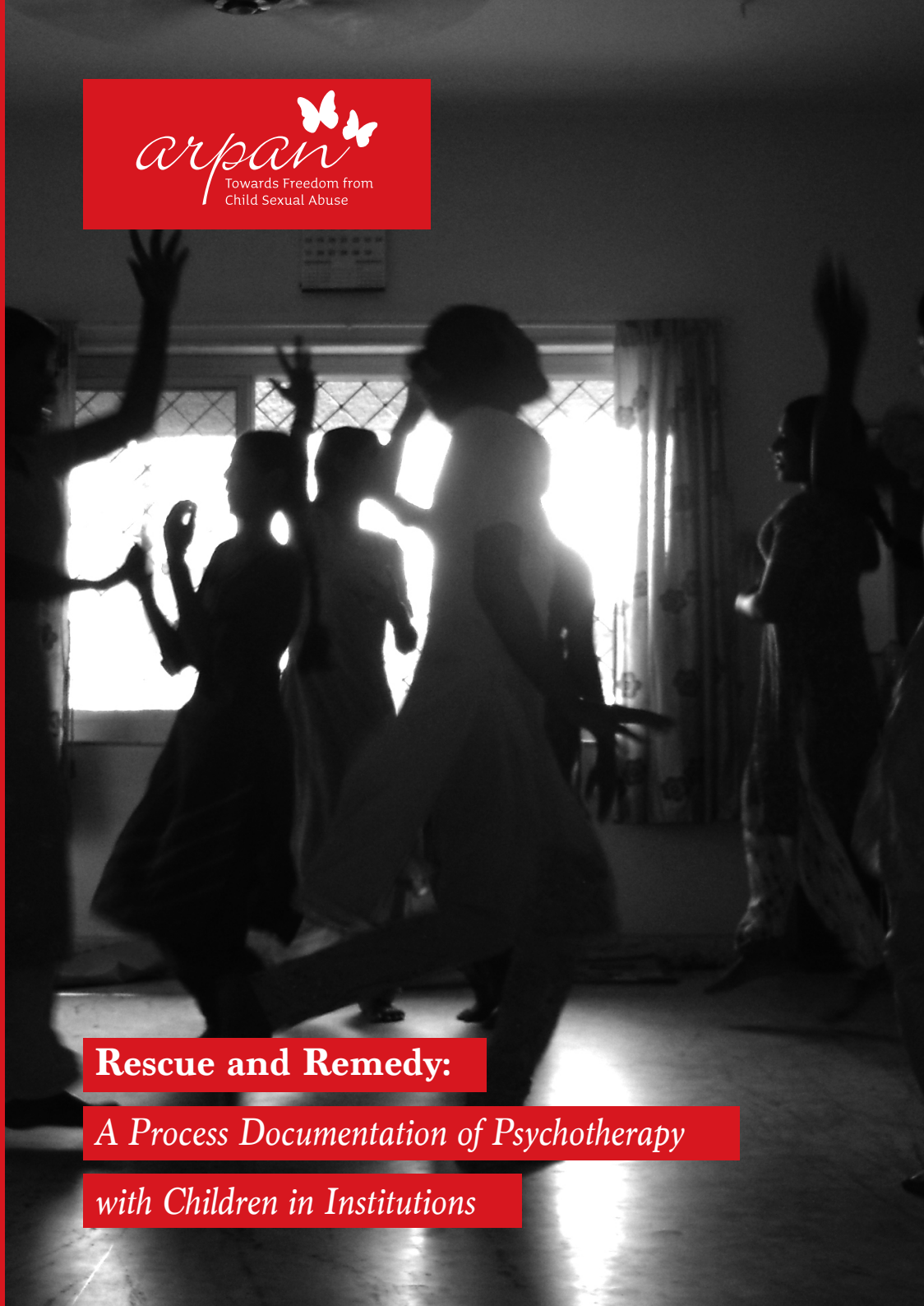

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Child Sexual Abuse

# Rescue and Remedy:

## *A Process Documentation of Psychotherapy with Children in Institutions*

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## Preface

In the last few years of working in the field of child sexual abuse, we have been repeatedly left amazed at the enormous progress that survivors of childhood sexual abuse have made because of the therapeutic help they have received. This experience opened us up to the possibility of undertaking long term psychotherapeutic projects with institutions that shelter survivors of trafficking and childhood sexual abuse. It was during this search that we stumbled upon Advait Home. Advait was working hard to provide their clients with basic necessities and comforts but was struggling to find professional help for their emotional and psychological well-being. Since the psychotherapeutic work was initiated with these children, we have witnessed the incredible journeys of growth that each of the clients have made with the support of their therapists. This document has been created with the hope that the model of psychotherapeutic intervention that Arpan has worked on with Advait, can be replicated and implemented in other institutions that work with young people healing from trauma. We strongly believe that therapeutic assistance can become a very powerful catalyst for abused children as they work towards healing and self-actualization.

## Section I

# Background and context of the Project Long term Psychotherapy in Institutions

### 1.1 Introduction to the Issue of Child Sexual Abuse and Commercial Sexual exploitation

Sexual abuse and commercial sexual exploitation can rob children of all positive life opportunities and cast a negative spell, irrevocably interfering with their emotional and psychological development. Despite efforts to date, Commercial Sexual Exploitation of Children (hereafter referred to as CSEC) and Child Sexual Abuse (hereafter referred to as CSA) are a startling everyday reality. CSEC and CSA are some of the least explored forms of child abuse. These are long-hidden issues that India is finally beginning to wrestle with. This is in congruence with the international environment of evolving human rights, law and public health – all of which are making concentrated efforts to make child maltreatment, in general, and CSA and CSEC in particular visible.

Lack of sound methodologies and indicators to conduct comprehensive research and to compile quantitative data often associated with the issue of abuse, exploitation and neglect, limits the availability of systematic quantitative and qualitative data. Inadequate and ineffective legal provisions and the absence of monitoring systems also impede data collection and conceptualization of the issues. Theoretical research studies, clinical studies and community based studies in the field of CSA and CSEC, to date, have not been able to throw consistent definition of the concept and its incidence and prevalence.

World Health Organization (2006) defines Child Sexual Abuse as the "involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violate the laws or social taboos of society. Child Sexual Abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person." Based on this, the National Study on Child Abuse in India further simplifies the definition as "inappropriate sexual behaviour with a child... committed by a person responsible for the care of a child (for example a baby-sitter, a parent, or a daycare provider), or related to the child" (2007). As such it differentiates between sexual assault and sexual abuse on the basis of whether the offender is a stranger or a known/familiar person entrusted with the care and responsibility of the child.

Drawing from both of these definitions, the present report, has evolved the following as the working definition of Child Sexual Abuse. Child Sexual Abuse is defined as "any act using a child (below 18 years of age) for the sexual gratification of the more powerful person". While recognizing that there will still be debate about various definitions, for the purpose of this report, 'Child Sexual Abuse' is understood as taking place both within and outside the family[1].

*1 The working definition further spells out the range of behavior that is considered in the spectrum of CSA in the purview of the present study. The working definition differentiates between contact and non- contact sexual abuse. Contact Sexual Abuse is the touching of the private body parts of the child or the child being forced to touch the private body parts of the abuser. Contact sexual abuse can be further divided into two types: Penetrative and Non Penetrative. Penetrative Sexual Abuse includes penile, digital and object penetration of the vagina, mouth or anus; and Non Penetrative Sexual Abuse includes fondling of private body parts of the child, sexual kissing or the child making to touch the private body parts of the abuser (Finklehor 1994). Based on this definition and the definition used in the National Study on Child Abuse (2007) in India the working definition formulates contact sexual abuse as including (a) Penetration of anus, vagina, oral sex, (b) Fondling child's private body parts, (c) Making the child fondle private parts and (d) Forcible kissing. Non-Contact Sexual abuse comprises (a) Making the child exhibit private body parts, (b) Exhibiting private body parts to a child, (c) Photographing child in the nude, (d) Making the child view pornographic material, and (e) Using sexually explicit talk and sexually abusive language with the child.*

Commercial Sexual Exploitation of Children commonly refers to using a child for sexual purposes in exchange for cash or in-kind favours between the client/customer and an intermediary or agent who profits from such trade in children. Child Sexual Abuse, thus, becomes sexual exploitation when a second party benefits through a profit or sexual gratification involving a child. In this case of Child Sexual Abuse, the child is not only treated as a sexual object but a commercial object as well. This may include prostitution, brothel and street-based sexual exploitation, trafficking for sexual purposes, customary prostitution, and sex tourism and child pornography. Those who profit include a wide range of persons, including parents, family members, procurers/agents and community members. They may be operating individually or as part of a syndicate. Cash may be paid to families, to be "repaid" through their child's earnings. Sometimes a "contract" is created that implies a legal indebtedness, which provides even more leverage to force (NIJ 2007). Traffickers also recruit children by convincing families — through "success" stories— that their children will be safer, better taken care of, and taught a useful skill or trade.

The factors that contribute to the sexual exploitation of children are many and diverse and is contextual in nature. However, one causal situation is common to children across the globe: a continuum of abuse, frequently starting with abuse by family members/friends/ relatives. Children who are sexually abused by someone in their own family or circle of friends are extremely vulnerable to sexual exploitation as well outside the family or later in life. In European and Latin American, countries surveys among adult prostitutes have shown that many entered commercial sex after being abused at home. A small-scale study in Bangladesh indicates the same. Underlying features of commercial sexual exploitation, thus, are: a) Minors (especially from economically deprived and marginalized groups)

are exploited for monetary gain and the sexual gratification of the exploiters and their clients; b) New "recruits" are constantly sought; c) False promises of a "better life" are a central recruitment tool; d) Once exploited, children are often threatened or assaulted to ensure obedience and prevent escape.

### 1.2 Prevalence and Incidence of Child Sexual Abuse and Commercial Sexual Exploitation of Children

Child Sexual Abuse and Commercial Sexual Exploitation of Children evolves as a multifaceted issue because all of us reticent by our own upbringing struggle to have a vocabulary to communicate around sexuality in general and sexual abuse in particular. This clandestine nature adds to the euphemism and ambiguity around the issue. To date, very little concerted, significant effort has been made to gather reliable data regarding the extent of CSA and CSEC. As with other so called "low visibility" issues, the greatest challenge in assessing the prevalence of CSA and CSEC is the "dark figure," i.e., the challenge to capture the unreported cases for every report of CSA and CSEC.

#### 1.2.1 Prevalence and Incidence of Child Sexual Abuse

There are no central databases and monitoring systems that bring together available statistics relating to Child Sexual Abuse in India. Nonetheless, police records and data collected from other public agencies, service providers, academic surveys and research by non-governmental organizations consistently show that children are sexually abused. It is, however, necessary to be cautious when assessing and comparing existing data, as different definitions for child, Child Sexual Abuse and the representative sample varies.

In the Indian context, the only source of primary data is the National Crime Records Bureau, India (NCRBI). NCRBI however does

not maintain a separate classification of offences against children. Generally, the offences committed against children or the crimes in which children are the victims are considered as Crime against Children. It follows the Indian Penal Code and the various Protective and Preventive `Special and Local Laws' which specifically mention the offences wherein children are victims. As there was no particular IPC or 'Special and Local Law' which addressed CSA per se[2], therefore, there is no way to derive comprehensive data about Child Sexual Abuse reportage. Hence, we have considered data on rape of children which is a direct indicator of one of the heinous forms of CSA. There is lack of clarity as to whether NCRBI has considered the age of the child as below 18 years as per the Juvenile Justice Act, 2000 or the age of the child as per the definition given in the concerned Acts i.e., Section 376 of the Indian Penal Code which is below 16 years of age. A total of 8,541 cases of child rape were reported in the country during 2012 as compared to 7,112 in 2011 accounting for an increase of 20.1% during the year 2012 (NCRBI 2012). Madhya Pradesh has reported the highest number of cases (1,632) followed by Uttar Pradesh (1,040) and Maharashtra (917). These three States together accounted for 42.0% of the total child rape cases reported in the country. Although this data is useful, it constitutes a minuscule proportion of the total crimes/violence committed against children because it does not encompass the entire gamut of Child Sexual Abuse.

Another important document for understanding Child Sexual Abuse is the National Study on Child Abuse which was conducted in 2007. This study, which is the largest of its kind, covered 13 states with a sample size of 12,447 children, 2,324 young adults and 2,449 stakeholders. The National Study reported the following:

- 53.22% children reported having faced one or more forms of

*2 This might change with the introduction of POCSO, 2012 which addresses the entire gamut of Child Sexual Abuse.*

sexual abuse.

- Andhra Pradesh, Assam, Bihar and Delhi reported the highest percentage of sexual abuse among both boys and girls.
- 21.90% child respondents reported facing severe forms of sexual abuse and 50.76% other forms of sexual abuse.
- Out of the child respondents, 5.69% reported being sexually assaulted.

Research by NGOs also becomes another source for assimilating data on CSA[3]. There is definitely dearth of information on prevalence and incidence of CSA in the Indian context. Nonetheless, it clearly emerges that CSA does occur and it does not occur as a sporadic incident but it is a reality that touches at least 40%-50% of children's lives in India.

### 1.2.2 Prevalence and Incidence of Commercial Sexual Exploitation of Children

The Commercial Sexual Exploitation of Children (CSEC) in India exists on a large scale and in many forms. One of its chief manifestations is the trafficking in children for commercial sexual exploitation, and India is a significant source, destination and transit country in this regard (Joffres et al 2008). The United Nations (UN) estimates that the trafficking of women and children for CSEC in Asia has victimized over 30 million people. India has been identified as one of the Asian countries with a severe CSEC trafficking problem (ECPAT International 2006). In India, more than 2.3 million girls and women were believed to be in the sex industry, and experts

*3 A study by RAHI, a NGO based in New Delhi in four cities (New Delhi, Mumbai, Kolkata, Chennai and Goa ) found that 76% of respondents were sexually abused as children (RAHI Study 1997); A study by Sakshi, Delhi based NGO, found that 63% of girls were abused as children by family members (Sakshi Study,1997); A study by Samvada, Bangalore based NGO, claims that 47 % of respondents were sexually abused as children (Samvada Study, 1996).*

believed that more than 200,000 persons were trafficked into, within, or through the country annually. A recent government report commissioned by the Department of Women and Child Development (India) estimated the number of persons trafficked for CSEC in India to be around 2.8 million, an increase of 22% from an earlier estimate. This increase has been attributed to increasing demand for younger children and virgins, partly fueled by the fear of HIV/AIDS; the emergence of new sources and destinations for trafficked persons; and an increase in the overall sophistication of trafficking networks, many of which are controlled by organized crime syndicates or insurgent factions.

According to an International Labor Organization (ILO) estimate, 15 percent of the country's estimated 2.3 million sex workers were children, while the UN reported that an estimated 40 percent of them were below 18 years of age (Human Rights Labour Report 2005). In 2005, the National Human Rights Commission (NHRC) estimated that almost half of the children trafficked within India are between the ages of 11 and 14; they are subjected to physical and sexual abuse and kept in conditions similar to slavery and bondage. Around 60 percent of these population belonged to the scheduled castes, tribes and backward classes (UNICEF 1995). Tribal persons made up a large proportion of the women forced into sexual exploitation.

Interstate trafficking represents 89% of trafficking for CSEC in India. Children are trafficked to and from states such as Andhra Pradesh, Bihar, Karnataka, Uttar Pradesh, Maharashtra, Madhya Pradesh, Rajasthan and West Bengal[4] Trafficking from neighbouring countries into India account for about 10% of trafficking for CSEC. Bangladesh and Nepal are the biggest suppliers, respectively accounting for 2.17%

*4 For instance, among the 23 districts of the State of Andhra Pradesh, 16 are identified as sending districts. Similarly, in the State of Bihar, 24 out of 37 districts are highly affected by trafficking in women and children. Rajasthan is also a major source State, where 27 out of 32 districts are found to be affected*

and 2.6% of the international traffic for CSEC[5]. They are sexually exploited in brothels, massage parlours, nightclubs, beauty salons, hotels, escort services, private houses known as 'madhu charkas' as well as at railway stations, bus stations, streets, public parks and more recently in circuses.

Report by the HAQ-Centre for Child Rights in India presents enough evidence to suggest that a significant number of girls rescued from commercial sexual exploitation are re-trafficked, which exposes serious flaws in existing programmes on rescue, return, rehabilitation and reintegration of victims. Non-acceptance by their families and communities, lack of alternative sources of income or livelihood options and increasing demand for young girls from brothel owners contribute to the re-trafficking of victims.

### 1.3 Mental health implications of Child Sexual Abuse and Commercial Sexual Exploitation of Children

Psychic trauma occurs "when a sudden, unexpected, overwhelming intense emotional blow or a series of blow assaults the person from outside. Traumatic events are external, but they quickly become incorporated into the mind" (Terr 1990). Put simply, "Traumatization occurs when both internal and external resources are inadequate to cope with external threat" (Van der Kolk 1989). It is apparent from these definitions, that it is not the trauma itself that damages. It is how the individuals mind and body reacts in its own unique way to the experience in combination with the unique response of the individual's social group. As such, "a traumatic experience impacts the entire person – the way we think, the way we learn, the way we remember things, the way we feel about ourselves, the way we feel

*5 Total estimates of Bangladeshi persons trafficked for CSEC into India vary between 200 000–300 000 annually. Estimates of Nepali persons trafficked into India vary from 100 000 to 200 000 annually.*

about other people and the way we make sense of the world are all profoundly altered by traumatic experience" (Bloom 1999).

Trauma exposure occurs along a continuum of "complexity". It generally falls into two categories. The less complex single, adult-onset incident (e.g., a car accident) where all else is stable in a person's life is known as Acute Traumatic stress. Complex trauma, on the other hand, refers to the repeated and intrusive trauma "frequently of an interpersonal nature (neglect, physical or sexual abuse), often involving a significant amount of stigma or shame" and where an individual may be more vulnerable, due to a variety of factors, to its effects (Briere & Spinazzola, 2005). It is on this far end of the continuum where victims of Child sexual abuse and Commercial Sexual Exploitation fall.

