feeling angry about that" or "You seem upset."
- Explore as needed.
  "Could you tell me more about that?"
- Ask for clarification if you don't understand.
  "Can you explain that again, please?"

V - Validate

Validating her feelings means letting the person know that you are listening carefully, understand what she is saying, and believe what she says without being judgmental. Validating that her feelings are normal, safe to express and she has a right to live without violence and fear.

Important things that you can say:

- It's not your fault. You are not to blame."
- "It's okay to talk."
- "Help is available." [Say this only if it is true.]
- "No one deserves to be hit by her husband."
- "You are not alone. Unfortunately, many other women have faced this problem, too."
- "What happened has no justification or excuse."
- "Your life, your health, you are of value."
- "Everybody deserves to feel safe at home."

- "I am worried that this may be affecting your health."

E - Ensure & Enhance Safety

Many women who have been subjected to violence have fears about their safety. Other women may not think they need a safety plan because they do not expect violence to occur again. Explain that partner violence is unlikely to stop spontaneously. It continues, worsens over time, and can happen more often. Safety assessment and planning is an ongoing process, not a one-off conversation.

- Assess safety after sexual assault or episode of intimate partner violence
- Assess the immediate risk of partner violence
- Find out whether there is any immediate risk of serious injury or it is safe to go home

<u>If NOT safe:</u>

- Help make a safety plan
- Make referrals (for example, shelter home, safe housing)
- Help identify a safe place where she can go
- Make a safety bag

<u>Be Cautious:</u>

- Talk about abuse only when you and the survivor are alone
- Maintain confidentiality of health records
- Discuss how she can explain where she has been when asked at home
- Discuss what to do with any paperwork that she will take home

S - Social Support Facilitation

Women's needs generally are beyond what you can provide in the One Stop Centre. You can help by discussing the woman's needs with her, telling her about other sources of help, and assisting her to get help. Based on her needs, you can connect a woman with other resources for her health, safety, and social support.

- Help her to identify and consider her options and what is most important to her
- Discuss her social support –she may prefer to rely on her informal network. Discuss her social support. Does she have a family member, friend, or trusted person in the community whom she could talk to? Does she have anyone who could help her with money?
- Connect her to resources through warm referrals

Dos & Don'ts of Psychological First Aid

Dos	Don'ts
Identify needs and concerns	Try to solve her problems
Respond to emotional, physical, safety and support needs	Try to convince her to leave a violent relationship/to go to the police or courts
Listen & validate experiences & concerns	Ask questions that force her to relive painful events
Help her feel connected to others, calm and hopeful	Ask her to analyze what happened or why
Empower her to feel in charge and control	Pressurize her to tell you her feelings & reactions

9. Psychological Interventions to Address Trauma related to Violence faced by Women

LEARNING OBJECTIVES:

- What is Psychological intervention?
- Relaxation techniques while providing psychological intervention
- Various psychological intervention techniques and its application
- Basic Counselling Skills
- Enhancing Self Efficacy
- Mental Health Referrals

Let's understand what psychological intervention is:

- Psychological interventions are performed to bring about changes in people.
- A wide range of intervention strategies exist and are directed towards various types of issues.
- It helps in understanding and treating the impact of violence experienced and how to manage the difficult emotional state or feelings.
- These interventions when effectively applied result in improved self-esteem, self-mastery, self-control and many other benefits in the life a survivor.

Now Let's Understand about Basic Counselling Skills

Basic Counselling skills	
Active listening:	Eye contact, nodding, saying hmm…I see... Whenever needed, Knowing when to use open and close ended questions, summarising, paraphrasing.
Empathy	Respectfully perceiving what the survivor is bringing from their frame of reference and communicate that back in a way that makes the client feel understood
Facilitating ventilation of feelings:	Ask open ended questions.
Validating her feelings	Making her feel that there is nothing wrong in feeling what she is feeling. Saying "Anyone in your situation would have felt the same way and it's natural to feel angry."
Providing reassurance	Assure her you are there to help her, but remember no to give false assurance. Saying "You look much better to me now than the first time we met.", "You've been experiencing this for a while now, it'll take some time for it to go away ". To Deal with guilt and shame you can say "It's not your fault".
Encourage problem solving:	Help her analyse the problem rationally and see the pattern in violence, Help her come up with alternatives after weighing the pros and cons.
Empower and enable resilience	Restore confidence and self-esteem by pointing out all the courage, strength, and positive ways of coping. Encouraging them to be a part of support groups.
Discuss support systems	Family, Relatives, neighbours, work place and other legal support system such as legal, medical and media.

Supervision of counsellor/ health professional	The process can be emotionally draining for the counsellor. Counsellors to beware of their own vulnerabilities and biases, and ensure that it is not interfering with the counselling process.

Dos in counselling:

- Listen
- Maintain Eye contact
- Show interest
- Respect
- Accept
- Problem oriented not person oriented
- Maintain Confidentiality
- Read up the case before follow up sessions
- Let the client set the pace
- Provide privacy and safe space as much as possible.

What should not be done in Counselling
Making decisions for the client.
Being biased or judgemental.
Criticizing the client for leaving/ not leaving the relationship.
Forcing clients to do or talk about things that she is not comfortable about.
Acts of breach of trust/confidentiality or being sworn to secrecy.
Not giving importance to suicidal or self-harm statements by the client.
Talk negatively/derogatorily about the woman's spouse.
Do not rush. Do not force her to talk if she is reluctant.
Do not talk in an open place in front of others
Do not check your phone, or allow anyone to enter the counselling room during the session

Now we will learn about various techniques

Relaxation Techniques

1. Diaphragmatic deep breathing

- Close your eyes.
- Inhale through your nose with a long deep breath, very slowly, filling your stomach with air.
- Exhale very slowly through the mouth, till the air is fully released.
- While exhaling, tell yourself to 'Relax' in your mind.
- Repeat this process till you feel calmer and relaxed.

2. Mindful Breathing

- Sit comfortably, with your eyes closed and your spine reasonably straight.
- Bring your attention to your breathing.
- Imagine that you have a balloon in your tummy. Every time you breathe in, the balloon inflates. Each time you breathe out, the balloon deflates.
- Notice the sensations in your abdomen as the balloon inflates and deflates. Your abdomen rising with the in-breath, and falling with the out-breath.
- Thoughts will come into your mind, because that's just what the human mind does. Simply notice those thoughts, then bring your attention back to your breathing.

3. Grounding Exercise

It is a set of simple strategies that can help you detach from emotional pain (e.g., anxiety, anger, sadness, self-harm).

Helps in healthy detachment/distraction by focusing on something other than the difficult emotions you are experiencing

For e.g., Take a deep breath, imagine yourself sitting in a peaceful place, maybe there are mountains covered with clouds, tell yourself – I am safe now, what happened was in the past, I am now in the present

Mental	Physical	Self-talk
5-things that you can see around you	Make a comfort bag.	Talking to yourself in a kind way
4- things that you can touch	Contents in the bag to be significant to the individual that would helping in soothing	Saying coping statements such as " I can handle this", "This feeling will pass"
3- things that you can hear	It can be connected to the 5 senses.	Planning a safe treat for yourself Such as your favourite meal, wearing your favourite outfit.
2- things that you can smell around you	Foe ex- familiar perfumes, jasmine fragrance, coffee beans, toys, touch of a fuzzy object	Painting, drawing or writing to express your feelings
1- thing that you can taste		

4. Mood Diary

Monday	☹ 😐 ☺ 1 2 3 4 5 6 7 8 9 10	+ Good things today: - Bad things today:
Tuesday	☹ 😐 ☺ 1 2 3 4 5 6 7 8 9 10	+ Good things today: - Bad things today:
Wednesday	☹ 😐 ☺ 1 2 3 4 5 6 7 8 9 10	+ Good things today: - Bad things today:
Thursday	☹ 😐 ☺ 1 2 3 4 5 6 7 8 9 10	+ Good things today: - Bad things today:
Friday	☹ 😐 ☺ 1 2 3 4 5 6 7 8 9 10	+ Good things today: - Bad things today:
Saturday	☹ 😐 ☺ 1 2 3 4 5 6 7 8 9 10	+ Good things today: - Bad things today:
Sunday	☹ 😐 ☺ 1 2 3 4 5 6 7 8 9 10	+ Good things today: - Bad things today:

5. Activity Schedule

This is a way of structuring one's day according to activities that are avoided and which is consistent with one's valued direction.

- There are two kinds of activities in an individual's life, such as activities which give pleasure and activities giving mastery (productive).
- We should identify activities which provide both pleasure and mastery, which is different for all individuals.