CSA and CSEC victims experience constant trauma and stress as a result of their victimization. Traumatic experiences like Child sexual Abuse is often shattering and life-altering for children as it is not only a violation of a child's body but of the trust, implicit in a care giving relationship. This violation can have a significant impact on how the child as a victim and later on as an adult survivor sees and experiences the world. Child Sexual Abuse brings in psychological trauma from childhood which may disturb a person in his/her everyday experience of both her/himself and others and restrict his/her possible thoughts, actions, and feelings. As children, they immediately experience conflicting emotions such as shock, shame, rage, confusion and guilt. Psychological impact includes unusual or unexplained fear of people or places, nightmares, eating and sleeping disturbances, anxiety, hyper-vigilance, clinging behavior, indifference,

frequent daydreaming and dissociation[6], lack of trust in self and others, regressive behaviors such as thumb sucking, soiling and bed wetting. The most profound impact might lead to include suicide ideation and psychosis. These can manifest in behavioral changes around sudden withdrawal, overly pleasing behaviour, increased hostility, aggression and drastic change in academic performance. Sexual abuse in childhood can cause drastic/visible change in sexual conduct and mannerisms. Some of these may include over dressing, under dressing, sexual anxiety, and repetitive sexual behavior such as excessive masturbation, continuous sexual play or use of sexually abusive language. It is also possible that the trauma of Child Sexual Abuse may create anxiety or confusion around the survivor's sexual identity.

These observed effects of childhood sexual abuse can intrude in to a person's life in his/her adolescence and also as an adult if it is not healed and supported. It is difficult to separate the short-term impact from the long-term impact as the former may often be the commencement of a long-term problem. Often, these emotions carry on as they grow into adults and lead to other dysfunctional behaviour as well in the areas of social relationships. The experience of betrayal of a child over the loss of a trusted figure can manifest itself in isolation and an aversion to intimate relationships and interpersonal dynamics. It can also lead to ambiguous sense of boundaries, making them vulnerable to future abuse and re-victimization. The experience of stigmatization can lead to low self-esteem, guilt, shame, and a consequent tendency to isolate oneself. The experience of powerlessness can manifest in depression, withdrawal or in antisocial behavior (drugs, alcohol) and delinquency including demonstrating

*6 "Dissociation is a way of organizing information ...(that) refers to a compartmentalization of experience: Elements of the trauma are not integrated into the unitary whole or integrated sense of self" (Kolk et al 1996)*

sexually offending behaviours and re-enacting their own abuse. The experiences of sexualization at an early age can lead to sexually promiscuous behavior or it may lead to aversion to sex because of flashbacks to the molestation experience, difficulty with arousal and orgasm as well as negative connotations toward their own self and sexuality.

Children who face commercial sexual exploitation experience continuous psychological, physical, and sexual abuse. They may exhibit feelings of guilt, shame, and worthlessness as a result of the acts they were forced into, as well as the psychological and emotional abuse they experienced from their traffickers/exploiters (Raymond & Hughes, 2001). The list of psychological problems faced by human trafficking victims is very long and psychotherapists and research studies attest to the fact that the following problems and challenges occur as a reaction to the experiences and situations the victims had been exposed to: post traumatic stress disorder (PTSD), complex PTSD or Disorder of Extreme Stress not Otherwise Specified, depression, absence of emotional reactions, anxiety disorder, self-blame, helplessness and meaninglessness, nightmares, boundary issue, anger and rage control problem, suicidal ideas and attempts, paranoia, Stockholm syndrome, temper tantrums, psychoactive substance abuse problems, alcohol abuse, problems in everyday grooming, sleeping problems and dissociative disorders. Many victims may also develop dissociative disorders and personality disorders as a result of the extensive trauma they experienced during childhood and as victims of sexual exploitation (Ross, Farley, & Schwartz, 2003; Farley, 2006; Williamson & Prior, 2009; Raymond & Hughes, 2001).

Nearly all trauma survivors have acute symptoms following a traumatic event, but these generally decrease over time. Various factors can make recovery more difficult: Previous exposure to trauma including chronic neglect, physical abuse, or abrupt separation from

a caregiver, duration of exposure to trauma, severity of exposure, relationship of the abuser, nature of sexual abuse, the age and gender of the victim, the support systems around the victim, caregivers response after exposure and the mental state of the victim at the time of abuse. In cases when children had early trauma, the sexual abuse and exploitation represents a trauma which cumulatively builds on the trauma which the person had endured in earlier life phases, most often in childhood. Therefore, we are talking about complex trauma when the person has had severe traumatic experiences that were not psychologically processed before she was sexually exploited.

### 1.4 Introduction to Arpan and the project on Long term psychotherapeutic work in institutions

Mental health in India is a highly taboo issue and there is a lot of social and cultural reservation and barrier to access mental health services. In case of CSA and CSEC, the client is doubly disadvantaged due to the socio-cultural restrictions regarding this issue and the constraints at accessing psychotherapeutic support for the same. For most victims, shame is seen as one of the greatest barriers preventing them from seeking mental health services. Providers note that the stigma associated with mental illness is an especially prominent challenge in engaging victims of CSA and CSEC. This is because victims of CSA and CSEC do not operate in a vacuum. They grow in situations of crisis and transition, lack of resources, patriarchal society ruled by gender inequality, gender based violence and discrimination of women, children and minorities. These social factors define the wider environment in which psychotherapy with the victim occurs and hinders the responsiveness of those services to the complex needs of survivors. Many of the needs of victims of CSA and CSEC stem directly from their experience with trauma and the brutal reality of unremitting threats or actual sexual offence. Identifying these needs and meeting them, in particular providing mental health support and

trauma-informed services, is what urged Arpan to start off 'Long term Psychotherapy' in institutions.

Arpan is an award winning organization working to address the issue of Child Sexual Abuse in India. Based in Mumbai, Arpan now is the largest NGO in the world in this specific area with over 40 social workers and counsellors providing prevention and intervention services to children and adults. Over the last 8 years Arpan has reached out to over 280,000 children and adults through direct and indirect services, training and capacity building of various stakeholders and public and policy advocacy.

Arpan understands the social barriers around providing psychotherapeutic services to this population and hence has structured the Counselling and Psycho-therapeutic services aiming at facilitating a journey of healing which will restore the sense of self- worth, trust and dignity for every child and adult survivor of childhood sexual abuse and commercial sexual exploitation. Long – term Counselling and Psycho-therapeutic services aimed at rescued minors within institutions thus focuses on working with:

- Specific groups like rescued minors with history of being sexually abused either through CSA and/ CSEC in institutional set ups in order to facilitate healing of the psychological, social, sexual and physical consequences of CSA.
- To build the capacities of the institutional staff like care takers, shelter in-charge etc. so that they are aware of the psycho-social and physical impact of Child Sexual Abuse which in turn enables them to respond to the children and provide them necessary support within the institutional set up.

To implement these objectives, Arpan enters into a formal partnership with the interested institution and provides psycho-therapeutic services to the clients within the institutional set up. A critical aspect

of this program is to work with the institutional management and staff in order to enable them with information about the psycho-social and physical impact of Child Sexual Abuse and commercial exploitation of children and enable them with knowledge and skills to respond effectively to children.

## Section II

# Scope and Utility of Process Documentation

### 2.1 Rationale of the Process documentation for the project on Long term psychotherapeutic work in institutions

Every social set-up, organization operates under its own articulated ideology, mission and perspectives. A variety of processes take place during the articulation and implementation. Process Documentation is a tool, which helps to collect data systematically on various processes. It is an exercise to gather all data for continuous reflection and analysis and re-examination of strategies for strategic and operational framework. As such, Process Documentation[7] is not an evaluation strategy, or a post-facto exercise. Rather, the focus on process documentation is to learn from implementation experience and in the light of this modify the strategy and ultimately, policy (Mosse 1998).

The conceptualization, evolution, growth and implementation strategies for process documentation differ from one organization/ project to another. Each project or agency has the potential to provide deeper insight into the enigmatic subject of psycho-social development, but differently. Each case has something to contribute to the learning process in the field of psychotherapeutic intervention, as there is no "blue print" approach and methods, models, criteria are situation and context specific. The rationale for conducting the Process Documentation (PD) exercise in the context of long term psychotherapeutic work in institutions is geared towards collection

*7 The term process documentation was first used in 1978 to refer to a pilot project in Philippines. In this project full time social scientists stayed in project villages and made detailed observations and documented the process of user group (farmers') formation and functioning.*

of authentic data about recurring phenomena on an ongoing basis to provide insights into programs, implementing strategies and organization development mechanisms. In essence 'Process Documentation' means and involves that the monitoring is inductive and open-ended thus broadening the frame of reference. Thus, the process information completely "breaks away from the general image of development projects or programmes as closed, static, predictable and controllable tech-rational systems" (Mosse1998).

### 2.2 Objective of the Process Documentation

In this sense, Process Documentation for the project on long term psychotherapeutic work in institutions, a project encompassing psychotherapeutic intervention of rescued minor provides a case study of a model, which is useful primarily in two ways:

1. To gain insights by Arpan for conducting similar initiative in a larger scale and build organizational capacities.
2. To gain policy insights by other organizations in formulation and implementation of similar initiatives by using the outcome of the project as a model.

The specific objective of the process documentation are:

- To record the processes as they occur to enable better understanding of the project
- Identify the important players within the organization, the stakeholders or those who have a vested interest in the outcomes
- Identify chronology of event
- To understand stakeholder participation and the way forward for the project
- To identify bottlenecks that are invisible to the organization and find room for improvement even in well-refined procedures
- To construct institutional and project ethnography

### 2.3 Methodology of Process Documentation

Process documentation starts with understanding the objectives of the organization, mapping the existing processes and then working towards closing the gaps that may exist. In the present report the following tools were used in order to elicit understanding of the project:

- Review Recall and written documents to understand the initial phase and Identify historical precedents
- Review of existing documentation
- Review of case files
- Observing Field-level activities
- Conducting semi structured interviews with stakeholders
- Conducting semi structured interviews with beneficiaries

As indicated above, the collection of primary data involved three different data sources (case files/documents, key adult informants, and child survivors) and two different data collection methods (interviews and case file/documents review). Data collection began with reviewing existing documents, followed by interviews with key adult informants: CEO of Arpan, Arpan's counsellor spearheading the project during initiation, Coordinator of Project Bharati, Advait; Therapist and caretakers of institution. Interviews with child survivors constituted the next element of data collection followed by case file reviews. This sequence of data collection was deliberate as the interviews with adults helped the interviewers to be better prepared to conduct interviewers with survivors and compare narratives of service providers with children's narratives. Cases filed were reviewed last, so as to create boundaries around interviewers being overwhelmed by children's histories and having an added expectation for survivors to narrate their past.

Ethnographic interviews were used with child survivors and their service providers so that they offer insights unknown to or unanticipated by the research team. Using open-ended questions

facilitated uncovering issues important to survivors and encouraged them to take the lead in the interviews.

### 2.4 Ethical consideration

The process documentation was in an arena, which is highly sensitive in nature. Hence adequate measures was taken to ensure participant safety involving but not limited to - right to quit, not answer, suggest and question; no attempt was made to elicit graphic details of past sexual abuse and exploitation and it was kept completely at the discretion of the survivors' willingness to share; no intrusive tool was issued to elicit information; informed consent was practised in its true sense; safety net was created for children before, during and after the interview by including a therapist in the research team to prepare, support and provide closure. Confidentiality of all survivors has been given utmost priority and all measures have been taken to ensure that the trust bestowed is valued and respected.

### 2.5 Limitations of the process documentation

- The scope of the process documentation is limited to map the project of long term psychotherapeutic intervention at Project Bharati, Advait. As such, it leaves out the process documentation of the institution in its entirety and looks at only one component.
- The project being in an otherwise unchartered terrain especially in an Indian context it has been difficult to compare best practices of other organizations so as to arrive at conclusion.
- The project being in a domain of silence, mistrust, confidentiality, betrayal and in a space where movements and shifts are momentary, intangible and minute – lack of documentation and limited access and reproduction of the same due to confidentiality and ethical consideration have challenged the data collection process.

## Section III

# The immediate micro environment of Long term Psychotherapeutic work

### 3.1 Introduction to Advait

Advait derived from the Sanskrit word ( a = no; davit = duality ) came into existence in 2003, when a band of energetic and like-minded professionals well entrenched in social work of rescuing young boys from exploitative situations, moved to rescuing and rehabilitating girls trafficked, abused and forced into a web of sexual exploitations. Advait Foundation acts as a catalyst and an advocate embracing a gamut of child rights issues under the guiding principle "in the best interest of the child" recognizing the fact that victimization in any form of the child abuse is a gross violation of the basic right to life, dignity, freedom and happiness of the child. Advait Foundation bases its short and long term strategy on five most emerging issues for the rehabilitation and reintegration of the child.

- Trafficking and rescue of minor girls and women
- Interventions for sexually abused children and survivors
- Children in institutional care and community reintegration
- Networking for the convergence and service
- Training on development issues and consultation for organization building

In an attempt for greater participation and involvement to deal with issues more practically and systematically, Advait Foundation has taken the initiative to locate a rehabilitation home in Vasai in the Thane District of Maharashtra State. The home, named Bharati,

caters to long-term rehabilitation of sexually abused girls, focusing on programs of alternative livelihoods, life skill development, psycho-social support and therapeutic measures, to help in overcoming the trauma and pain (Unpublished document, Advait Foundation). The home is licensed to receive cases under Immoral Trafficking Prevention Act (ITPA). However, given the scarcity of institutions housing sexually offended minors, the home also receives girls with a history of sexual abuse and sexual assault. The age of the clientele ranges from 13 to 20 years, as some clients are given an extension post 18 years of age depending on their vulnerability and the potential of the girl to shape her future. There is no screening procedure used by the home and all girls referred by the CWC (Child Welfare Committee) are accepted except girls with disability and pregnant girls as the home does not have the infrastructural facilities and human resource needed to support girls with special needs. Girls who were part of the formal schooling system prior to their victimization are also discouraged as it is not feasible for the home to ensure formal schooling as there are legal constraints on children's freedom of movement and they need to be accompanied by police personnel or a caretaker for visiting the school. The home works towards giving each resident a sense of dignity and respect which becomes their resource when they move out.

It is here, that Arpan partners with Advait Foundation for providing long term psychotherapeutic intervention for sexually abused girls in their project Bharati (Henceforth Project Bharati and Advait has been used interchangeably).

### 3.2 Key stakeholders and beneficiaries of the project

A stakeholder, for this report, is defined as any individual, community, group or organization with an interest in the outcome of a project, either as a result of being affected by it positively or

negatively, or be being able to influence the activity in a positive or negative way. A beneficiary is the person or communities that utilize the projects outputs. The critical stakeholder of the project are: Arpan management, Advait management, counsellor and donors. The beneficiaries of the programme are the adolescent girls who are rescued either from commercial sexual exploitation and/or from unsafe homes/relationships.

The matrix below shows the stakeholders and beneficiaries' impact on the process.

| | Major Impact on | | | | |
|---|---|---|---|---|---|
| Stakeholder group | Continuing of psychotherapeutic service | Quality of psychotherapeutic services | Smooth functioning of psychotherapeutic intervention | Financial contribution | Reputation |
| Arpan management | ✓ | ✓ | | ✓ | ✓ |
| Advait management | ✓ | | | | ✓ |
| Counsellor | | ✓ | ✓ | | ✓ |
| Caretakers | | | ✓ | | |
| Donors | | | | ✓ | |
| Beneficiary group | | | ✓ | | |

*Figure 1: Matrix highlighting stakeholders' and Beneficiaries Impact on the process*

### 3.3 Chronology of event

It was in the initial years of Arpan's journey that two key individuals at Arpan, namely the CEO Ms. Pooja Taparia and the then psychotherapeutic coordinator Ms. Pushpa Venkatraman envisaged that as an organization Arpan would eventually work with government run homes for rescued minors by providing the much needed psychotherapeutic support. As a stepping stone, to begin with somewhere, because "the kind of mammoth task this was" (Excerpts from Interview with Ms. Pushpa Venkatraman) they started off with Advait Foundation. Ms. Sangeeta Punekar, the Coordinator of the Project Bharati of Advait Foundation was a close colleague of Ms. Venkatraman from earlier times of work and she visited the institution.

Spending the day at the home and being part of the daily proceedings, Project Bharati left an imprint of a well- run, neat and clean home, having a well defined schedule and structure and where children's basic needs were met beautifully. Amidst this what struck was a "strong image of a girl who came in with a tray ... and the look on her face... a mask" (Excerpts from Interview with Ms. Pushpa Venkatraman). Being a therapist herself and long experience of working with this population she was pained by the "mask" that she saw. The "mask", "shattered expression", "flat affect" (Excerpts from Interview with Ms. Pushpa Venkatraman) which was invisible to people who were not trained in psychotherapy and trauma and was read as composed and "well settled" was actually a classic example of dissociation. This observation nudged that some action be taken so that not only children's basic need but their mental health is also taken care off. When this was brought to the notice of Ms. Sangeeta Punekar and Ms. Pooja Taparia both were more than willing to partner for a cause and take it ahead. Prior to this, there had been initiatives from Advait to connect with psychotherapist as they also

felt the need to start therapeutic work with the girls and wanted to understand the nature of the process (Excerpts from Interview with Ms. Sangeeta Punekar). From Arpan's perspective to start of this "spadework" (Excerpts from Interview with Ms. Pushpa Venkatraman) in an unchartered terrain, it was important to ensure that the pilot project is started off in a safe manageable pace, structured environment, good infrastructure, a well-run home where investment of time and energy to ensure other necessities are met can be kept outside the purview of Arpan's intervention. This was critical as it would ensure higher productivity and commitment to work in a focused manner on psychotherapeutic needs of children and would facilitate their wellbeing. This alignment of need and goal, passion, zeal and conviction to do and 'be the change' and ability and skill were the binding factors which facilitated the process in absence of formal structure and an earlier example to learn from or follow.

The next tasks were to look for a therapist who will be confident to work with this extremely vulnerable population and accumulate funding to kick start the project. Both were challenging. As Project Bharati being situated in suburb of Mumbai, even earlier attempts by Advait to secure a counsellor and trainers for other vocational services (Excerpts from Interview with Ms. Sangeeta Punekar) had faced hiccups. Funding for mental health was challenging at that given point of time because lack of awareness around mental health issues in the country (Excerpts from Interview with Ms. Pooja Taparia) and the difficulty in mapping tangible outcomes (Excerpts from Interview with Ms. Pushpa Venkatraman).

Simultaneously, Yoga classes were initiated as it aids therapy. It was started with the intention that even in the absence of therapy, Yoga could have a certain level of calming effect and help relieve stress, frustration and anger. Such exercises could also help children increase

the power of concentration and remain involved in a routine for longer periods of time. It was perceived as an activity to start with, a stop-gap situation before therapy could be initiated.