Some examples of Pleasure and Mastery Activities	
PLEASURE	**MASTERY**
Talking to friends	Gardening
Spending time with pets	Going to work
Shopping	Artistic activities like painting, singing
Reading	Solving a problem

6. Sleep Hygiene

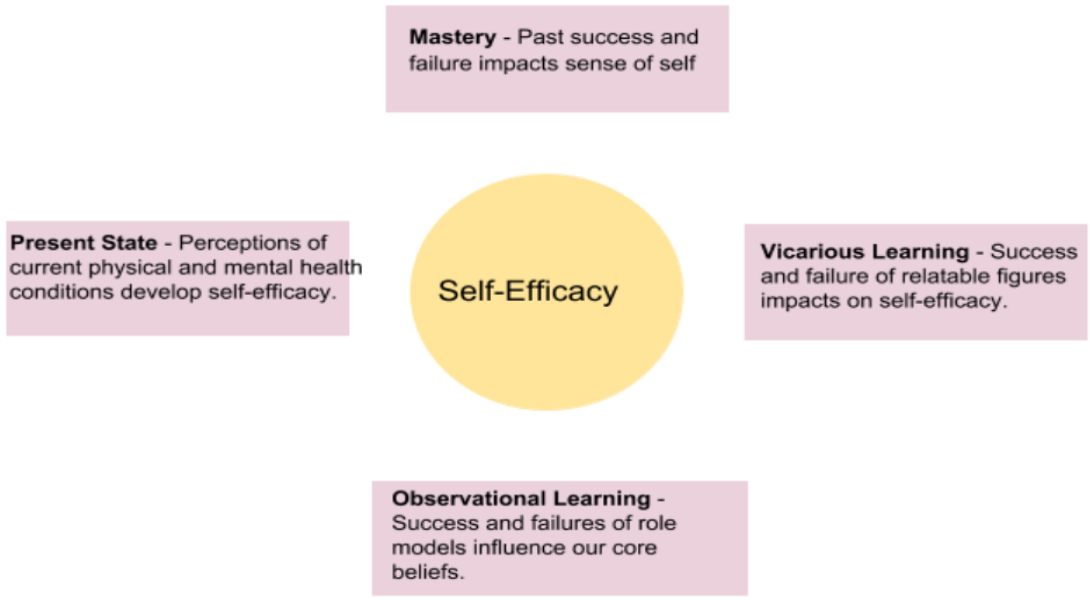
Making sure you get a good quality sleep defines the overall quality of mental and physical health. Some of the ways of maintaining sleep hygiene are as follows.

- Room to be dark, with a dim night light while sleeping
- Avoiding tea/coffee or any energy drinks after 6pm.
- Avoiding the use of mobile phone or watching TV before sleeping.
- Maintaining regular time of going to sleep and waking up every day.
- Having light Dinner and heavy breakfast.
- Physical exercise during the day.

- Avoiding or reducing day time sleep.
- Avoiding any stimulating exercise or any work before sleep.

Psychological Intervention	When to Use?
Deep Breathing, Mindful Breathing	Anxiety, Depression (Mild symptoms), Somatization, Sleep problems, General state of distress
Mood Diary	Frequent mood swings and emotional dysregulation, high level of anger
Grounding Techniques	Extreme emotional pain, flashback, hyper vigilance, dissociation
Activity Schedule	When general functioning is disrupted due to psychological symptoms (like in depression)
Sleep Hygiene	Sleep related problems due to psychological causes

Enhancing Self- Efficacy



Internal and External Sources Of Self-Efficacy

4 ways to enhance self-efficacy in your everyday life

- Stay in stretch zone- Make most use of their abilities.
- Set simple goals- Set goals reasonably and break into sub-goals.
- Look at the bigger picture- Look beyond short-term losses.
- Reframe obstacles- Look at obstacles as challenges and reconstruct the way we look at failures.

Removing Victimhood

What is Victimhood?

- Victimhood is "an ongoing feeling that the self is a victim, which is generalized across many kinds of relationships. As a result, victimization becomes a central part of the individual's identity."
- They believe that one's life is entirely under the control of forces outside one's self, such as fate, luck or the mercy of other people.
- Victims constantly talk about their past and their causes-effect rather than discussing possible solutions.
- Victims may also constantly seek recognition for one's victimhood.

Removing Victimhood: From victimhood to growth

- As socialization processes can instil a victimhood mind set, it can also instil a personal growth mind set.
- Traumas don't define and us and do not form the core of our identity.
- It is possible to grow from one's trauma.
- One can use the experiences in life, toward working to instil hope to others in a similar situation.

Trauma Informed Care (TIC)

- It is a holistic approach evaluating the effects of trauma on survivors, taking steps to address trauma and empowering survivors to experience a sense of security and recovery.
- TIC shifts the focus from "What's wrong with you?" to "What happened to you?".

TRAUMA INFORMED CARE	
REALISE Trauma affects all aspects of a person's life.	**RECOGNISE** The symptoms
RESPONDING On an individual and organisational level in a way that promotes healing.	**RESIST** Re-traumatization

Referrals for mental health care

- The counsellor should develop a network with other professionals.
- Accompany women and their families or make an introductory call, to prevent women from reliving trauma.
- Referrals can be made to:

- Women's organizations
- Legal professionals
- Mental health professionals

Reflective Exercise

Amina, a 38 year old female, has been married for the last 11 years. She has studied upto 8th standard and is a homemaker. She has 3 children (9 year old son, 7 year old daughter and 5 year old daughter). Amina ever since the time of her marriage, has been facing physical and verbal violence from her husband.

Unable to bear anymore, she has reported to OSC and meets the counsellor. The counsellor sees that Amina looks distressed and asks how she can help her.

Amina refuses to talk initially and keeps crying, the counsellor gives her own time and informs her that she can share about her concerns as much as she is comfortable and that it would be confidential and offers some water. The survivor later opens up about how her husband has been drinking alcohol ever since the time of marriage and would beat her stating that she does not do the household chores as expected. Amina tells the counsellor that she feels guilty to have failed as a successful wife and asks the counsellor about how she can become a better wife so that her husband doesn't beat her.

Amina also tells the counsellor that all three children witness the violence, and at times they also get beaten up. The husband would also send the oldest son to go buy Alcohol for him and when Amina tries to stop, he would beat her up again. Whenever violence escalates Amina goes to her mother's house which is nearby and spends few weeks there.

Even though Amina acknowledges that her maternal family is supportive, and would continue to support her even if she chooses to leave her husband, she believes that a woman's place is in her husband's house and yearns for him to love her.

The husband would come to Amina's maternal house, and would apologize for his behaviour and would request her to come back home. Amina feels that her husband has changed and goes back to live with him, but within 1-2 days, he starts to drink again and beats her up.

This cycle of violence has been repeating since 11 years where Amina leaves her husband, goes to her maternal family and comes back to him and again faces violence.

Amina wants the counsellor to make her husband love her, so that she can live happily with him. Amina also tells the counsellor that she finds it difficult to concentrate in her work and keeps crying the whole day.

The counsellor tries asking about her support system and other ways how the survivor needs any help, but the survivor keeps coming back to the topic of how her husband hits her on a regular basis and that she feels belittled. The counsellor finds it difficult to ask Amina about anything else, as her focus of conversation is on being beaten up.

Questions

- How did the counsellor make Amina feel comfortable when she initially visited?
- Identify the cycle of Violence and what are your thoughts on Amina's statement of "becoming a better wife so that her husband does not hit her?"
- What interventions would you plan here in this situation?
- Discuss the ground realities that the counsellor has faced.

10. Ethical and Professional Issues in Counselling Practice

LEARNING OBJECTIVES:

- To understand the importance of ethics
- To discuss various ethical pillars of counselling and its process
- To acknowledge the ethical importance of confidentiality and its limits
- To demonstrate common ethical issues in counselling

Ethical Principles in Counselling:

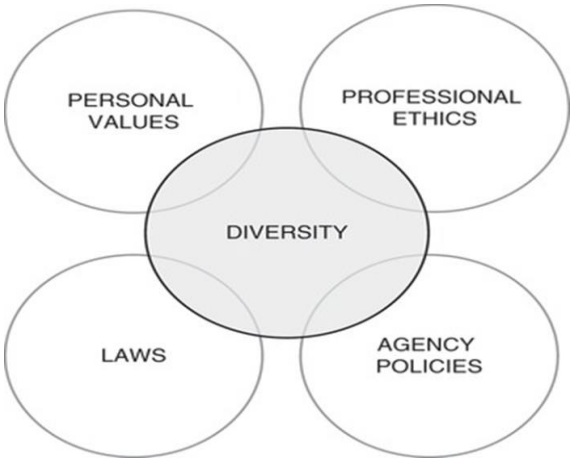
- Working with women facing violence is filled with several ethical dilemmas.
- Maintaining ethical standards contributes to the welfare of any organization as well as the development of the individual.