In this time frame, a therapist was located residing in Vasai itself. It is believed by all the key stakeholders who were an integral part of initiating this project that finding a therapist residing close to the home and a participant of the Working group of Trauma[8] was "destined". This initiation of psychotherapeutic intervention with rescued minors at Project Bharati of Advait has been "organic" (Excerpts from Interview with Ms. Pooja Taparia) and orchestrated. It started off with providing group sessions with clients. However, soon the need to conduct capacity building sessions with caretakers was identified. This was followed by conducting of individual session with clients from the second year onwards.

*8 Working group of Trauma is a study circle run by Arpan for therapists to have sustained dialogue and supervision on Trauma*

The chronology of events is presented in a tabular format


*Figure 2: Chronology of Events*

### 3.4 Situation analysis of the Clients/beneficiaries

#### 3.4.1 Socio economic condition of client's family

In the last 5 years counselling services have been provided to 65 clients. Among whom 22 children were present during the interview. The 22 children rescued and placed in the 'home' and 5 ex Advait clients who were interviewed belonged to low socio economic strata

of the society. Only one child reportedly spoke about belonging to a middle class family. These children are largely from families that are "vulnerable", "at risk", "urban poor", and "rural poor" and facing challenges around alcoholism, violence, prostitution, unemployment, abandonment, abuse, debt, dowry, place of stay, chronic and acute illness. The reason behind the flocking of children from low socio economic families do signal two things – children from low socio economic families are most vulnerable to experience commercial sexual exploitation as they are duped or tricked to get into the sex trade to better their economic conditions and/or use it as a means to pursue avenues of their interest. Family members and relatives' need for sustenance or a better life can also propel them to sell their children. However, whereas this is true for commercial sexual exploitation; Child Sexual Abuse is not significantly a class based phenomenon. The reason behind children with CSA history being in the institution solely from low socio-economic class points to that fact that sexual abuse of children in middle and upper class society is silenced and is largely not brought out in the open. It also reflects the children and their families from low socioeconomic families hardly have a support system available for removing the child from an unsafe home to a safe place through kinship ties.

### 3.4.2 Place of origin

The children who were presently residing in the home came from Mumbai, Thane, Mumbra, West Bengal, UP, Gujarat, Rajasthan, Uttar Pradesh and Nepal. Over the last 5 years, girls placed with this home also had a significant proportion of girls trafficked from Bangladesh.

### 3.4.3 Reason for placing in the home

Based on review of case, interviews with key stakeholders and revelation of past history by clients, who were willing to share,

a multitude of reasons manifested for clients being placed with the home. These clients are a mixed group who have experienced commercial sexual exploitation and sexual abuse by known people/ strangers or both. Most of them have undergone sexual abuse prior to sexual exploitation and has been abused on multiple occasions by various people. Some of the girls were trafficked for commercial sexual exploitation and they have been rescued from brothels. In some cases, parents were involved in trafficking of the children and have been declared unfit. Some of them have faced sexual abuse at home. Some of them have experienced sexual assault like gang rape by strangers after they ran away from home because of induction to prostitution. In case of trafficking, children reported to have been deceived or conned by traffickers who lured them on the pretext of finding suitable jobs in big cities or faked love and marriage. Some children were sold for monetary benefits by family members who wanted to use the money to either treat chronic illness, build a house, repay debt and /or marry off an elder sister by paying dowry. While some parents realized that the job in question is prostitution, others simply do not know what lies in store for their children. Some children were coerced to earn money through prostitution and as 'bar girls' and faced a lot of physical abuse to comply. Some children were also introduced to prostitution as a customary practice through social sanction because they belong to a particular community, namely Bedia community.

The reason for the clientele being sent to the institution is illustrated below:

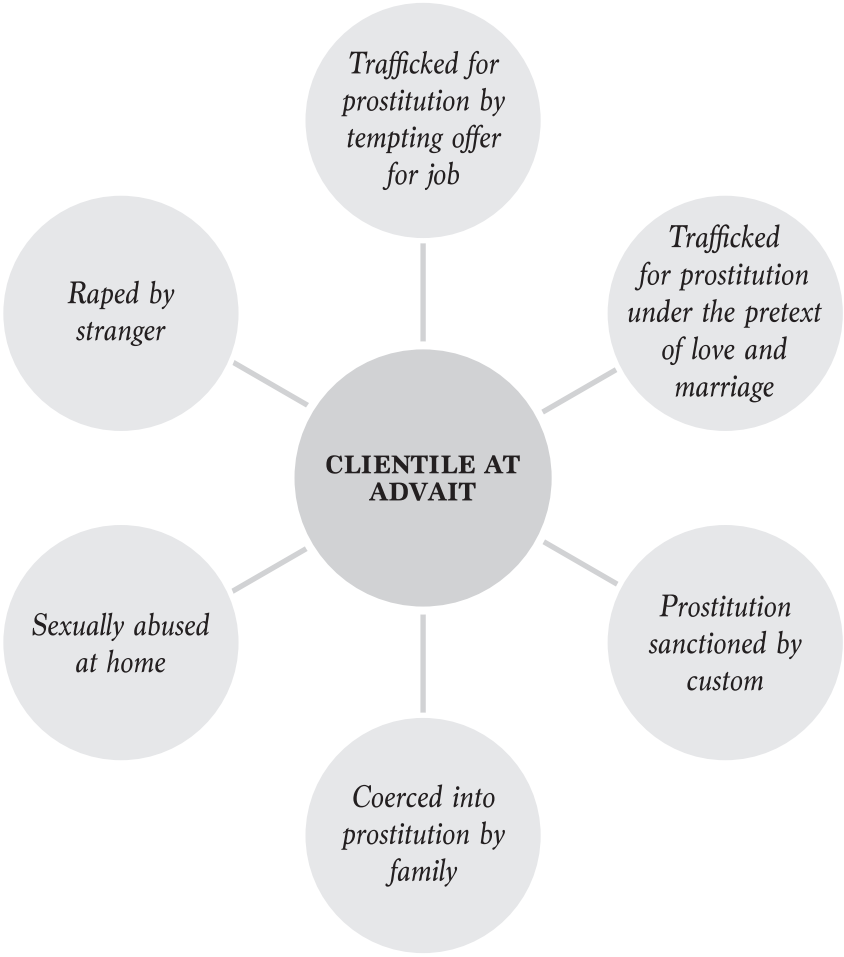



*Figure 3: Reason for client's placement in the Institution*

### 3.4.4 Symptoms/Behavioural issues of children

The presenting concerns of children when they are placed in the home are multiple and varied. They show almost all symptoms of trauma as mentioned in Section 1.4. This significantly manifest in two forms in case of adolescent trauma victims - the first is expressed as a lack of feeling and a sense of emptiness and the second is based

on repeated experiences of defeat over a long period. It is as though the childhood "self" has been abandoned but no growing adult "self" has replaced it and this vacuum engenders a high level of anxiety. Although child victims start looking and thinking like adults in many cases, it is important to acknowledge that such "growing up" is forced upon them due to their circumstances. They operate from a fear of social abandonment and experience social frustration and engage in acting out behaviours such as running away or acts of aggression (Conger 1991).

Their initial challenges are around settling down in a place with systems, rules and a timetable, which in most cases is starkly different from where they were before. They actually need to come to terms with a system which is alien – starting with a practical shift in waking hours from night to day to more complex shifts from freedom (however apparent that freedom is) to live life in a locked up shelter. The children have to wake up at a particular time, usually much earlier than what they have been used to in their own home set-up as well as in their days of living in brothels, in the case of sex trafficking. They are expected to finish their personal chores such as bathing, washing clothes, and so on, in a fixed time, take responsibility in completing the task allocated on a rotational basis and are then expected to be ready for the programmes of non-formal, or formal education and vocational training. The routine and schedule helps children to give a structure to their life which has become unstructured and unpredictable but at the same time sufficient time is allocated for adjustment as this is a new way of life hence it cannot be "too flexible nor regimental" (Excerpts from interview with Ms. Sangeeta Punekar). Moreover, several children have to live together in a limited space and share limited resources. This gives rise to arguments and conflicts among the groups, which largely depend on the power that the groups hold over one another, for example, old members versus new members and the staff group versus the

users' group (Brown, 1989). Various problems also arise as children are introduced to vocational training because children with trauma exposure often lack the inclination or interest to learn new skills; their attention span is often very short they lack concentration and are restless. Thus, supporting the healing journey of these adolescents poses special challenges and opportunities because of their unique stage of physical and mental development and their exposure to severe sexual abuse and chronic neglect.

### 3.4.5 Situational analysis at the initiation of counselling/therapy

Counselling was initiated by Arpan in Project Bharati when the latter was it its fifth year of existence. It was already a home which had dealt with its initial setting up challenges and have set up a system and protocol of functioning. However, the home though had been able to develop an efficient operation and functional protocol, trauma and psychotherapy was a new arena for them as well as other stakeholders involved in the process. They were struggling with issues around discipline, understanding children's cry to go back to unsafe homes, anger outburst, self-harm behaviours, fights and resistance. Even for Arpan, it was the project in an unchartered terrain and a first of its kind to explore and learn. The counsellor of the home, Ms. Sandra Farel though had strong theoretical knowledge on trauma and psychotherapy however was new to work with this extremely traumatized population. She recalls, "I was very confident... I had a good theoretical background" but "at that time I didn't know what I was getting into".

The 23 girls who were placed in the home during the initiation were there for the last 4 years and were 'well settled' in the routine and the rules of the home. They were an "obedient" bunch of girls conditioned to please adults for being accepted. But anybody with a trauma lens would understand that it was neither their true self nor what was expected and healthy. The first visit of the counsellor

to the home in understanding the clientele surfaced this duality that need to be dealt with.

## Section IV

# The Long term Psychotherapeutic Intervention

### 4.1 Major Process involved for delivery of the psychotherapeutic intervention

The major processes for psychotherapeutic intervention were:

- Provide mainstream and alternative psychotherapeutic services through Group and Individual therapy in order to reduce the acute as well as complex trauma in order to increase functionality and wellbeing.
- Conduct capacity building sessions with the institutional caretakers and relevant staff members at regular intervals.
- Document client data (quantitative and qualitative) in formats like intake sheets, session case notes, client database etc.
- Conduct feedback sessions with the clients and the institutional caretakers about the impact of the psychotherapeutic intervention and capacity building sessions respectively.

### 4.2 Group Sessions

Group sessions involves the therapists working with several people at the same time. In the present context, a group session is used both as a solitary tool as well as integrated into a comprehensive treatment plan that also includes individual therapy and medication depending on the requirement. In the initial two years, the clients were only addressed through group sessions after which individual sessions were started. Group sessions takes place twice a week for a duration of 2-3 hrs. In the initial years, a single group was addressed as the clients time span of staying in the institution has been largely the same. However, the last 2 years have seen a lot of inflow and out

flow of clients making it challenging to address the group coherently. Hence in the last two years the group has been divided into two based on the time span children are placed with the institution. Clients generally start attending group session as soon as they have joined the institution and have undergone initial assessment by the therapist. In certain situations, the initial assessment as well as their participation in the group sessions is kept on hold as per the clinical judgment of the therapist. In the past this had been followed for clients showing high tendencies of self-harm behavior. This was done to ensure that group discussions do not trigger past trauma which can escalate self-harm behaviour. The minimum time span for a client to be in a group has been 3 weeks (as the girls shifted, as per court order) to 3 years.

Group sessions allow girls to receive the support and encouragement of the other members of the group as in this space they can see that there are others going through the same thing, which can help them feel less alone. By seeing someone who is successfully coping with a problem, other members of the group can see that there is hope and recovery is possible. As each person progresses, they can in turn serve as a role model and support figure for others. It also helps the therapist to experience/see first-hand how each person responds to other people and behaves in social situations. Using this information, the therapist can provide valuable feedback to each client. Group sessions are also very cost effective. Instead of focusing on just one client at a time, the therapist can devote her time to a much larger group of people and address issues which are common to all.

In the last 5 years, the group sessions have focused on three basic domains – psycho-education, skill building and need based intervention. This is in line with the key therapeutic principles of group psychotherapy as mentioned by Irvin Yalom (2005) – imparting

of information, installation of hope, corrective recapitulation, feeling of universality, existential factors, and development of socialization technique, interpersonal learning and group cohesiveness. The modality of conducting the group session has been to create a non-threatening, safe platform for the group so that it can facilitate knowledge gathering, gaining insights about self, attitudinal shifts and instil hope. The topic for discussion thus is chosen based on the group's articulation of a specific concern or challenge and the counsellor's observation of their need and requirement. Some sessions are structured whereas others are free flowing depending on the requirement. The tools used for the group sessions are sharing, role play for skill development, psychodrama, film discussion and debate.

The group sessions over a period of a year sequentially progresses from dealing with basic day to day challenges and settling down issues to more complex concepts and challenges that the clients need to understand and resolve. This progression of discussion is in line with children's gain of trust and comfort and sense of belonging to discuss issues closer to their heart. The initial sessions focus on evolving a safety contract so that they participate in their own safety by not indulging in self-harm behaviour and inculcating positive behaviour to take care of themselves. The concept of safety being the most central idea is the initial discussion point in all sessions. The earlier sessions also focuses on dealing with day to day challenges, for example dealing with caretakers because children who have experienced chronic neglect or sexual abuse generally have complex experiences with adults or authority figures. In this time span, communicating needs to caretakers is a critical tool to seek help and even develop a relationship with them. Hence the focus is on giving them skills to ask and not to take rejection personally. This is done through providing them with scripts to communicate their needs assertively to ask for help from the caretakers through role

play. It is encouraged that they verbalize their needs rather than the counsellor articulating it on their behalf. If they have any challenges, the counsellors' role has been to listen, validate and normalize it. The focus of these sessions is to help them settle down in the institution set up and aiding them to feel better so that they can take optimal benefit of the available facilities, studies and vocational training.

Once these basic requirements are satisfied, then the focus is on understanding relationship, expressing negative emotions, understanding unsafe behaviour so that the children can make sense of what happened to them in their past life. This helps to change their world view which revolves around, "I am responsible for whatever had happened and I am responsible to make my parents happy" [Excepts from interview of Ms. Sandra Farel]. This also opens up other key areas of discussion namely over-responsibility, sexuality, sex, body image, friendship and loyalty. Skill building also happens on inculcating self-soothing techniques like deep breathing, grounding exercise, identifying defense mechanism, self-talk and dialogues with different parts.

These input session are based on the counsellors observation of issues surfacing and children's concerns. Most children who have faced sexual abuse and undergone sexual exploitation generally have been observed to develop a belief system, "Post sex, a girl is damaged goods". Hence, this was taken up as a topic for discussion in one of the sessions using debate as a tool to elicit varied responses. The group which was in favour was very upfront in articulating their views and they had ample examples to quote and share from their own socialization and life experiences. However, the group against the motion was feeling lost since they had no information at all. Half way through the free flowing debate between group members, the counsellor facilitated the discussion by posing some

"thinking questions". The questions and takeaways of the session is reproduced below:

**The thinking questions:**
**Do men become 'damaged goods' if they have sex before marriage? Do we label people who remarry with religious and social sanction? What is sexuality?**

*Take Away from the session: Premarital sex before 18 years is not encouraged in the society for multiple of reasons. Some of the factual reasons are - anyone who gets into sexual relationship needs to be emotionally matured, well versed about sexuality and emotional complication it might bring in later; need to have knowledge about safe sex and how our country does not have many resources for unwed mothers. The idea is not to negate sexuality or sexual urges; but to understand that it is nature's beautiful gift and there is place, time and age for it. This is because impulsive sexual activity can bring consequences which a child is not emotionally or physically matured enough to face. At the same time submitting to sexual demand for maintaining a relationship will also have its own repercussion/s. Sexual assault on the other hand through force and/or manipulation jeopardizes the child's emotional and physical self. But none of these justify "girls being damaged goods" after pre-marital sex.*

*Figure 4: The take away in one of the group sessions*

On another occasion the therapist was discussing sexuality with the aim of addressing and reducing children's guilt about being sexually active at a young age. An interesting dialogue unfolded as clients themselves rationalize that everybody had different situational context for being sexually active and that does not demean them as individuals.

The conversation is replicated below:

**Counsellor:** *Why would a girl have physical relations?*

*• If she's in love and she really feels that this is my way of showing my boyfriend that I love him and that she ends up having physical relationship. Or*

*• Under compulsion… because there is a dire need – financial or otherwise.*

**Counsellor:** *So in both situations is it the girl's fault? I mean how?*

*Counsellor observes one group member starts sobbing and then crying.*

**Counsellor** *takes a break, "Are we triggering you? Do you want to take a break?*

**Client (who was crying):** *No. I want to be there. I want to know what it is.*

**Counsellor:** *I really want you to know, if you really feel something… if I said something which triggered you I am sorry.*

*[This client was a victim of rape so for her the sexual act was not out of love nor out compulsion but it was forced on her]*

**Client (who was crying):** *In case it's neither of these – the sexual act was not out of love or compulsion but somebody raped her.*

**Counsellor:** *Ok. Let's add that to the list. Tell me, out of these three girls, who do you think the society will support the most?*

**Client (who was crying):** *The rape victim.*

**Counsellor:** *True. Because it is not her fault. Because the girl who was in love, society will say it was her fault. They will thrust responsibility on her. Blame her. In case she did it out of compulsion she will still be blamed. In case of rape, though she would be blamed, but there is a sense of wrong committed to her where her agency is considered limited.*

Through these kinds of dialogues and debates not only do clients' belief system and normative frameworks get questioned but their hope is flickered. They get to realize that even after a traumatic experience still they are neither damaged nor objectified. But they are worthy of love and care as they are beautiful individual/s with huge potential to thrive.