Our ethics guide us through -

- Respecting and recognizing each individual's right to make decisions and act according to their beliefs and wishes
- To form a commitment to benefit the client
- Not to harm others intentionally
- A fair distribution of services within society
- It helps the counsellor to differentiate among:
    - ➢ Being friendly vs. friends
    - ➢ Being with the client, not becoming the client.

- It helps to avoid “rescuer” roles such as providing sponsorship, lending them money, assisting the client in child care etc.

Ethical dilemma



Ethical Principles in Counselling

Main ethical principles of counselling	Integral part of counselling
● Beneficence ● Non-maleficence ● Autonomy ● Justice	● Confidentiality ● Being trustworthy ● Patience ● Genuineness ● Unconditional positive regard ● Professional responsibility

Main Ethical Principles of Counselling

Beneficence:

- Beneficence refers to acting to the best interest of the client.
- Providing services based on adequate training, experience and supervised practice.
- Understanding one's limits of competence.
- Providing assistance to clients whose capacity for making choices and decision making is decreased due to a pre-existing intellectual disability and sensory impairment
- Additionally those in extreme distress, serious disturbances or other significant personal restrictions/limitations.

Autonomy

- Counsellors needs to decrease client dependency and encourage independent decision making.
- Respect and acknowledge client's ability to self-direct; the client is in control and can decide according to their needs.
- Acting in accordance to client's needs/wishes (instead of obeying the wishes/needs of others).
- Counsellors should not knowingly or unintentionally impose their views on the client.
- Respecting the client's right to decline, discontinue or resume counselling at any point.

Non-Maleficence:

- "Above all do no harm" - not causing harm to client.
- Avoiding sexual, emotional, financial or any form of exploitation.
- Not providing services when unfit to do so due to illness, personal circumstances or intoxication.

Justice

- A Counsellor should be fair and not discriminate based on caste, class, marital status, sexual orientation, religion, disability etc.
- Committed to equality of opportunity and services.
- Respecting human rights and dignity.
- Every client is different; not the same solution for every client.
- Fair provision of services that are affordable and appropriate to the needs of clients.

Integral Components of Counselling

Confidentiality

Respect her privacy and confidentiality:

- Counsellors should not reveal information about their clients to anyone
- Ensure you protect the woman's privacy
- Do not discuss her story with anyone unless it is in her interest, with her consent
- Storage:
    - All formal and informal verbal exchanges
    - Written reports and case records
- Sharing:
    - Sharing of information to family members and professionals - done only with the consent of the client
- Security: The protection of stored information, whether it is in physical or electronic form.
- Disclose any issues related to IPV/GBV only with the woman's consent
- Help her see the pros and cons of disclosure and take an informed decision
- Use discretion of the woman while disclosing IPV/GBV to other professionals, referral agencies or even to family members

When can we break confidentiality?

- When a client has risk of harming self (suicidal ideas/behaviours)

- When a client has risk of harming others
- In cases of child abuse or neglect
- When vulnerable adults are being abused (For ex: A person with intellectual disability, sensory impairment)
- During court-ordered psychological evaluations
- For the purpose of involuntary hospitalization
- When a client raises the issue of mental condition in legal proceedings

Being trustworthy (fidelity)

- A trusting and therapeutic environment is created without deceit and exploitation.
    - ➢ Honoring the trust placed in the counsellor
    - ➢ Restricting any disclosure of confidential information about client
    - ➢ Transparency in fees structure

Patience

- Having patience means being able to tolerate frustration without experiencing extreme negative emotions or exhibiting typical signs of frustration.
- The client's lack of initiative and reluctance affects the counsellor, resulting in the counsellor giving up on the client.
- The client will take some time to make a positive change

Genuineness

- Counsellor’s genuine care about the client’s wellbeing and understanding why the client has come.
- Self-awareness: Counsellors need to be aware of their strengths and limitations and can communicate their feelings appropriately.

- Comfortable with the client- create a safe environment where they will feel comfortable enough to open up and talk.
- Counsellors need to make them realize that they have strengths regardless of their circumstances.