In the last five years the group sessions have covered the following topics which are presented below in a tabular form:

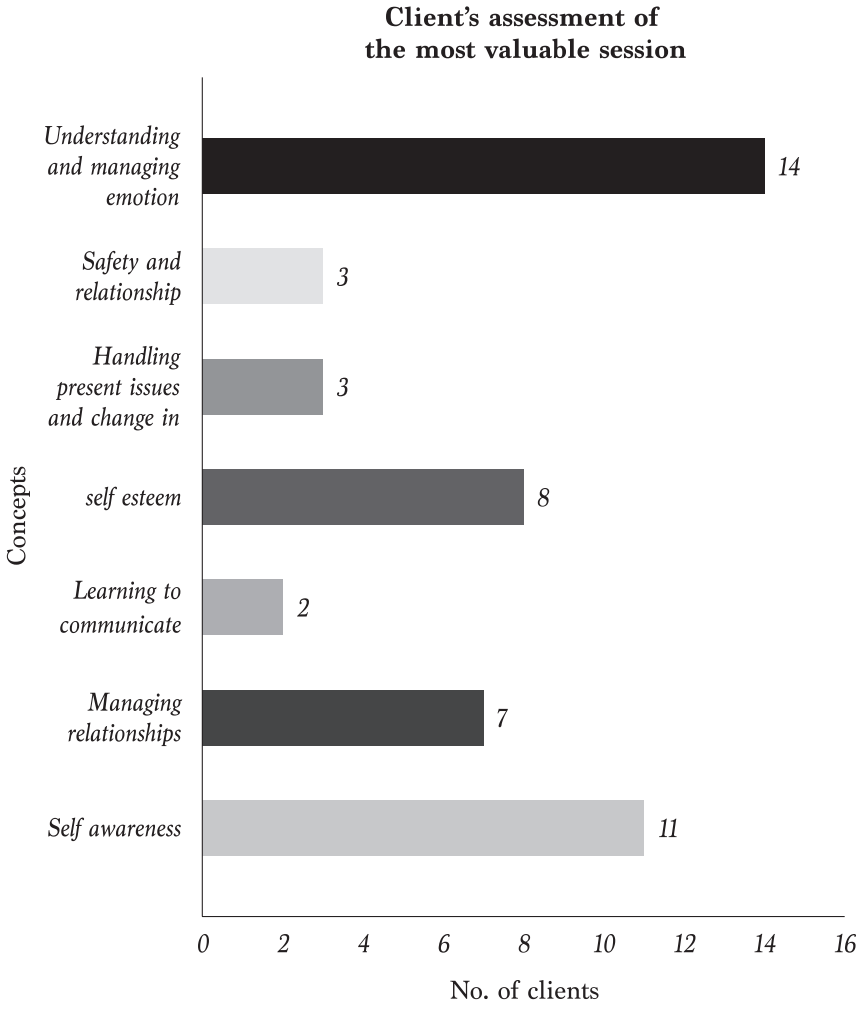
| PSYCHO EDUCATION | SKILL BUILDING | NEED BASED INTERVENTION |
|---|---|---|
| • *Trauma -Triggers and symptoms*<br>• *Neurobiology/Brain's response to trauma*<br>• *Attachment*<br>• *Idealization of parents*<br>• *Dissociation and grounding*<br>• *Sexuality*<br>• *Friendship*<br>• *Love*<br>• *Boundary settings*<br>• *Self harm*<br>• *Individual and groups session*<br>• *Suppressed anger*<br>• *Safety*<br>• *Antisocial Personality*<br>• *Trust*<br>• *Positive affect*<br>• *Emotion/feelings* | • *Handling Attraction*<br>• *Problem solving*<br>• *Respond to peer's acting out*<br>• *Communication skills*<br>• *Responding to new rules*<br>• *Dealing with urge to go back to unsafe environments*<br>• *Handling peer pressure*<br>• *Dealing with crisis*<br>• *Providing peer support while going for court cases*<br>• *Responding to disrespectful adults*<br>• *Coping with irresponsible adults*<br>• *Taking care of one's needs*<br>• *Identifying and labeling different emotion and linking it to day to day* | • *Trauma -Triggers and symptoms*<br>• *Neurobiology/Brain's response to trauma*<br>• *Attachment*<br>• *Idealization of parents*<br>• *Dissociation and grounding*<br>• *Sexuality*<br>• *Friendship*<br>• *Love*<br>• *Boundary settings*<br>• *Self harm*<br>• *Individual and groups session*<br>• *Suppressed anger*<br>• *Safety*<br>• *Antisocial Personality*<br>• *Trust*<br>• *Positive affect*<br>• *Emotion/feelings* |

| PSYCHO EDUCATION | SKILL BUILDING | NEED BASED INTERVENTION |
|---|---|---|
| | *event*<br>• *Working on compulsion to repeat traumatic behavior*<br>• *Identifying one's strength – self awareness*<br>• *Identifying healthy and unhealthy disassociation*<br>• *Dealing with institutional changes*<br>• *Conflict resolution*<br>• *Identifying peer strength*<br>• *How to receive compliments*<br>• *Personal safety*<br>• *Deal with perpetrator in the future*<br>• *Sharing of past in new relationship* | |

*Figure 5: Concepts dealt in group session*

According to the clients interviewed, 19 who attended group sessions and 8 clients who attended both group and individual session, 14 of them felt that sessions on understanding and managing emotion had benefitted them the most, followed by self-awareness, self-esteem, managing relationship, understanding safety, handling present challenges and communication skills. This is understandable as

children who have experienced complex trauma often have difficulty identifying, expressing, and managing emotions, and may have limited language for feeling states.




*Graph 1: Client's assessment of concepts dealt in group session*

The flow of a typical group session is reproduced below:

**A Typical Group Session at Project Bharati**

*ICE BREAKERS*

**Counsellor:** *Which movie did you watched on Sunday?*

**Clients:** *starts opening up and talking.*

*SAFETY ISSUES*

**Counsellor:** *How was this week? Did you take good care of yourself? Did anybody stop eating? Did anybody harm themselves? Did anybody use abusive language? Did anybody have the urge to raise their hand on each other?*

**Client 1:** *Very shyly says that she did not eat.*

**Counsellor:** *What happened? Something must have happened that you know you couldn't take care of yourself. Why would somebody continue doing unsafe behavior when cognitively she knows that it is unsafe. So there has to be some payback. So what was the payback?*

**Other group members:** *Started smiling and laughing because they knew what was happening with this particular girl… when she stopped eating. She used to get a lot of attention.*

**Counsellor:** *So if you really love her then what are you going to tell her? |counsellor coaches them how they need to verbalize to help her|*

**Other group member:** *I understand your anger, I know you are trying to tell me something but unless you tell me in words I am not going to come to you.*

**Counsellor:** *Because this person is angry and she is not telling me in words, she is telling me by not eating. So I don't want that. I want her to say that I am angry with you. And not take it out on something else.*

**Client 2:** *One of the group members always say "why don't I die"?*

**Counsellor:** *What does that mean? It means someone is feeling so helpless that she is frustrated? So then what can we do? Can she express her helplessness in a different manner?*

*CONCERNS BY CLIENT*

**Client 3:** *I got a phone call from my home. I am very upset about what my mom said to me. She told me about lot of problems at home and kept the phone*

**Counsellor:** *Do you think what her mom did was okay for her? How is she feeling?*

**Other clients:** *Worried*

**Counsellor:** *Let's talk about the adult's job and the child's responsibility and how we can separate them so if the next time my mom calls me up and tells me there are hundred worries, what would I tell her?*

*|Counsellor coaches them on a script to express themselves to their family member as they need the skill of assertively|*

*"You know mom I know that you are worried, but when you tell me your worries I am not able to study after you keep the phone down. So I want you to ask me how I am doing and find somebody else to talk to about your worries and not to me. I am here and I can't help you but when you tell me I feel restless. I can't sleep, I can't eat, and I can't study".*

**Counsellor:** *You know you are helping your mom, you are not damaging her. So she will seek help somewhere else from another adult who is in a position to help her.*

*CLOSURE*

*Figure 6: Template of flow of a group session*

This template brings out the fact that group session provides an atmosphere that encourages diversity of opinion and provides positive feedback for children's attempt to stand up for themselves. However, certain precautionary measures are also taken to ensure the safety of children which is of foremost importance in trauma work:

- Check on whether everyone has followed the safety contract
- To observe whether clients are taking care of themselves by grooming themselves, eating, bathing
- Before a client starts sharing personal details, to check with her if this is safe to do/will she feel better after sharing or worse
- To check feelings of clients after sharing

- To interrupt if somebody is overwhelmed and check whether any sharing is triggering
- To allow clients to leave the space and calm themselves, in case of any strong feelings
- Ask clarifying questions and draw out opinions from the group.

### 4.2.1 Outcome of group session

### A. Counsellor assessment

The focus of the group session has been to provide psycho-education so that children can acquire knowledge and skills to be safe and handle day to day challenges. The group sessions have been effective in bringing a drastic change in children's understanding of safety and safe relationship, understanding responsibility, self-awareness of their emotions, understand that their emotions are reasonable, friendship and sexuality. Some of those moments of empowerment in clients that have left an imprint on the counsellor have been replicated below.

#### A.1 Understanding Safety and Safe Relationship

When they come into the institution children yearn to go back to their parents even if they are the perpetrators or involved in their trafficking. Hence when rules are crafted forbidding children to meet such people, it is normal that there are a lot of angry outburst and attachment cries. However, when children have undergone a significant number of group sessions they are able to see merit in such rules. As the group sessions give them the platform to examine the rules and they are not pressurized to abide by them without realizing the rationale.

In one such group session, there was a discussion around a rule which permitted only mothers and safe individuals to have meeting rights with clients and restricting others who might utilize these spaces to re-

groom the child. In the session a client, whose stepfather had sexually abused her, was very angry. She expressed her anger saying, "why is it that rule made? I don't agree with it ... Even if my biological father is not there... if my step father is coming to meet me, what's the harm?" [Excerpt from Ms. Sandra Farel's interview]. The counsellor validated her anger and initiated a discussion on the web of responsibilities of adults in taking care of the child. The first responsibility of the child is located in the family, with the parents; the second circle consists of relatives in the family; if both these circles fail, then organizations take over and rescue the child and place them in front of the CWC who places them in institutions. So if these primary and secondary circles of people were unable to protect children then the next circle comes into action. In this schema, she validated the child's anger as it is painful to accept that one's parents and family have failed to take care of them.

The conversation moved on to discuss the consequences of the stepfather coming to visit the client. The dialogue unfolded that when the stepfather keeps on visiting and giving the girl attractive gifts along with love and attention, the client will experience conflicted feelings. She will have conflicting feelings because one part of her will have hatred because of past experiences and one part will be attached to this person because of the love she is experiencing now. As with every individual the need for love (attachment) is much stronger than the need for hate, the client will start idealizing the abusive authority figure and accepting the sexual abuse as her fault. Here both the defense mechanism (fight/flight/freeze/submit) and attachment cries get simultaneously activated. This is a sign of a disorganized attachment type where the source of comfort is also the source of pain. Experiencing this double bind is common among trauma victims and it needs to be brought to their awareness. The girl understood the rule as a safety measure and internalized it and hence did not see it as a

measure to separate her from her loved ones. She internalized it to the extent that whenever a new girl would join the group session and the counsellor would explain the safety contract to be followed, she would be the spokesperson to say, "And only safe people are allowed to meet you. It's not about whether it's a relative or not; it's about who is safe" (Excerpt from Interview with Ms. Sandra Farel). This apparently trivial information given in a non-judgmental space in a gentle manner with validation of the client's emotions and empathizing with her reason for getting attached to her step father made her look at the rule in a different light and participate in her safety. She internalized it for herself as well became a catalyst of change in someone else's life.

### A.2 Participating In self care

Children participate actively in self-care once they have internalized the messages of the safety contract which is reiterated in the group sessions frequently at regular interval. Clients actively participate in personal grooming which also becomes an important indicator to map self-care. As the therapist communicates, "If somebody comes shabbily it talks a lot about self-perception. " I'm not significant enough"... so I always observe their appearance. If they are coming in nice costume I always make a comment on that... it talks a lot about them. It says, "You know I am a good person... Lovable" as well as "I am in love with myself".

Self-care also includes clients using other avenues to channelize their negative emotions of anger, sadness, helplessness and reduction in self-harm behaviours like self-cutting, head banging and starving. Within a month of participation in group sessions (Excerpts from Interview of Ms. Sandra Farel) girls express themselves without using abusive language or raising their hand as children learn to identify their own feelings and create a safe space around them either by distancing themselves at times of experiencing extreme emotion or

using self-soothing techniques to calm down before responding. This is a significant shift. There is also a drastic reduction in self-harm behavior compared to their past. This becomes evident by critical observation of the number of self-injury marks when clients start group sessions and after they have been part of it for a minimum time period. There are times, when girls express their anger, or sadness through only crying. In the group sessions this is addressed and after validating the clients' hurt, anger or any other underlying emotions; skills are inculcated to find alternative ways of expressing themselves so that she can get relief as well as help.

### A.3 Understanding Sexuality

In one of the group sessions, the counsellor was discussing sexuality and sexual need. In the discussion sexual acting out as a consequence of trauma was also flagged as some clients in the institution were touching other girls inappropriately, or getting physical with girls in a sexual way. The counsellor was discussing the fact that having sexual needs is normal; however, the urge to gratify it immediately is often the outcome of poor impulse control and lack of skills for delayed gratification. To kick start the discussion and elicit responses from clients, the counsellor posed a question:

**Counsellor:** *If you were born in a safe universe do you think at fourteen or fifteen your parents would have allowed you to have physical relationship with somebody?*
**Clients:** *No*
**Counsellor:** *Why not? Because you are not physically and mentally ready. What do you do if you have urges? How you can distract yourself? You need to validate that need or urge, accepting that part of self and considering it as age appropriate. You need to have conversation with that part and explain how there is an appropriate time for everything. You can go back to group or involve yourself in some activity – play/ fun/ journal writing etc. and other constructive things.*
**Client 1:** *Didi (Referring to the counsellor) if somebody who is 35 years old and*

*whose husband has left her and if she has urge what would she do?*
*[The client was referring to her mother as her mother is sexually active after her father abandoned them. She wanted to understand, "I am young and I should distract myself but what would a 35 year old do"… Is her sexual urges and need for immediate gratification valid]*
**Counsellor:** *The urge is absolutely normal but satisfying it in an unsafe manner is not healthy. At the age of your mother there is societal approval for somebody to meet her sexual needs as she is physically and mentally matured. Instead of running around and hiding and feeling ashamed about it, she can take a step to accept it. There are different ways for acceptance and that is determined by the individual's value system.*
*After this discussion, the client spoke to her mother: "why don't you get married and start a new life".*

*Figure 7: Discussion on sexual urges*

The information, that the counsellor thought was helping them and had not even envisaged that she would be thinking in relation to her mother, in turn helped her mother as well. These are some moments which stayed with the counsellor as gratifying and fulfilling as the information is not limited to clients and creating a dent in their mind; but the clients see the value in translating and living it and they are empowered enough to be the catalyst of change in someone else's life. This is not a solitary incident but there are multiple instances shared by clients and caretakers where clients sit with their journal (where they document their learnings from counselling sessions) and talk to their mothers and younger siblings so that their family members can learn and unlearn through them. This clearly shows that the information and knowledge is liberating in the true sense of the term and they are in a position to take it forward.

### A.4 Over –Responsibility

Reenactments of the traumatic past are common among trauma survivors. This frequently represents either explicit or coded repetitions of the unprocessed trauma (Chu, 1991; Messman & Long, 1996; Van der Kolk, 1989). Reenactments can be expressed psychologically, relationally, and somatically and may occur with conscious intent or with little or no awareness. Added to this, the aftermath of insecure disorganized patterns of attachment includes impaired self-worth and a belief that one deserves to be abused, patterns of traumatic bonding with those who do harm and parentification –caretaking of others, approval seeking behavior leave the clients particularly at risk for additional exploitation, re-victimization, and difficulties in life.

For trauma survivors when a parental-type role becomes a more consistent, patterned way of systemic functioning it is thought to have negative consequences for the child. Thus over responsibility and parentification are some of the key themes that are dealt with through the group sessions. When clients start group sessions they are overwhelmed and anxious. They are constantly worried about what is going to happen to their family members in their absence. Through psycho-education they learn to develop boundaries and communicate their feelings and say 'NO' without feeling guilty about it. These input sessions help them to connect back to their adolescent self and encourage them to start exploring life from an adolescent's lens with age appropriate rights and responsibilities. This gives them the skills to communicate to their parents that they need to take care of themselves and that they are not in a position to help them. Once this sense of over responsibility goes down, they are better able to utilize the opportunities available to them.

As one of the clients mentions, "I could not say "No". Once our

sessions with Didi [cousellor] began, it helped me to understand that I needed to say "No" in situations where I was not comfortable with something. I am able to say it now." [Excerpts from Quarterly Reports of Ms. Sandra Farel]

These shifts do not happen overnight but need consistent deliberation, in a safe space with trust and comfort. Hence being part of the group sessions over a period of time the clients become more vocal, more expressive, have more trust and are able to confront each other in the group, giving and receiving feedback and posing questions which are in relation to larger issues of life. On the one hand the psycho-education helps children put their abuse in perspective at a cognitive level. On the other hand, as they understand that their parents/ caregivers were not in a position to protect them - it helps them lessen their shame. It is as they would tell us, "My family could not keep me safe, not because they don't love me. But because they did not have information or resources" and hence "there is no point in blaming myself for it" (Excerpt from Interview with Ms. Sandra Farel). Simultaneously, skill building in group sessions equip them with assertive communication skill, interpersonal exchanges, self-care, alternative ways of expressing their emotional pain and helplessness without using abusive language or inflicting harm on others or themselves, working on their sense of feeling over-responsible for their family, bond with each other and caregivers and seek help.

The tools that have been used for mapping the shifts are observation by the counsellor (clinical assessment) to map progress within sessions; feedback from the caretakers, peer feedback and clients' self-assessment for mapping shifts in out-of-session progress. This mapping helps both in the articulation of tangible outcomes in a spectrum that is otherwise so fluid yet momentous as well as in future planning of sessions based on the client's requirements.