Unconditional positive regard

- Caring, nurturing and acceptance-even when another person has done something questionable
- Providing warmth through nonverbal behaviour such as a smile, tone of voice, and facial expressions
- Counsellor can ask a client to explain why they behaved in a particular manner
- Rather than condemning the person's action

Professional responsibility

- An accurate assessment of a client's situation is essential; otherwise, the individual may not receive appropriate treatment.
- Use of only standardized, reliable tools for authentic results.
- Provide beneficial services to the client within the boundaries of competence, referring the client when necessary.
- Manage personal stress and provide adequate service

Supervision of counsellor

- Counsellors may experience a range of emotions themselves such as shock, helplessness, grief, anger etc…
- It is important to be aware of their vulnerabilities, biases, values and principles
- Ensure that it is in no way interfering with the counselling process
- Counsellors may require regular debriefing with supervisor

Transference and Countertransference

Transference:

- Client's unrealistic and often inappropriate feelings, thoughts, and behaviors towards therapist.
- An unconscious displacement of attitudes held originally towards significant persons in the client's life.
- Clients may attribute motherly/fatherly feelings towards counsellor. They can be good or bad feelings.

Transference indicators

- Client attitude towards therapist suddenly changes (Angry, sad, too friendly, vague, unusually talkative)
- Client makes remarks ("no one understands me"; "I disappoint everyone")
- Client confronts therapist with the accusation "I am not getting anything out of therapy"; "you like your other clients more"
- Boredom, irritation, disinterested, distracted
- Sexual Attraction
- Avoidant or afraid
- Not trying to follow effective skills/advice in therapy
- Missing appointments, not adhering to timings.

Factors that increase transference

- **Situations** in which a person is relatively helpless or afraid, who requires protective relationship
- The client's **anxiety** about her physical or psychological safety (e.g. when sick and afraid)

- **Personality:** lesser ability to reflect on their state of mind, feelings and needs

Countertransference

- Countertransference refers to a range of reactions and responses based on the counsellor's past experiences and personal issues (including the client's transference reactions).
- Countertransference occurs:
    - ➢ when a therapist redirects their own feelings or desires onto their clients
    - ➢ When the counsellor loses his/her objectivity
    - ➢ Overwhelmed, angry, or sad when hearing a client's story.
    - ➢ For example, if the client is dealing with issues arising from her sexual abuse experience, the counsellor also is an abuse survivor
- Then it is quite likely that the client's experiences will evoke in the counsellor extreme feelings such as rage and shame arising from one's own abuse experience.
- These emotions can affect the objectivity and compromise one's capacity to help the client.
- The therapist should examine:
- Identifying with the client, when empathy has become sympathy.
- Irritated and impatient at the lack of progress.
- The development of a strong liking for or dislike of the client.

Reflective Exercises:

Ethical or Unethical

1) One of your clients tells you that you have been very helpful to her and in order to show her appreciation to you, she gives you an expensive bag as a gift. You accept the gift.

2) A client cannot afford to pay for her child's education and she requests you for a job to help her out. You ask her to babysit your 2-year-old son at your home.

3) One of your clients feels sexually attracted to you and tells you this. Immediately following counselling termination, you and the client mutually agree to start a dating relationship.

4) You and your colleagues have dinner at your home. One of your colleagues tells you that she is emotionally disturbed by some conflict in her marriage. You take your colleague into the next room and provide her with a brief counselling session there.

5) You go to lunch with another counsellor. In the restaurant, each of you talks about some of your cases to learn from each other. Neither of you mentions the names of any of your clients.

6) One of your clients is seeking counselling for her anger issues towards her husband. You could observe that the woman felt threatened and suspicious of others during the sessions. You recommend a psychiatrist referral several times following the necessary evaluation, but she rejects it. You continue counselling as the client prefers it.

11. Tele-Counselling for Women facing Violence

LEARNING OBJECTIVES

- What is Tele-Counselling?
- Why is Tele-Counselling important for women facing violence?
- The basic guidelines of Tele-counselling.
- How to do tele counselling for women facing violence?
- What are the benefits of Tele-counselling?
- To understand the challenges involved in Tele-counselling.

What is Tele counselling?

Tele-Counselling is a method of providing psychosocial support via phone or secured online platform. It includes using video sessions, text messages, telephone calls or a combination of these for assisting people through crisis.

Why is Tele-counselling needed?

- It is a practical method of providing services during pandemics, disasters, and crisis.
- Cost- effective.
- Can reach larger populations because of its wide reach.
- It helps in bridging the gaps in receiving help.

- Women facing domestic violence may have restrictions in going out or difficulty in leaving children behind.
- Restrictions on physical contact and travel during Covid-19 pandemic will not affect receiving adequate services.
- Women who have faced sexual violence (rape) may not be willing to come to OSCs for fear of stigma, shame or physical health problems.