The counsellor's assessment parameters are reproduced in tabular form:

| BEHAVIOUR PATTERNS WITHIN SESSION | BEHAVIOUR PATTERNS OUTSIDE SESSION |
|---|---|
| • *Participation*<br>• *Nature of discussion*<br>• *Personal sharing*<br>• *Mutual Feedback*<br>• *Mutual Interaction during group activities*<br>• *Sharing of current challenges*<br>• *Talking about unpleasant emotion*<br>• *Expressing need* | • *Willingness to learn*<br>• *Participation in group activities*<br>• *Personal grooming*<br>• *Ability to express emotion*<br>• *Taking initiative to communicate*<br>• *Asking for help*<br>• *Emotional Outburst*<br>• *Mood swings*<br>• *Assertiveness and taking care of ones' need*<br>• *Ability to express unpleasant emotion*<br>• *Deal with interpersonal conflict*<br>• *Self harm*<br>• *Withdrawal/Isolation*<br>• *Blaming* |

*Figure 8: Parameters to map Group session*

Based on these parameters, the following shifts are mapped in clients participating in group sessions for a period of one year as per counsellor assessment:

| PARAMETER OF ASSESSMENT – DURING SESSION | DURING INITIATION | AFTER 3 MONTHS | AFTER 6 MONTHS | AFTER 9 MONTHS | AFTER 1 YEAR |
|---|---|---|---|---|---|
| Participation | Limited participation; checking out the counselor and the group | Increase in comfort; but tend to participate when asked; | Full-fledged participation by most clients | Full-fledged participation by most clients | Full-fledged participation by most clients |
| Nature of discussion | Self-care, safety and importance of counselling; Discussion has to be structured | Self-care, safety and group dynamics; | Problem solving and Interpersonal skills; discussion are around their present concerns and challenges | Trauma, Problem solving and Future planning | Sexuality, friendship, family concerns |
| Personal sharing | Clients are not comfortable; Personal sharing is not encouraged till history of clients are being taken; testing time for clients | Clients are skeptical of personal sharing | Clients opens up but counselor does not encourage till all the group have developed trust | Comfortable to personal sharing of daily challenges and future issues; personal sharing regarding past abuse not encouraged | Comfortable to personal sharing of daily challenges and future issues; personal sharing regarding past abuse not encouraged |

| PARAMETER OF ASSESSMENT – DURING SESSION | DURING INITIATION | AFTER 3 MONTHS | AFTER 6 MONTHS | AFTER 9 MONTHS | AFTER 1 YEAR |
|---|---|---|---|---|---|
| Mutual feedback | New clients are weary of giving feedback to seniors fearing consequences; they were on guard in the fear of evoking anger | Still not comfortable giving feedback; become aggressive when needs are not met | Some clients are comfortable; whereas some are still hesitant | Clients are comfortable to give feedback to each other in their group; but not with others | Clients are comfortable to give feedback within groups as well; except few who get triggered |
| Verbalizing their strengths | Very skeptical even to acknowledge their strength | Still not comfortable | Trying but efforts need to be focused | Can articulate with counsellor's assistance; but still not spontaneous as it is still perceived as boastful and associated with shame | Can articulate with counsellor's assistance; but still not spontaneous as it is still perceived as boastful and associated with shame |
| Seeking help | Hesitant to seek help | Taking initiative to connect with counsellor for individual session and family issues | Can seek help within session; gets disappointed if cousellor cannot accommodate post group session; still can't seek help from resources other than counsellor | Can seek help within session comfortably which is encouraged and appreciated | Can seek help within session as well outside it. |

| PARAMETER OF ASSESSMENT – DURING SESSION | DURING INITIATION | AFTER 3 MONTHS | AFTER 6 MONTHS | AFTER 9 MONTHS | AFTER 1 YEAR |
|---|---|---|---|---|---|
| Talking about negative emotion | Not familiar how to identify and label emotion | Clients are more into acting out | Can identify and label their emotion like shame, sad, anger, hurt and fear | Still hesitant to talk about emotions like envy and jealous | Most clients' can share emotion without shame and others can accept it as well |

*Figure 9: Progress of clients' within group session*

The counsellor assessment based on the progress of the clients outside the sessions based on clients' sharing, peer feedback and caretakers' feedback:

| PARAMETER OF ASSESSMENT – OUTSIDE GROUP SESSION | DURING INITIATION | AFTER 3 MONTHS | AFTER 6 MONTHS | AFTER 9 MONTHS | AFTER 1 YEAR |
|---|---|---|---|---|---|
| Personal grooming | Practiced because of caretaker insistence; few wear dress shabbily | Personal grooming is understood as part of self-care and safety contract of group session | It's taken seriously and clients groom themselves | It's taken seriously and clients groom themselves | It's taken seriously and clients groom themselves |

| PARAMETER OF ASSESSMENT – OUTSIDE GROUP SESSION | DURING INITIATION | AFTER 3 MONTHS | AFTER 6 MONTHS | AFTER 9 MONTHS | AFTER 1 YEAR |
|---|---|---|---|---|---|
| Willingness to learn | Fearful of new learning; did not see value in vocational training; some clients show resistance to tailoring | Started showing interest in new learnings; no resistance is shown | Each client is at different level and not giving up | Most of them are willing to learn; preparing for giving exam; learning new language so that they can appear in future | Convinced that education is the way for better future; they are also using each other's strength to complete a task. |
| Participation in group activities | Participates in group activities as it is organization policy; some do resist as well; conflict within group members is frequent | Conflict persist; but able to distinguish between healthy and unhealthy disagreements; can resolve conflict without adult involvement | Gang/mob mentality is not evident; senior housemate have stopped bullying the newer ones and are forthcoming in supporting them | Newer clients are ready to seek help from senior house mates | Have evolved better ways of solving group dynamics |
| Ability to concentrate on studies | Less concentration and focus | Started to concentrate | Most of the clients can concentrate; some of the clients' get distracted because of sexually acting out | Addressing sexual acting out helped the clients to concern better but needs more help and acceptance | Most of the clients can concentrate; some clients are being triggered into sexually acting out is coping better |

| PARAMETER OF ASSESSMENT – OUTSIDE GROUP SESSION | DURING INITIATION | AFTER 3 MONTHS | AFTER 6 MONTHS | AFTER 9 MONTHS | AFTER 1 YEAR |
|---|---|---|---|---|---|
| Taking initiative to communicate | Hesitant to take initiative and communicate; few feels they are helpless | Labelling of caretakers as good and bad hinder the process of effective communication | Most of the girls has started initiating conversation depending on their comfort with at least one caretaker; needs encouragement from the counsellor or their peers | Most of the girls initiate conversation | Most of the girls initiate conversation; comfort with each caretaker varies; some clients have started showing leadership quality and support their peers |
| Emotional Outburst | Repressing their emotion | Few clients are showing emotional outburst as copying mechanism; does not show any remorse afterwards | Clients who were using emotional outburst are willing to talk about it later | Mostly clients not using emotional outburst except one client on medication | No incident of emotional outburst was reported; even if client feel negative emotion they reconnect quickly; caretakers also acceptable of negative emotion |

| PARAMETER OF ASSESSMENT – OUTSIDE GROUP SESSION | DURING INITIATION | AFTER 3 MONTHS | AFTER 6 MONTHS | AFTER 9 MONTHS | AFTER 1 YEAR |
|---|---|---|---|---|---|
| Expressing emotion | Hesitant to express, especially with caretakers | Clients are still reluctant | Clients have initiated | Client have started asking for individual spaces to express their hurt with caretakers | Are more comfortable to express emotion |
| Blaming | Clients find challenging to take responsibility of their emotion | Clients take responsibility in session with counsellor's support; swing between over-responsibility and responsibility | Cognitively they understand the difference between responsibility and over-responsibility; can handle to some extent with peers but not with adults | Can take responsibility only when they feel safe | Can take responsibility only when they feel safe |

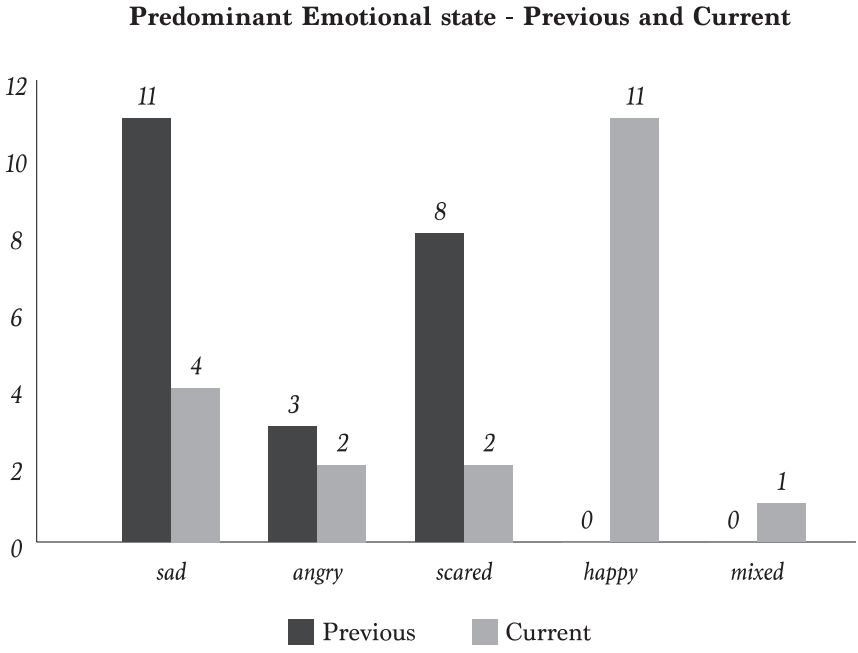
*Figure 10: Progress of clients' outside the session*

### B. Assessment by clients

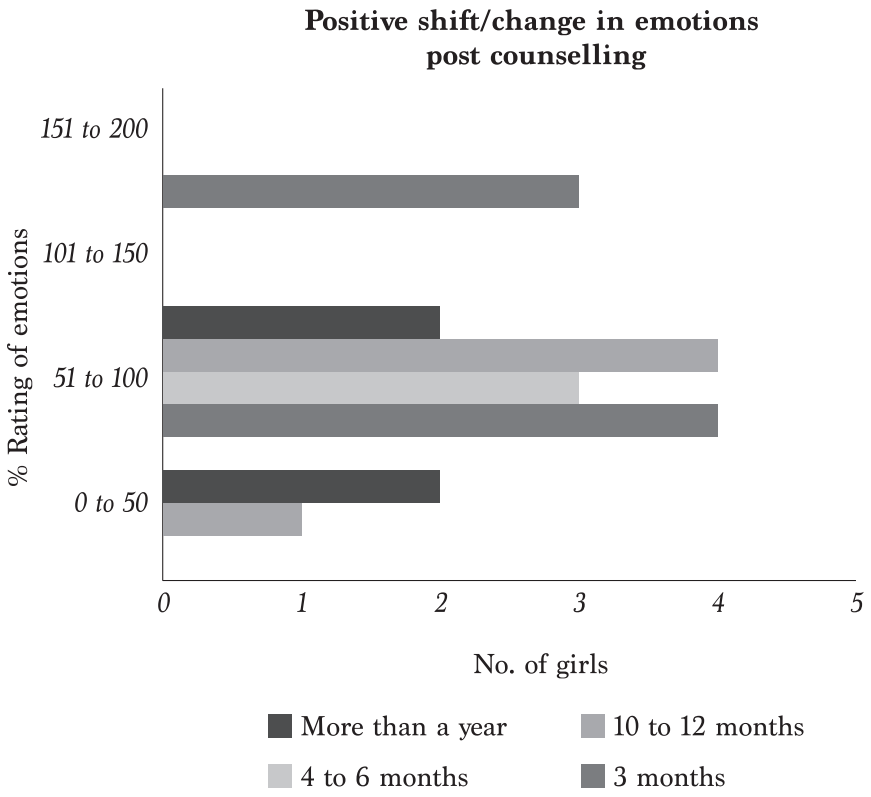
19 girls who were attending group sessions ranging from a couple of weeks to 2 years were interviewed to understand the clients' assessment of the counselling process and their self-assessment of shifts in themselves. Five parameters were used for clients' self-assessment - Predominant feeling before and after attending group sessions, acquired skills in handling emotion, acquired skills in communication and expressing need, Instillation of hope and goals for

future and becoming the catalyst of change.

### B.1 Clients' self-assessment



### B.1.1 Predominant Emotional State – Pre and Post therapy




*Graph 2 and 3: Predominant feeling pre and post session and concomitant positive shift*

Defining emotion is difficult. For our purposes, we have defined emotion as the feeling, or affect that occurs when a person is in a state or an interaction that is important for him or her, especially to his or her well-being (Campos, 2004). Clients, when placed in institutions are often either uprooted from their homes, unsafe in most cases, or are transferred from another institution for long term stay, or rescued from brothels/dance bars. However, because of the displacement along with their chronic trauma history children are restless, angry, sad, numb, scared, confused, and anxious. Before embarking on the

process of counselling, the majority of the clients recollect having been sad, scared and angry. However after engagement in group sessions children reported to be happy predominantly (57.89%) and significant reductions in feeling sad, angry and scared. The shift is encouraging as growing evidence suggests that, beyond making people feel good, the experience of positive emotions such as joy, happiness, and contentment holds numerous social, intellectual, and physical benefits for the individual (Fredrickson 2001). Enhancing people's levels of positive emotions who had been exposed to trauma thus appears to be an important empirical objective.

3 of the 7 clients (42.8%) who were part of the group sessions for 3 months reported the maximum positive shift ranging between 151% to 200%. This dramatic shift and heightened sense of well-being is noticed at the initiation of the therapy. Being part of a non-judgmental safe space gives them a sense of belonging and validation which helps to release negative emotions and hold and contain themselves.

*"I was sad and scared. I felt lost. I was separated from family. I wanted to run away. I feel happy now. I feel like I am safe here. I learn a lot and study. I know I am away from home and that I have been through a bad incident (hadsa). But I also know that it's not the end of my life". – Client attending group sessions for three months, trafficked by her boyfriend*

14 of 19 clients (68.4%) reported to have undergone 51% -100% shift from having negative to positive emotion as well as a lessening in intensity of negative emotions. 4 of these clients were undergoing therapy for three months whereas the rest were in therapy for longer period. The reason for children reporting 51% to 100% in their sense of wellbeing can be an indicator for the children being better equipped to read finer emotions - feel two compatible emotions, two

incompatible emotion, ambivalent emotion; it might signify that children are growing through the normal ups and downs curve in therapy; or that children have arrived at a plateau after the initial sense of jubilation. This also corresponds to the concept of 'Betwixt' which talks about the in-between state in therapy where there is a certain dip in the feeling of 'well -being' post the initial feeling of elation.

*"I was fearful that what happened in the past will happen again. Even when I was in the last home 10-15 people (older girls) used to hit me. I would cry continuously. I thought nobody will talk to me as I am bad. I would be angry and tell everybody to leave me alone. I could not sleep. I used to have nightmares. I used to hear all those sound, lights - loud music, all those people, my own people hitting me to extract money. Now my anger and sense of feeling scared has come down. I can't say I am happy. Two days I feel sad, two days I am ok, two days I am happy - and as if I am asking myself why "am I happy I need to be sad"" – Client attending group sessions for six months, coerced into sexual exploitation in a bar by family members.*

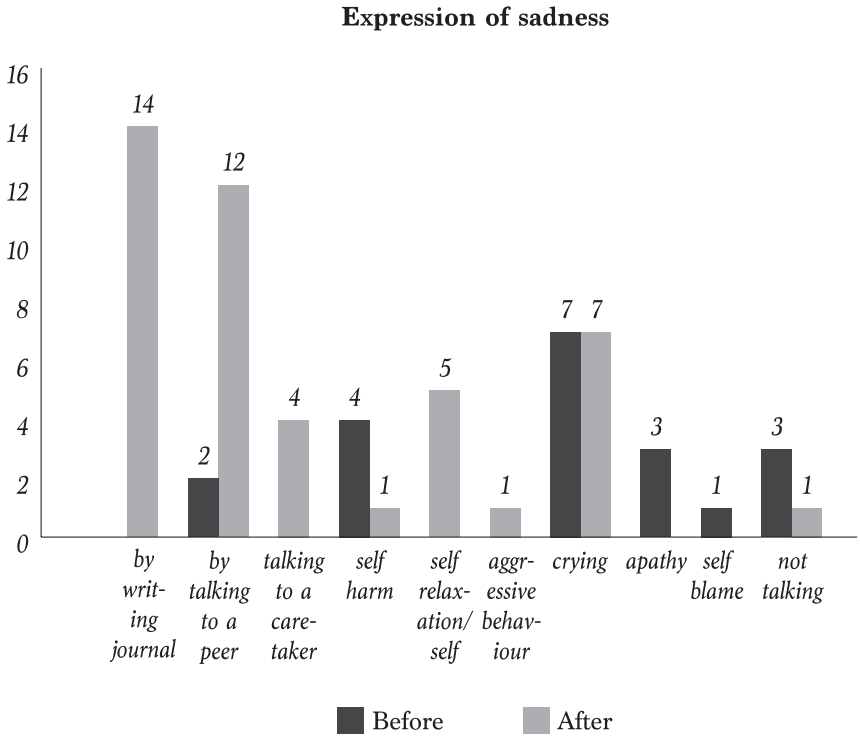
The minimum shift (0%-50%) has been mapped in clients who has been in group sessions for more than 1 year. This neither signify that children have not embarked in a journey of well-being nor that they have not reached the optimum level. But this speaks of the anxiety that they concurred with the interviewers about their future as they would shift out of the comfort of the home and the therapy where they have started belonging and owning up. It also talks about two important factors. Children who have lived in the institution for a considerable time span, also feel safe to express and communicate negative feelings more openly compared to newer ones who might still feel the need to display 'pleasing behaviour'. The other factor speaks about the hindrance of doing trauma work in an institution. This is because, for children with a trauma history it becomes challenging to live with other individuals with traumatic backgrounds as they not

only have to handle their own emotion but also be empathetic to other people's acting out. It is also possible that the interviewers in cases of dissociative clients happened to have interviewed the 'Emotional Part of the Personality' (EP) rather than the 'Apparently Normal Part of the Personality' (ANP). This would also explain children's perception of feeling negative emotions as vehement emotions become dominant when the EP is explicit as it is mediated by action systems of defense (the EP can be the sad, bereft part, sometimes experienced as a "child", the socially submissive "happy" part and /or angry, fearful, submissive, frozen parts, etc.); in contrast to ANP which is mediated by action systems of daily life. In the latter, the individual is better positioned to embark in an objective assessment of the situation.

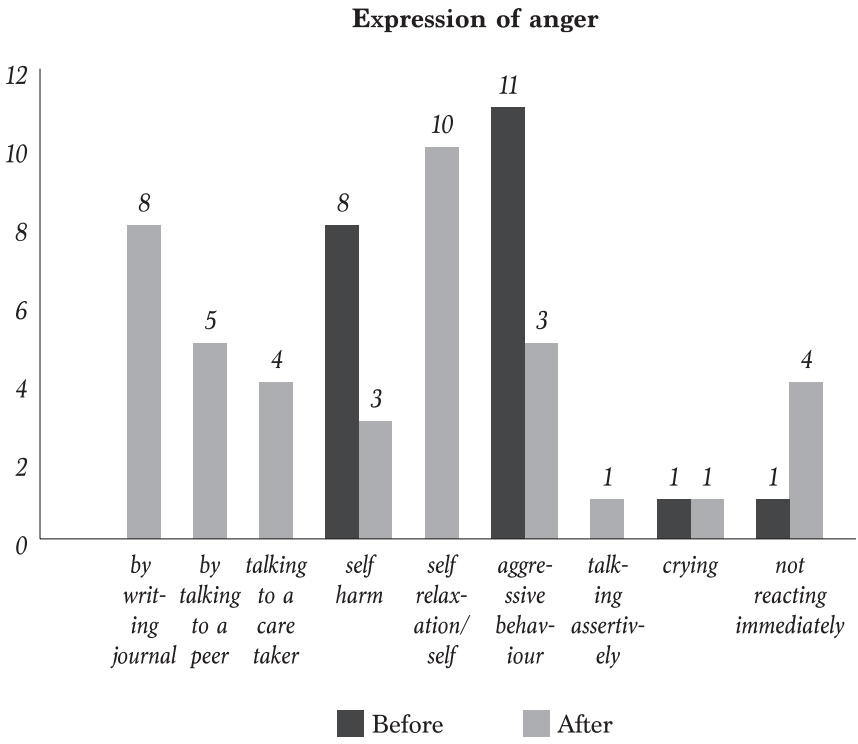
*"I am 18 in January, I can't go back home; I need to go to another hostel; I have a court session this month; I am anxious; I want to be in a hostel where I can work; what will it mean to be 18 if I still stay in a closed home" - client undergoing group sessions for more than a year, trafficked by family under the pretext of a job.*

This showcases the fact that each child embarks on a journey of her own and the sense of wellbeing in a therapeutic process rather than being static is fluid. It is dependent not only on the therapeutic process but the outcome is a combination of the therapy, children's receptivity, resilience and parallel life situations. It also talks about the therapeutic process both as change-oriented work that has an ending to long-term and maintenance-oriented work that doesn't have an end point.