Basic Skills for Tele- Counselling

- Empathetic responding to the clients.
- Non -judgmental attitude.
- Active listening (hmmm, uh-huh).
- Validation.
- Reflection of feelings- "I can sense that you are feeling hurt by your husbands' response."
- Be considerate.
- Paraphrase the information shared by the client.

Guidelines

- Discuss about recording the sessions.
- Counsellors can disable data protection and confidentiality issues-data-recording setting.
- Safety protocol has to be shared in the first session.
- Consent to be taken- photo of a written document of consent or verbally (recorded) or email or chat.
- If family calls, information may be provided only if the woman consents (this must be checked when alone and safe).
- Be non- judgmental and do not show any personal biases.
- Have adequate knowledge about the devices used.

- Have adequate knowledge about gender-based violence, legal issues, and other services available.

Guidelines: Safety Protocol

- Telephone helpline numbers may be monitored by abusers, be watchful of this and educate the client also about this.
- Safety protocol should be discussed with the client in the first session.
- If there is ongoing violence, try not to call the client back as it may be risking the safety of the woman.
- Ask survivors to call back if the call gets disconnected.
- Delete the call from the record of the phone.
- Establishment of a code/a red flag phrase. Find a word that makes both the client and the woman understand that warns about risky situation.
- Any requested calls back from the counsellor should be accompanied by a safety plan.

What to say?

- 'You can talk as much or as little as you want to; there is no pressure to talk'.
- 'Can I continue this call?' Answer by Yes/No.
- 'Is it safe to talk now?'
- 'If someone comes in, talk to me as if I am your friend or cut the call as wrong number'.
- 'You can save this number in a friend's name'.
- 'Delete the number once you keep the phone down'.

Ground rules to maintain boundaries.

Discuss:

- Availability of the therapist during the hours.
- Duration of sessions. The length of the sessions can be discussed earlier.

- The routine of responding to messages. When can the messages be sent, when will they receive a response in case of messages.
- No contact over social media. Establish it as a rule not to contact the therapist through other social media platforms as the relationship between the client and the therapist is purely professional.
- Alternative ways of contacting in case of technical issues.

Working with family members

- Session with perpetrator only if the client consents.
- Contact other support systems if there is any threat to safety.
- Ensure client is present on call while contacting support system.
- Maintain confidentiality.

Crisis Intervention

- Introduce self; Take consent for online sessions. Mention confidentiality.
- Assess safety of the client.
- Share maximum information and inputs for the client to reach in case of any need.
- Suicidal risk assessment.
- Create a safety plan with the client.
- Explore social support.
- Make referrals and provide necessary resources.

What not to do in Tele-counselling?

- Do not call the client back. Wait until they get back to you.
- Do not record the tele-counselling session.
- Do not use information from the sessions for any research purpose.
- Do not give incomplete or misleading information.

- Do not provide false reassurances.
- Do not assume that you have understood the caller.

Benefits of Tele- counselling:

- Access to immediate support during a crisis.
- Case management and crisis support can be provided remotely.
- Confidentiality is maintained.
- Cost -effective.
- Stigma from seeking help can be reduced.
- Accessible to all groups – adolescents, elderly & marginalized population.
- Continuity of services is ensured- coordinating follow ups, communication during a crisis.

Limitations:

- Not an alternative for in-person counselling.
- Scope of non-verbal communication and behavioural observation is eliminated.
- May not allow the counsellors for providing comprehensive services.
- Network problems.
- Presence of perpetrator.

When not to do tele – counselling?

- If case of active suicidal ideas
- When there is unsafe environment (perpetrator around)
- In case of PTSD.

12. Self – Care for One Stop Center (OSC) Staff and Counsellors

LEARNING OBJECTIVES

- What is the need for self–care?
- Compassion fatigue, burnout and vicarious trauma
- Warning signs
- Self–care wheel
- How to practice self-care?

Why is Self-care important?

Every counsellor is a human first; our emotions & thoughts are equally important and genuine. We need to take care of our mental health. When listening to or talking with women about violence, you should be aware of your emotions/thoughts. You may experience strong reactions or emotions like anger. You may start re-experiencing your trauma in the form of thought/emotions.

Compassion Fatigue, Burnout & Vicarious Trauma

Compassion Satisfaction is the pleasure a clinician derives from doing their work well.