## B.1.2 Acquired skills in handling emotion




*Graph 4: Expression of Sadness before and after Therapy*




*Graph 5: Expression of Anger before and after Therapy*

Emotions organize cognitive processes and inclinations for actions, thereby shaping social interaction in a significant way. As emotions shape social interaction, expression of emotions i.e., the complexity of one's own and others' emotion is an important skill for self-understanding and social interactions. Emotion is characterized by behavior that expresses the pleasantness or unpleasantness of the state individuals are in, or the transactions they are experiencing. Emotional expressions serve the important functions of signaling to others how one feels, regulating one's own behaviour, and playing pivotal roles in social exchange and hence becomes another important parameter to map. While experiencing emotion is universal, however, display rules—when, where, and how emotions should be expressed—

are not culturally universal (Shiraev & Levy, 2004; Triandis, 1994). In India, and other Asian countries the emphasis being on social connections; displaying difficult emotions that might disrupt communication in a close-knit group is rarely encouraged. This has its consequence for children who are not taught to express difficult emotion safely but to bottle it up until the time they can; after which it explodes.

Further in the case of children who have experienced complex trauma often have difficulty identifying, expressing, and managing emotions, and may have limited language for feeling states. They often internalize and/or externalize stress reactions and as a result may experience significant depression, anxiety, or anger. Their emotional responses may be unpredictable or explosive. A child may react to a reminder of a traumatic event with trembling, anger, sadness, or avoidance. For a child with a complex trauma history, reminders of various traumatic events may be everywhere in the environment. Such a child may react often, powerfully, and have difficulty calming down when upset. Since the traumas are often of an interpersonal nature, even mildly stressful interactions with others may serve as trauma reminders and trigger intense emotional responses

Through the above graphs depicting expression of emotion (feeling of sadness and anger) it is clear that children even having experienced complex trauma when exposed to positive ways of channelling difficult emotions are capable of using them to express difficult emotions assertively. The resources that were working best with children in descending order are: writing journals, self-soothing/relaxation techniques, self-talk, interacting with a peer or caregiver. This skill building helped to reduce angry outburst, crying spells, sulking, fierce arguments, fights and self-harm behaviour. This is a significant movement in clients as it helps them process, uncover, and express

anger and sadness as well as make them feel empowered, appropriately attribute responsibility, establish boundaries, and promote self-efficacy and power (Van Velsor and Cox 2001).

Though children cognitively were well aware of positive channels of expressing difficult emotions, to translate it into action was a continuous challenge. While it was easy to follow and execute in cases where the incidents were trivial in their perception; it became difficult in cases of blaming, labelling and situations which they perceived to question their identity and existence. The testimonials of clients undergoing therapy for 3 months, 6 months and more than a year is reproduced below.

*"I used to be angry before. I used to beat people up if I wanted to. Now I have calmed down a lot. I even feel nice when my family scolds me. I feel like someone is out there to care for me" – Client undergoing group sessions for 3 months, trafficked by mother and stepfather.*

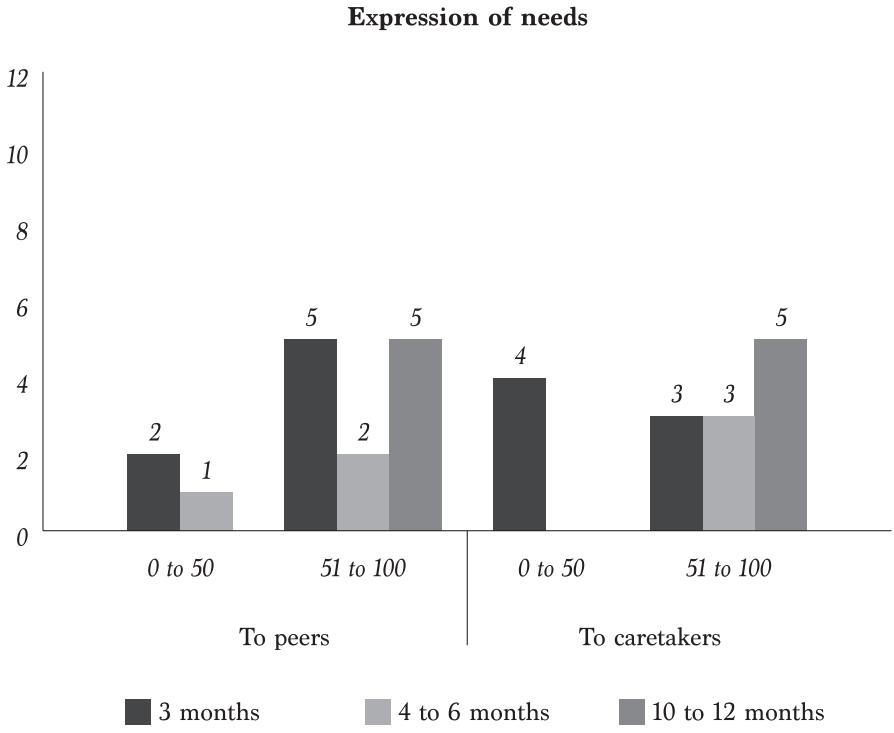
*"Earlier I would bang my head (sar patakti thi) I would harm myself; I would shout. I would be angry even if they are talking lovingly to me. I will throw utensils, I have thrown bowl of oil out of anger. I used to hit myself. Now, I can talk to few girls who understand me when I am angry or sad. I know it is not safe to talk to everyone about my past. They can make fun. We learnt that [in counselling] I need to share a little and wait to see of the person is capable of taking care of my trust" - Client undergoing group sessions for 6 months, coerced into sexual exploitation in a bar by family members*

*"I used to keep it inside me. I did not tell anyone. Earlier I did not even know what feeling sad or angry means. Now I know how I am feeling. The counsellor has given me a letter, she has asked to write down whenever there is a fight, name, date, time and reason of fight; to see whether there is decrease/increase in anger; I ask myself am I fighting with one single person or everybody; is it because of work; things like*

*somebody kept water and I have dipped my hand in it. Or what? This helps". I don't react if I am angry by not eating. But I tell sister [caretaker] to keep the food covered and eat once I have calmed down" - Client undergoing group sessions for 2 years*

These testimonies bear witness to the fact that children at different levels of therapy are also at different levels of self-awareness and in a process of translating the knowledge and internalizing it in their daily lives. While someone, with 3 months therapy, is being able to use relaxation techniques to calm down as well as take feedback in good spirit; a child exposed to therapy for six months is articulate about her boundaries and relationships; while a person in long term therapy is capable of introspection and self-awareness. This is not to claim that it's a linear progression in time; but it talks about the change that group sessions are capable of bringing in children who are often characterized by angry outbursts, misplaced trust, aggressive behaviour, low self-esteem because of their exposure to chronic neglect and sexual abuse.

### B.1.3 Acquired skills in expressing needs




*Graph 6: Expression of need by clients after therapy*

Children learn their self-worth from the reactions of others, particularly those closest to them. Caregivers have the greatest influence on a child's sense of self-worth and value. Abuse and neglect make a child feel worthless and despondent. A child who is abused will often blame herself, lack confidence to seek help and does not believe that others are capable to help. They also often take rejection personally hence can fall into the vicious circle of 'I am bad – no body is there to help – she did not help me – I know the world is a dangerous place'. Hence, shame, guilt, low self-esteem, and a poor self-image and lack of trust are common among children with complex trauma histories. To seek help one needs to believe help is available as

well as see one's need as justified, having meaning and value. Through therapy children understands that they are individuals with needs and rights and they need to ask for help, if they need people to listen to them. It is clear that children are able to articulate their needs both to their peers and caretakers after undergoing therapy. However, children exposed to trauma and unsafe adults have internalized that their needs will not be valued. Hence to relearn this takes time along with positive life experiences which will question their already established belief system. 3 of 7 clients undergoing group sessions for 3 months and 1 of 6 clients undergoing group sessions for 6 months have been able to articulate their needs to their peers in a range of 0%-50%. This movement is crucial as adolescent victims require and depend on social conformity and approval from their peers. A sense of belonging to the group is important to them. A testimony by the client reveals the challenges that she still faces in articulation of her needs to peers as she is still working on building her self-image and self-worth:

*"Counselling teaches us if you need help you can ask. There are certain things that I don't ask. I first think to myself whether it is justified or not. Then I ask. If I am having difficulty in studying by myself then I can ask for help as it is justified. But there are certain things which I can't ask. For example I can't ask for 'make up' [cosmetics for grooming] as they will then look down upon me" – Client undergoing group sessions for 3 months*

4 of 7 clients undergoing group sessions for 3 months have developed confidence to articulate their need to the caretakers in the range of 0%-50%.

*"I feel shy talking to elders. That's what was taught to me. I still have a lot of hesitation in talking to elders. I am afraid they will scold me or misunderstand me. It will take me time to be able to open up". – Client undergoing therapy for 3 months*

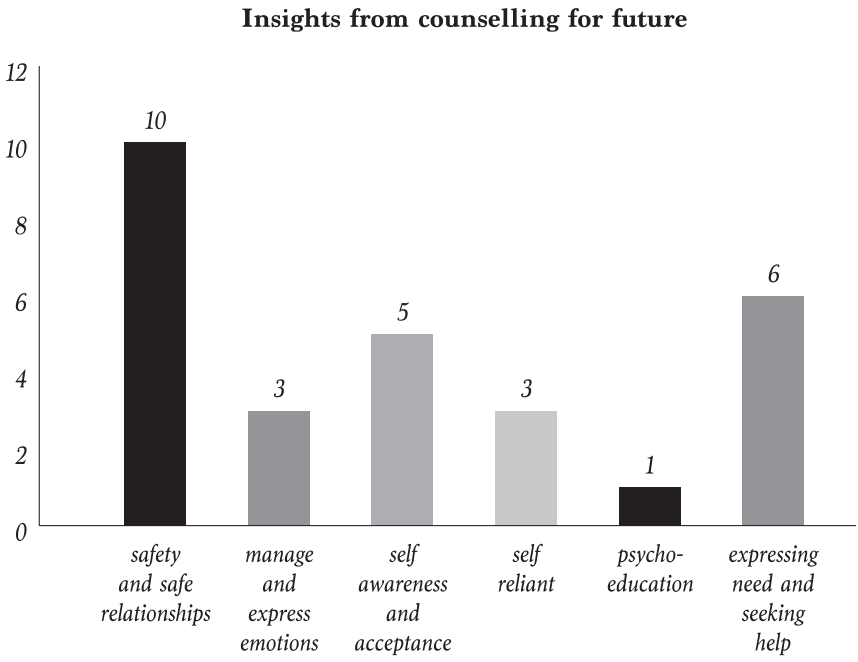
The rest of the clients have developed confidence in the range of 50%-100% to articulate their needs both to caretakers and peers.

*"I needed to call home and talk to my uncle as I am worried about my sister. I was trafficked by my uncle and aunt I did not want my sister to face the same. In therapy, the counsellor asked me if I have told the caretakers that I want to call. I lied initially. But then I told her I haven't. She accepted me. She told me to go and tell them what I need. She made me do role play so that I feel more confident" – Client undergoing therapy for 6 months.*
*"Initially I used to hesitate. But through counselling I have learnt to seek help from adults; if you don't tell how they will know; I ask for help, whether big or small even if I hesitate a little. With peers I can share but they cannot help me because they also need similar things which I require" – Client undergoing therapy for more than a year.*

### B.1.4 Instillation of hope and goals for future

| % of Feeling Hopeful | 3 months | 4 to 6 months | 10 to 12 months | more than a year |
|---|---|---|---|---|
| 0 to 50 | | | | 1 |
| 51 to 100 | 7 | 3 | 5 | 3 |

*Figure 11: Percentage of Feeling hopeful*




*Graph 7: Insights from couselling for future*

To plan for the future with a sense of hope and purpose, a child needs to value herself. It requires a sense of hope, control, and the ability to see one's own actions as having significance and worth. A complexly traumatized child may view herself as powerless, "damaged," and may perceive the world as a meaningless place in which planning and positive action is futile. Having learned to operate in "survival mode," the child lives from moment-to-moment without pausing to think about, plan for, or even dream about a future. Their negative expectations interfere with positive problem-solving, and foreclose opportunities to make a difference in their own lives.

However, being in the counselling process all 19 clients except one communicated that they feel 50%-100% hopeful about future; whereas 1 client felt that she feels 0%-50% hopeful about future. The clients

communicated that they are hopeful about the future as they now have better insights to keep themselves safe, understand and manage safe relationship, are more self-aware, have developed skills and resources to be self-reliant and are confident of expressing their needs and seeking help in case of any adversities. Clients also communicated that through the therapy process they have been aware of their inner resources and strengths which have made them confident about the future and able to aspire to dream and set a goal for themselves – be it being a dancer, designer, teacher, do higher studies, hotel management or just being independent.

*"If my family tells me that I shouldn't work I know how to tell them and convince them. If they are not trusting me I will take them to my place of work and show it to them" – Client undergoing therapy for 3 months*

*"Earlier I did not understand whether a guy is safe/unsafe for me. Now I will check with adults; I will talk to his parents and neighbours as that will help me assess him. I won't just trust anyone. He will have to be worthy of my love. I will think about my life. I used to think that if we had sex before marriage we can never have families; but now I know I can; the film stars also get married…don't they" – Client undergoing therapy for 6 months*

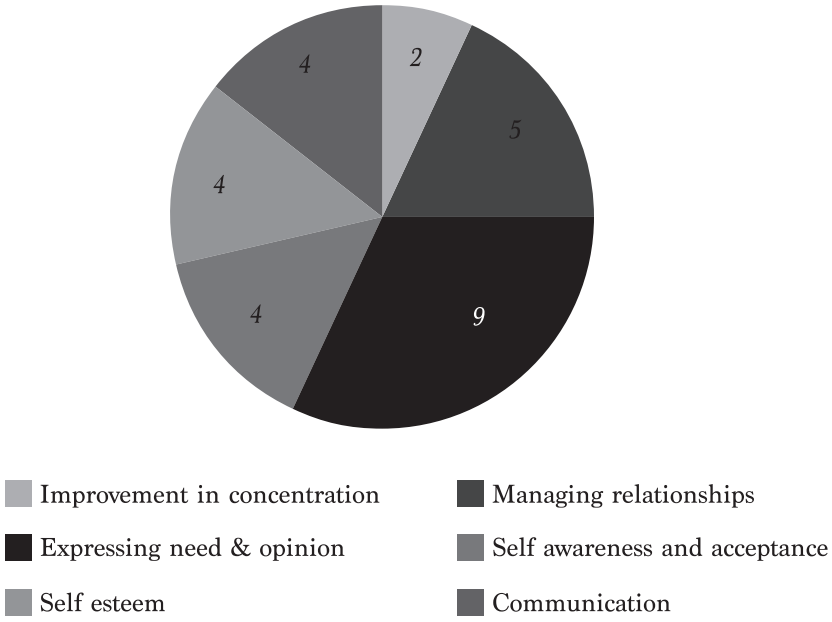
*"I am better able to understand what I want from a relationship. I know what kind of a boyfriend I want. I can also tell them to wait till I am 18 if they want to marry or have a physical relationship. I know if they love me, they can wait for me". – Client undergoing therapy for 12 months*

### B.1.5 Catalyst of change

Therapy sessions help clients deal with the psychological aftermath of neglect, sexual abuse and exploitation. It helps them to reconstruct a sense of equilibrium. When clients move from 'pain to power' from personal experiences of healing to a broader social analysis of abuse

and violence – they want to help other victims. This process helps survivors regain a sense of control and channel their fear and rage into positive efforts of facilitating someone else's journey of healing. All 19 clients felt that they have seen a significant shift in at least one aspect of their life due to counselling; some even reported to have seen amazing transformations in multiple arenas. The aspects which clients communicated to have undergone drastic life changing movements are – expressing needs and opinions, managing relationships, self-awareness, self-esteem and improvement in concentration.

**Changes in life due to counselling**




*Graph 8: Changes post counselling*

Clients also articulated that being in group sessions helped them to realize that they were not alone in their suffering and could give each other valuable affirmation and support. This led them to believe

that these learnings should not get restricted to them but passed on to others who would benefit from them. 11 of 19 clients hence went forward to share their learnings to people who mattered to them – friends, family members primarily mothers and sisters and roommates. 9 out of 11 respondents shared, in order to help.