Compassion fatigue can happen in 2 ways:

1. Burnout: Feeling of hopelessness and difficulties in carrying out one's job effectively

2. Secondary/Vicarious Trauma: a consequence of direct or indirect exposure to people who have experienced and/or reading/watching material about such cases

Professionals with a history of trauma may experience Vicarious Trauma but also 'primary trauma' from reactivation of their own trauma experiences such as similar story, similar experience, similar age, similar cultural background etc.

Warning signs – Need for Self–Care

What are some of the physical signs?

- Difficulty falling asleep
- Disrupted sleep (nightmares/restlessness/wakefulness)
- Exhausted/lethargic, feeling tired
- Frequent headaches, back pain, muscle aches
- Drinking alcohol or abusing substances to cope
- No physical/leisure activity
- Poor appetite/lack of interest to eat

What are some of the psychological signs?

- Feeling unable to cope or afraid nearly all the time, self-doubt, sense of failure
- Anger, Irritability, decreased satisfaction
- Engaged in thoughts about difficult or terrifying work events

What are some of the social signs?

- Isolated or avoiding connections with colleagues
- Cut off from friends and family
- Avoiding or dreading any social activity

Self – Care Wheel: How to take care of yourself?

Regularly engaging in activities that reduces stress and maintain or enhance health and well-being

Striking a balance between all six domains of self-care ensure optimal health and well-being to professionals

Distress tolerance like BREATHE technique

BREATHE Technique:

Breathe

Reach out

Eat well

Accept imperfections

Take time out

Hygiene (sleep)

Exercise

It's important to identify if you need self-care

Red (Stop, take action) – Physical: Disturbed sleep, Psychological: anxious most times, Social: social isolation

Yellow (Possible risk) – More tired, irritation, reduced social contact

Green (No Risk) – normal sleep: active and adequate leisure activities and interaction with loved ones

You may administer **Professional Quality of Life Scale (PROQL)** and identify your compassion satisfaction, burnout & secondary traumatic stress scores and its interpretation.

Prepare your self-care kit: Brainstorm possible techniques, that you have used in past or consider can be useful prepare our own kit.

Reflective Exercise:

A young woman came along with her husband and two small children to the OSC.

While talking to the woman, the woman admitted that she has been emotionally and physically abused. But, when asked by whom, she initially refused to say, but later, she told that it was her husband. She narrated what usually happens and described the abusive behaviour of the husband. She looked very disturbed and upset.

After listening to the description and seeing the woman so disturbed and helpless the counsellor felt incredibly fearful and panicky, her heart was racing and her palms became sweaty.

She was initially afraid - 'would this man become suspicious and possibly become angry or upset and try to hurt me?'

Counsellor alerted the supervisor and met with the team. Sensing her fear, the supervisor assured the counsellor that the concern was real and valid.

They asked the woman whether she felt she was in imminent danger, and what her options were. After giving the basic counselling the woman was given a follow up date. On her way home, the counsellor stopped at the grocery store, as she was shopping, she kept turning her head to see who was around her and she felt extremely anxious and hyper vigilant. She finished her shopping quickly and rushed home, locked the door and broke down crying.

Later that night, various thoughts were running in her mind as to how she can help her out. She tried explaining the incident to a close friend, and cried uncontrollably.
For weeks, she could not work properly and was pretty upset or unhappy.
She was not able to get good sleep, and felt she was being more irritable than usual.

Questions:

- What are the burnout symptoms do you notice?
- Have you encountered similar situation in your professional life?
- How do you feel when someone shares their most distressing incidents?
- Has there been any incident where you re-experienced your own trauma?
- How did you deal with it?

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Women may face violence in several contexts- at home, in the workplace, and in communities. Violence can take many forms- physical, psychological, and sexual. Such violence is a core human rights violation and makes the woman vulnerable to experiencing debilitating consequences to her mental, physical, and reproductive health. This resource material by the Project Stree Manoraksha team has been developed for the training of OSC Counsellors and Staff in a modular format. The book covers didactics and reflective exercises of the training curriculum that includes Violence against Women and its Multigenerational and Lifetime implications, Guiding Principles of Providing Psychosocial Support to Women facing Sexual Violence, Mental Health Impact of Violence against Women and its Assessment, Suicide risk Assessment and Primary Interventions, Violence between Couples and in Family Context, and ways to intervene, Psychological First Aid and various Psychological Interventions and Referral Pathways for Women facing Violence. It also covers Ethical and Professional Principles in Counselling and Tele-counselling for Women facing Violence. Lastly, it covers the need for Self-care for OSC Counsellors and Staff and ways to manage burnout and compassion fatigue.

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