*"I have told my best friend. I feel like telling her what I have learnt so that she can use it too when she is upset. She is the closest to me so I want to help her" – Client undergoing therapy for 3 months.*

*"I have told my mother if you love someone and feel confident he will take care and is safe for you - go ahead and marry. Do what you feel, ask your heart; if you ask 10 people they will suggest 10 things and you will feel confused. If you ask me I can't guide you because I am younger to you" – client undergoing therapy for one year, trafficked by relatives.*

*"When new girls come in I teach them what I learnt; if I teach the new girls they can share with others; when I will go from here they can teach others and keep themselves safe as well" – Client undergoing therapy for 2 years.*

One client shared about the learnings in the course of mutual sharing; and the other in communicating with parents about her decision to continue staying in the institution:

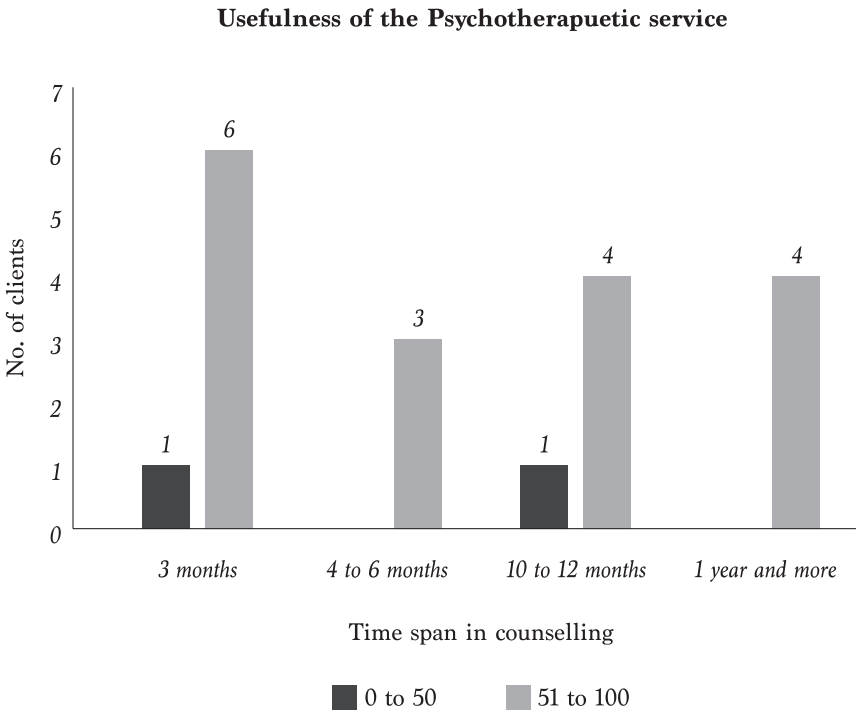
*"Parents were asking me to go home; but I told them that facilities I get here I will not get at home; I will come home after I become something; I can do what I want staying here. Parents have their own way of thinking I cannot change theirs but I can change mine".*

### B.2 The parameters used for mapping counselling process

The parameters used for mapping the counselling process by the clients were usefulness and uniqueness of the service, acceptance in

the counselling process and comfort with the counsellor.

### B.2.1 Usefulness of the Psychotherapeutic Service

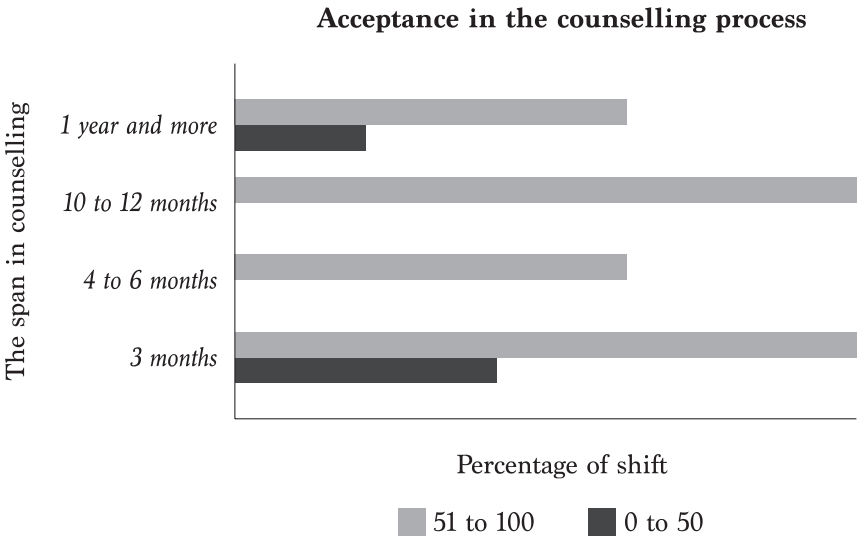



*Graph 9: Usefulness of Psychotherapeutic service*

17 of 19 clients, irrespective of their time span in the therapeutic process stated the process as useful in the range of 50% to 100%; only 2 clients averred the process to be useful in the range of 0% -50%. 8 of 19 clients who had prior experience of psychotherapy in other institutions asserted that current psychotherapeutic service provided was drastically different, falling in the range of 50% -100%. It is also beautiful to see how the clients have evolved their own definition of the therapeutic process which sums up the essence of counselling. While some defined it as a process for self-awareness; to others it's

a space of trust and for seeking and receiving help; to certain others it's a learning process of inculcating skills for managing emotions, communicating and keeping oneself safe.

### B.2.2 Acceptance in the counselling process

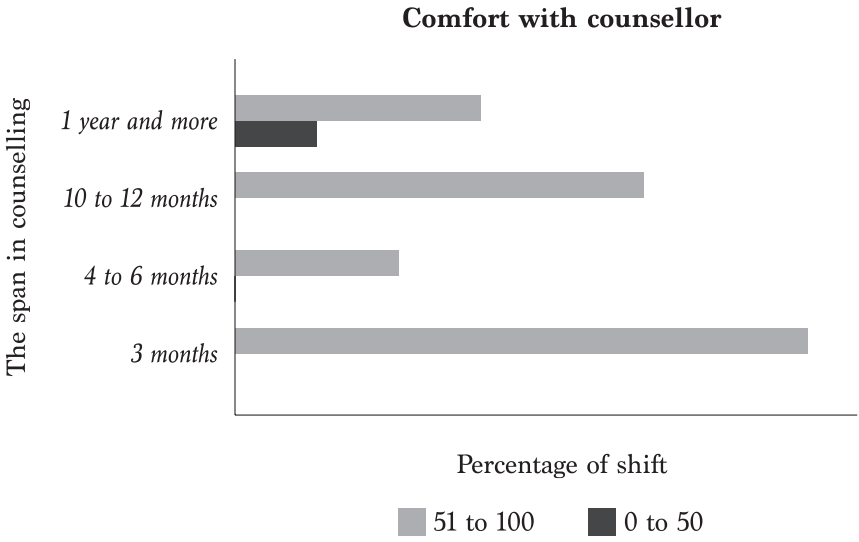



*Graph 10: Acceptance in the counselling process*

16 out of 19 clients across time spans in counselling sessions felt completely accepted in the process. They felt that the counsellor's unconditional positive regard and empathic understanding have been the key factors leading to change in their otherwise disruptive life. Openness to all aspects of the client's experience and the capacity to respond to the client from this experience has been instrumental to their change. Only 2 clients who are attending the session for 3 months and 1 client who has been in therapy for more than one year felt accepted in the range of 0% -50%.

*"I used to love someone; I came to know he is married; I was very sad; I cried a lot; then the cousellor helped me a lot; she explained to me that it was not love but attraction; how attraction is more stronger than love; when my mother did not have job there was no body to help. At that point of time also the consellor helped me. She inculcated skills in me so that I could articulate my needs and ask for help from the caretakers" – Client undergoing therapy for 11 months; trafficked by extended family*

### B.2.3 Comfort with the Counsellor




*Graph 11: Comfort with the counsellor*

This comfort with the counsellor follows directly from feeling accepted. All clients except one who is undergoing therapy for more than one year communicated to have been extremely comfortable with the therapist.

*"No one understands us the way the counsellor can. I am learning a lot about myself because of these sessions. We can say anything to her. She is very non judgmental. She tells us that we are very brave to be speaking about our past. I feel excited to see*

*her because I will feel better afterward!" – Client undergoing therapy for six months.*

The fact that one client even after being in therapy neither feels completely accepted nor feels comfortable with the therapist brings one face to face with the fact that distrust is a common reaction to trauma. General distrust is compounded by the tendency to perceive adults and others as either all good or all bad (i.e., splitting). The consistent expectation that trust will be betrayed can create a pattern in which individuals can be idealized when the client is getting everything she wants, but then quickly shifts to be seen as completely untrustworthy following even the slightest disappointment. Given that any trust produces anxiety considering the risk of being hurt, a client may prefer to maintain the safer and less anxiety-producing expectation of distrust.

*"Some concerns get addressed but some others don't. Something has happened with me in the past which I am scared till date. So I am not sure will anything help; Sometimes I can express; but at times I cannot; something I can share; something my heart stops me to share; I feel scared; what will happen if I share; if I get blamed even without doing anything; I trust didi [the counselor] but I can't trust the girls; something has also happened which has robbed my trust further. I had a fight in the cooking group I told didi [the counsellor] I want to talk. But a lot of girls were talking to her. So she could not hear me. I told her if you don't listen to me I feel angry". I don't think anyone will understand; if I don't tell how will she [the counsellor] know? But then I feel "why can't she understand me if she [the counsellor] can understand others"? - Client undergoing therapy for more than one year.*

### 4.3 Individual therapy with clients

Individual therapy (sometimes called "psychotherapy" or "counselling") is a process through which clients work one-on-one with a trained therapist—in a safe, caring, and confidential environment—to explore their feelings, beliefs, or behaviors, to work

through challenging or influential memories, to better understand themselves and others, set personal goals and work towards a desired change. Individual therapy is an effective collaborative approach between a therapist and clients in order to move the latter towards the change they desire and improve quality of life. In the individual sessions, the client and therapist work towards promoting personal strength through interpersonal interaction. One of the great benefits of individual therapy is having the opportunity to truly connect with someone who will listen to the client carefully and effectively and provide guidance when needed. The highly personal nature of the exchange between the therapist and the client allows for specific focus on the issues presented. While the dynamics of the relationship between the therapist and client are typically considered important, they can often take a while to emerge before they can have a therapeutic effect.

Individual sessions with the therapist on average range from 45 minutes to one hour long and take place once a week. Clients are chosen for individual therapy based on counsellors' assessment, caretakers' feedback and the client's expression of need for individual therapy. Clients are taken in individual sessions generally once they have been part of the group sessions for a considerable period of time so that the clients have had substantial psycho-education before embarking on individual therapy. Exceptions to this are made, if the counsellor assesses a particular client to have extreme suicidal ideation and her clinical judgment proclaim that group sessions will not suffice. Exceptions are also made in cases where a client will reunite with the family in the near future. In the latter case, individual therapy is based on a short term goal of working on anticipatory triggers so that the client is prepared to face the outside world. The individual therapy, thus with clients vary from 2-3 weeks (one time need based intervention) to 2 years and more (Long term therapeutic work).

Individual therapy takes place in the therapist's clinic. The therapist's office was chosen as the venue for individual therapy as this is a safe and neutral space compared to the institution. Though this had been chosen as the venue to minimize triggers it is difficult to anticipate and avoid all the triggers as client's complete history is not available to therapist at the initiation of therapy. For example, in the first year of individual therapy, for one client the elevator which they had to use to come to the therapist's clinic was a trigger. The elevator was associated with her trafficking experience and she was reliving her experience of having a panic attack. She could not communicate her overwhelming emotions with the caretaker who accompanied her. The therapist using her clinical judgment could identify her emotional state and intervened [Excerpts from Ms. Sandra Farel's letter to Ms. Pooja Taparia, CEO Arpan]

At present, the clients travel to the therapist's clinic in a group by themselves for the individual session. They change two or three forms of transport and come to the clinic. However, this empowering practice did not start overnight but was evolved gradually. Initially, caretakers used to accompany them which used to evoke lot of uncomfortable feeling in the girls that they are not trustworthy. The therapist then started working on caretakers' anxiety as well as equipping the girls to be trustworthy enough. Then the clients used to commute in a fixed rickshaw and a known driver who would drop them and pick them up. However, they did not stop at this as the therapist wanted them to start exploring independence and freedom as once the clients leave the institution there is no monitoring.

This becomes the first step of creating a therapeutic relationship. The relationship between a client and counsellor requires clients to experience trust and a sense of safety within a therapeutic setting. For female adolescents who have been sexually traumatized, this is no

small feat. Since these girls have been abused by individuals of trust or power, their basic ability to trust people or feel safe with them has been demolished. Thus traumatized adolescents often use avoidance, denial, rationalization, and distraction as preferred strategies for dealing with negative affect. Not only do these defense mechanisms naturally lead to treatment resistance, but also interfere with the ability to mature in dealing appropriately with negative emotions and stimulation. Consequently, the first step taken by the counselor is to build a strong therapeutic alliance prior to directly addressing trauma. As effective therapy cannot begin with this population until a trusting, health relationship has been established (Sapsford, 1997). Furthermore, since the likelihood of attachment styles increase with sexual abuse, negative implicit memories of the trauma are encoded into relationship schemas (Schore, 1996). Developing a healthy therapeutic relationship with traumatized clients creates new encodings of positive relational interactions and new relationship representations then become internalized (Rothschild, 2000). Effective trauma-work cannot begin until the counsellor-client relationship is developed and a sense of safety is experienced. Safety is the first step in trauma-work therapy.

Individual therapy with trauma clients generally is assumed to be focused on trauma processing post stabilization and eventually move towards reintegration. However, to work with victims of sexual abuse and commercial sexual exploitation with chronic neglect and exposure to other forms of violence this linear progression of 'stabilization-trauma processing-reintegration' is nothing but Utopian thinking. To assume that clients after receiving psycho-education through group sessions are prepared for revealing past abuse and working on the past is not correct. As, the counsellor of the institution puts it, "It's not happening like that. It doesn't happen like that. And slowly I am getting prepared for that". These children's chronic exposure

to violence and neglect is so huge that it places the counsellor at a cross road as to which aspect need to be starting point of the healing journey – "the abuse or the deficit" [Excerpts from Interview with Ms. Sandra Farel].

In this dilemma, both attachment theory and Eye Movement Desensitization and Reprocessing (EMDR) have proved to be effective resources. Attachment theory is now used explicitly to inform interventions in individual therapy (Fosha 2000; Holmes, 1996), and it forms the basis of one of the best-validated and most effective tools in individual therapy (Fosha 2000; Holmes, 1996). EMDR, on the other hand, is a treatment modality that alleges to reduce or eliminate traumatic memories and psychological symptoms. Implementing EMDR starts by instructing the client to follow the therapist's finger in left-right eye movements in rhythmic form (Erwin, 2001) while thinking of a traumatic image, physical sensation of trauma, and a negative self-cognition or emotion (Wilson, Becker, & Tinker, 1995). The foundation of the approach is that desensitization will occur while the client reports the images, cognitions, emotions or physical experience. Early efficacy studies on EMDR (Shapiro, 1989), indicated clinical significance but were typically criticized for methodological shortcomings. EMDR research increased in the mid-1990s but show mixed results on its efficacy. EMDR had being judged as validated treatment by the APA Division 12 Task Force (Erwin, 2001) after a study produced reduction of symptoms and increase in positive cognitions. Since research around EMDR is still growing, the approach itself has undergone numerous modifications.

The EMDR protocol directs the therapist to take the clients' symptoms, go in to the past, find the roots, work on that and then work on the present and future trigger successively. However, in the spectrum of work with these clients for 5 years, this standard

protocol doesn't work with clients with complex PTSD and clients with high level of dissociation. In this space, the effective tool has been the EMDR inverted protocol – "work on the future - work on their present – work on past" [Excerpts from Interview with Ms. Sandra Farel]. The focus is thus to facilitate hope in the future (how would clients envision their future to be); then move on to current triggers. In most cases, the current triggers are very overwhelming as our rehabilitation centers are not so well-equipped that they are trauma free. Rather, they can be re-traumatizing because of the adult's ignorance and expectation as well as lack of skilled professional. Hence stabilization goes on for a prolonged period. The counsellor equips the clients to identify present triggers related to the trauma that are causing current distress such as: rage, depression or despair, anxiety or terror. Through the identification of triggers and teaching strategies for calming, self-soothing, and affect regulation, conversations about the origins of the triggers flow more naturally. The counsellor then begins to explore the client's view of self and address distortions, help them to normalize and become less reactive to disappointment and small injustices so that they can settle down at home, concentrate on studies and other vocational training.

Along with this, the effective strategy has been to do "piece work" i.e., to work on only one memory in the past for not more than 15 minutes irrespective of the fact that client might be doing well. The safety of the child is given utmost importance, in this process, where the counsellor does not wait for the client to get overwhelmed. This practice has evolved through experience in the last 5 years as a one hour session of trauma processing often makes clients feeling overwhelmed and reverting back to their original maladaptive response for dealing with the original trauma. Some may dissociate, while others may regress or rely on addictions to deal with the traumatic material. This hinders not only trauma process but also

leads to worsening of clients' present situation. Hence, the creative way of applying EMDR, where all three timespan - future past and present is handled in a continuum works best for this clientele. The intensity of trauma exposure is manipulated in individual clients so that the intensity remains within a therapeutic window and does not re-traumatize (Briere and Scott 2006). This also helps as clients "feel in charge of their own therapy work" which is crucial for sexually victimized clients. As the counsellor verbalizes it, "If I wait for one thing to get over and then go to the next, it's never going to happen. So with this girl with whom I am working for last two years it's always like that. And she still feels overwhelming to go back to past. Because she has a huge history of being in brothel. She was almost settled there for year and a half or two years" [Excerpts from Interview of Ms. Sandra Farel]. Thus the counsellor assumes responsibility for protecting complex PTSD clients from re-traumatization during treatment. In addition to watching for over stimulation, regression, and dissociation in the sessions, it also dictates to check for an increase in out-of-session symptoms which is maintained by interacting with caretakers through regular follow up. Treating trauma is a thus a very fluid process.

This is in sync with current the model of treating trauma which suggests that counsellors are responsible for managing the intensity of exposure to traumatic materials during counselling. Unlike early models of treating trauma which believed retelling the trauma was the central component of treatment and proposed this as a curative and necessary; more recent research claims that while some individuals do experience symptoms of relief after talking about the trauma, others respond with an exacerbation of symptoms (van der Kolk & McFarlane, 1996). In fact, exploring traumatic memories can even be damaging to some clients. "A client is most at risk for becoming overwhelmed, possibly retraumatized, as a result of treatment when

the therapy process accelerates faster than he (sic) can contain" (Rothschild 2000).

In this context, the goals of trauma treatment through individual therapy thus includes helping clients develop more adequate coping strategies (e.g., relaxation training, stress reduction exercises, cognitive modulation of affect through self-talk) prior to asking them to re-experience the trauma in sessions. Strategies such as problem-solving, behaviour change and emotional regulation is also implemented to assist in affect regulation and improving relationship skills. Other traditional cognitive behavioural therapy strategies (e.g., challenging distorted beliefs, implementing behavioral change, setting up contingency programs) are used to address symptoms such as anxiety, depression, and self-destructive or addictive behaviors. The main focal areas of intervention in individual therapy over the last 4 years were:

| **ASSESSMENT, TREATMENT GOAL AND STABILIZATION** | **TRAUMA PROCESSING** | **NEED BASED INTERVENTION** |
|---|---|---|
| • *History taking, assessment, treatment goals*<br>• *Psychoeducation - Trauma, Dissociation, attachment, positive affect, tolerance, myths of counselling, grief, importance of medication, Borderline Personality Disorder* | • *Preparation for EMDR*<br>• *EMDR process work*<br>• *Dissociation screening*<br>• *Dissociation work*<br>• *Current stressor process work*<br>• *Process work of strong emotion*<br>• *Attachment work*<br>• *Symptom reduction* | • *Career planning*<br>• *Problem solving*<br>• *Problem solving regarding family reunion*<br>• *Preparation for trip*<br>• *Fear for future*<br>• *Therapy interfering behaviour*<br>• *Exam anxiety and related* |

| ASSESSMENT, TREATMENT GOAL AND STABILIZATION | TRAUMA PROCESSING | NEED BASED INTERVENTION |
|---|---|---|
| • *Skill building - Anxiety reduction, crisis management, impulse control, dialogue with parts, self soothing techniques*<br>• *Resource building - safe/calm imagery, mastery techniques, copying strategies in between session, crisis resources*<br>• *Boundary Setting*<br>• *Transference issues* | • *Work on Defence mechanism* | • *Dealing with peretrator*<br>• *Dealing with failure preparartion for termination*<br>• *Post exam stress*<br>• *Safe Future planning Preparartion for marriage/new relationship rehabilitation option dealing with Family pressure*<br>• *Handling finances work related stress*<br>• *Preparartion for court cases and CWC*<br>• *Job related challenges* |

*Figure 12: Focal Areas for Individual therapy*

### 4.3.1 Outcome of individual therapy

#### A. Counsellor's Assessment

*Client A had extreme traumatic past as she was living in the brothel for considerable time span before being rescued. When she was in group session she would shake … almost on verge of panic attacks and generalized anxiety. She came into individual therapy extremely parentified, in the sense that she always believed that taking care of her mother was her responsibility and she used to almost go weak in her knees with the worry that how can she take care of her mother. Post her individual session/s, she*

*understood that she was falling prey to over-responsibility. When she eventually went back to stay with her mom she said, "I am going to take care of you and support you as long as you are not going to take the added responsibility of looking after my irresponsible brother as that is an extra burden on me. If he |brother| wants to be happy then he has to start taking care of himself the way I did. And if you want to invest in taking care of him, I am not going to take that responsibility".*
*This client at present is working as the Manager in one of the reputed corporate house in hospitality sector and owns a house.*

*Figure 12: Shifts in Client undergoing Individual therapy*

Without therapeutic intervention, she would have done anything to make her mom happy. The vicious circle of her mother feeling happy about taking care of her brother, her feeling happy taking care of her mother would have continued but she stopped it and said no. She assertively communicated her boundaries and concerns. This empowerment in communication without the fear of being rejected or compromising on her decision to get approval from her mother might seem trivial if not placed in the context where the child showed symptoms of complex PTSD and has dealt with past memories which were severely traumatic.

This is not a solitary outcome. Children in individual therapy have been able to shape their life in a way unthinkable to them – some have pursued education, started working, got married. There are others who have been assertive enough to communicate to their parents that they do not want to go back to their homes as they understand it is not safe for them; still others who have been confident enough to let their boyfriends know that they would not marry just because they are 18 but will pursue further studies and be financially independent before tying the knot. These have not been magical shifts happening overnight but they have been slow progress as the counsellor rightly puts it, "in trauma work, slow is fast"

[Excerpts from Interview with Ms. Sandra Farel]. Hence to behold that the individual sessions have gone beyond reduction in symptoms of angry outburst, disturbed sleep, relationship problems, somatic complaints and have provided children with hope and the skills to lead a better life is incredible. What is of utmost importance is clients themselves understanding the need. As the counsellor mentions about one client who would be placed in other home as she is 18 years of age often asks the caretakers if she could continue with her counselling sessions. She also communicated to the counsellor, "If no one supports my counselling after I am out of Advait, I would save enough money to continue my sessions" [Excerpts from Interview with Ms. Sandra Farel]. Children through individual sessions have not only regained control of their lives and started shaping it in their own way but they also have become catalysts of change. One of the clients being in therapy insisted that even her fiancé should come for therapy. She requested her own counsellor to look for another therapist after knowing that she does not practice couple therapy as she felt it is immensely valuable to craft anyone's life.

Progress is thus mapped though reduction of symptoms or angry outbursts in a week with peers and caretakers, nature of sleeping pattern, their attachment cries, concentration difficulties, hitches in interpersonal relationship, feeling over responsible towards parents or others around, pleasing or approval seeking behaviours, nightmares, somatic complains like body aches, irregular menstruation, low appetite or over eating, anxiety, difficulty in expressing emotions and needs, inappropriate fear of authority figures, self-care and most importantly their optimism and hope for a better future. This is mapped through client' feedback and adult' feedback.

For example, as the counsellor recalls about another client who started individual session within three months of joining the institution and is still under therapy:

*"When she came to therapy she used to be like a zombie. She is not a trouble maker. She was nowhere a trouble maker. But caretaker didn't know what to do because she was never present. She was always lost. At present, she has appeared for 10th exam; now she's the most responsible girl in the house so caretakers can give her the keys. They can send her down and get simple work done for e.g. getting Xeroxes. It's a huge shift. [However] Trauma work has been minimal. But her current triggers have gone down and her self-confidence has gone up tremendously." [Excerpts from Interview with Ms. Sandra Farel]*

The presenting concerns and the movement of some clients through long term psychotherapeutic intervention is reproduced below. This shows minute shifts start taking place in the first 3 months just because the client has somebody who listens to her, trusts and believes her and is non-judgmental. This safe environment in itself becomes therapeutic and self-blaming starts reducing.

| **Client** | **No. of Session** | **Presenting Symptoms** | **Year 1 2011** | **Year 2 2012** | **Year 3 2013** |
|---|---|---|---|---|---|
| 1 | 56 | • Very suspicious of people around her<br>• Gets very angry and into fights with everyone around | • Is less suspicious of her peers<br>• Share better relationships with her peers and adults | • Has found suitable job for herself<br>• Feels positive about herself | Got Married and settled |

| Client | No. of Session | Presenting Symptoms | Year 1 2011 | Year 2 2012 | Year 3 2013 |
|---|---|---|---|---|---|
| 1 | | • Have relationship problems with peers as well as adults<br>• Have lot of memory problems<br>• Have lot of memory problems<br>• Can't take any feedback ( positive as well as negative)<br>• Very low self worth<br>• Very lethargic and doesn't take interest in vocational training | • Has able to make few friends who has began confiding in her<br>• Appears to be happy and shares with others how her past is haunting her present<br>• Takes interest in vocational training | • Is facing new set of problems but so far not using unsafe ways to dealing with it<br>• Is very active and shows interest in her work<br>• Is very active and shows interest in her work<br>• Has severe dissociation and needs lot of work still | |
| 2 | 31 | • Suspicious of people talking about her<br>• Angry outburst – uncontrollable rage<br>• Lot of shame in seeking help<br>• Fear of harm by perpetrator<br>• Judgmental and harsh with peer<br>• Perfectionist<br>• Exam anxiety and fear<br>• Self doubt | Joined in June 2011 | • Cleared her 10th exams and would like to study further<br>• Has got a job and more confident<br>• Sexual acting out became more evident once she joined vocational course outside home. The process work on this area could not be completed. | • Continuing individual sessions after leaving the present institution<br>• Career planning and some work on traumatic memories.<br>•Worked on sexual acting out and relationships with opposite sex.<br>• Planning to pursue career in counselling |

| Client | No. of Session | Presenting Symptoms | Year 1 2011 | Year 2 2012 | Year 3 2013 |
|---|---|---|---|---|---|
| 2 | | • Sexual acting out around boys<br>• Relationship with mother strained | | • Shares good relationships with her mother and able to protect her boundaries | • At present she is active in the social sector<br>• Able to take care of her sibling without feeling over responsible and guilt.<br>• Doing extremely well and is able to set boundaries with most the people around her. |
| 3 | 20 sessions | • PTSD case<br>• Flashbacks<br>• Nightmares<br>• Avoidance<br>• Day dreaming<br>• Lack of concentration<br>• Psycho-somatic illness<br>• Passive aggression<br>• Trust issues | Joined in Sept 2011 | • Sleep has improved<br>• Appearing for 10th exams<br>• Better relationship with her peers<br>• Is able to express unpleasant emotions to peers as well as adults<br>• Lots to work yet able to concentrate on her career<br>• More motivated to do well in future | • Is appearing for exam.<br>• Highly dissociative and work is moving at slower pace.<br>• Working on traumatic memories and dissociative symptoms.<br>Is still in session. |

| Client | No. of Session | Presenting Symptoms | Year 1 2011 | Year 2 2012 | Year 3 2013 |
|---|---|---|---|---|---|
| | | | | • Able to keep herself in present and concentrate most of the time | |

*Figure 13: Progress in clients' undergoing Individual therapy*

*These outcomes become the facet of the process which is otherwise often intangible, momentary and lacks visible proof. From this tabular representation it is clear that the clients' movement in therapy session is at a slow place. Whereas, over a period of 2 -3 years, their present triggers are minimized and clients can function adequately well even in the outside world, however their trauma work on past memories or process work on dissociation takes a prolonged time. The cousellor however, cautions to look at these as solely attributed to individual therapy – "It's a combination of many things - change in caretakers' skills and attitude to deal, positive discipline policies at Advait, client's participation in group sessions and individual therapy" and their resilience, zeal to take control of their own lives and move ahead. The most startling outcome is that clients take these learnings with them even if their session is discontinued due to legal issues. To the counsellor, this realization has been a huge relief given high mobility of clients. The cousellor introspects, "Earlier, when I was a naïve counsellor, I am still naïve at some points, but initially when I used to believe in my omnipotence and I used to believe that therapy is like the end of the world … I used to feel very helpless when they used to go and I used to think God … How she's going to survive? But now I don't get so scared. Now I trust that whatever learning they have done, they will know how to use it and I show that trust, which helps them… which empowers them. And EMDR Philosophy gives me a lot of strength then… that each individual has natural healing capacity. Provided, you have a support system. What happens in their life is not in their control. They might still get face to face with the perpetrator or similar kind of an abusive situation but now what is different is that they can pick up the phone and call up and say "sister [Caretaker] somebody is doing this to me." Which needs to be communicated to them again and*

*again and again that now you are not alone. When it happened [in the past] then you were alone, you didn't know what to do. Now if anything unpleasant happens that is violating your boundaries, just pick up the phone and call up and help will be given to you. That gives a lot of confidence and calmness to me and empowers them. Because, otherwise, they are going into the real world and who is safe out there. You are not safe. I am not safe so how can I guarantee that after therapy they are going to be safe? It's not about safety but it is about "I will know what to do". This belief system has not erupted from a vacuum; but from experience,*
*"So far everybody who has gone back, at some point of time or the other has got in touch with the caretaker and have sought help if there was some crisis". [Excerpts from Interview with Ms. Sandra Farel]*

## B. Assessment of Clients

### B.1 Self-assessment by clients receiving individual therapy

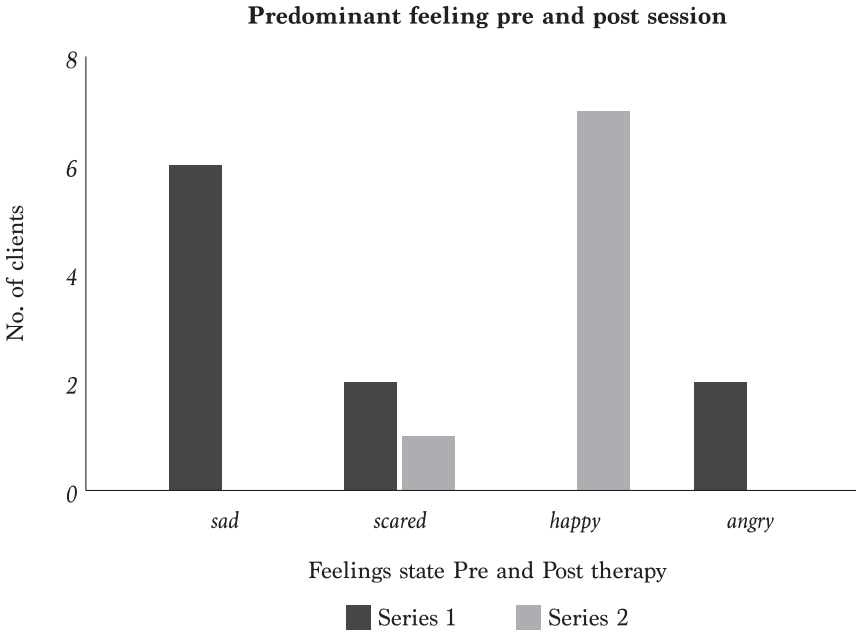
8 clients were interviewed to understand client's self-assessment of shifts in them and their assessment of the counselling process; 3 of these clients were presently continuing individual sessions and 5 clients have already left the institution and presently have discontinued individual therapy with the counsellor at Advait. The clients were initiated to individual therapy based on their own need as well the therapist's clinical assessment and caretakers' observation. All these clients have been attending individual therapy for a time span of between 6 months and 2 years. All of them have been part of group sessions prior to individual sessions for a time span of 3 months to 2 years and more depending on the reason behind their initiation of individual therapy as mentioned earlier [Section on Individual therapy]. In case of ex-Advait clients, their individual therapy was discontinued after they moved out of Advait, which again resumed after a gap as clients wanted to continue it. As one of the client mentions:

*"At that time I had shifted to a new home; all the past memories were coming*

*back to me and I was very disturbed. In that new place I was not sure with whom I can share. I gave myself time to ponder as to what was happening; I realized it has nothing to do with present but its roots are in my past; I thought I need to do something about this otherwise it will always come to me and will unsettle my present; to do that I re-started counselling". – Ex Advait client who re-started counselling after leaving the institution*

5 parameters were used for clients' self-assessment - predominant feeling before and after attending therapy sessions, acquired skills in handling emotion, acquired skills in communication and expressing needs, instillation of hope and goals for future and becoming the catalyst of change.

### B.1.1 Predominant feeling before and after therapy




*Graph 12: Predominant Feelings before and after sessions*

7 out of 8 clients (87.5%) reported to be presently in a happy state of mind most of the time. As one client recollects,

*"I came here from [name of another institution]; when they brought me here they told me that they would show me the home and then only if I like they will keep me. However they made me stay here. I was angry because they did not tell me the truth; I was sad it was a new place; I would cry sitting on the stairs. I was very sad because I had no contact with my mother and family. I did not get a call from my mother, nobody visited me. This was eating me up from inside; If anybody came and talked to me including the Sisters [Caretakers] I will give back bad words; After I started talking to the counsellor about my feelings, I got to see a solution and my sadness decreased." – Ex-client of Advait*

One client who is in individual therapy for the minimal time span mentioned she still feels scared, though the intensity has decreased as she puts it:

*"I still feel scared sometimes. A lot of things are triggering. I keep getting reminded of my past". – Client undergoing therapy*

All clients who have been part of individual therapy were able to pinpoint the reason behind the shift. They attributed the shift to the therapy process primarily; however some of them mentioned the support from peers and caretakers as crucial in their healing journey. They endorsed the therapy as a process which spurred self-awareness, skills in articulation, managing emotion and gifted them with a confidant who would listen without being judgmental and all of these they believed ushered the positive shift. Clients undergoing individual therapy came out as more self-aware compared to their counterparts in group sessions; even within this population, ex clients who have been in therapy for a considerable time span and have had closure seem to be more in sync with their own emotion and feelings. The sharing by

clients undergoing individual sessions and of an ex-client will bring this level of self-awareness and self-acceptance into light.

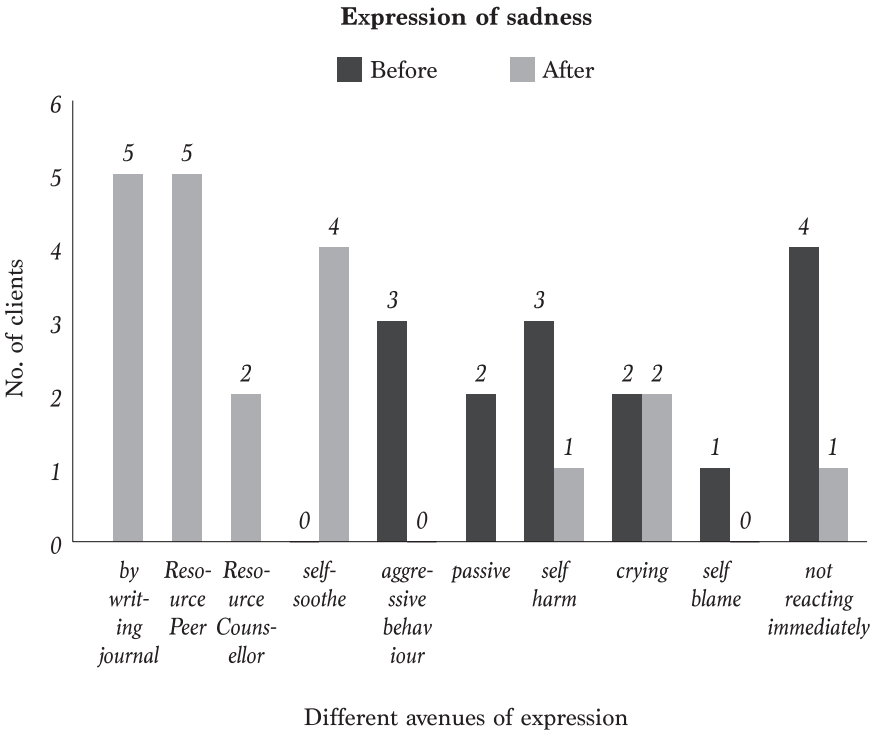
*"I didn't know what to expect. I was all alone. I was worried that people might misunderstand me and hit me. I used to be very angry before starting the individual sessions. Now I've started to understand and love myself and so I can understand and love others. I am very free. I do "masti" [fun] all the time. I can be assertive about my needs. – Client undergoing individual therapy*

*"I started understanding that I am angry inside. I understood what changes I need to make in myself. I was very angry about what had happened to me but with counselling I was able to deal with that anger. I am happy generally. But it is a little hard for me at times. I sometimes remember what happened to me, then it hurts. I become a little anxious then, but I come back to normal in some time. If I see that someone else has gone through the same thing as me, then I feel angry."*
*- Ex Advait Client*

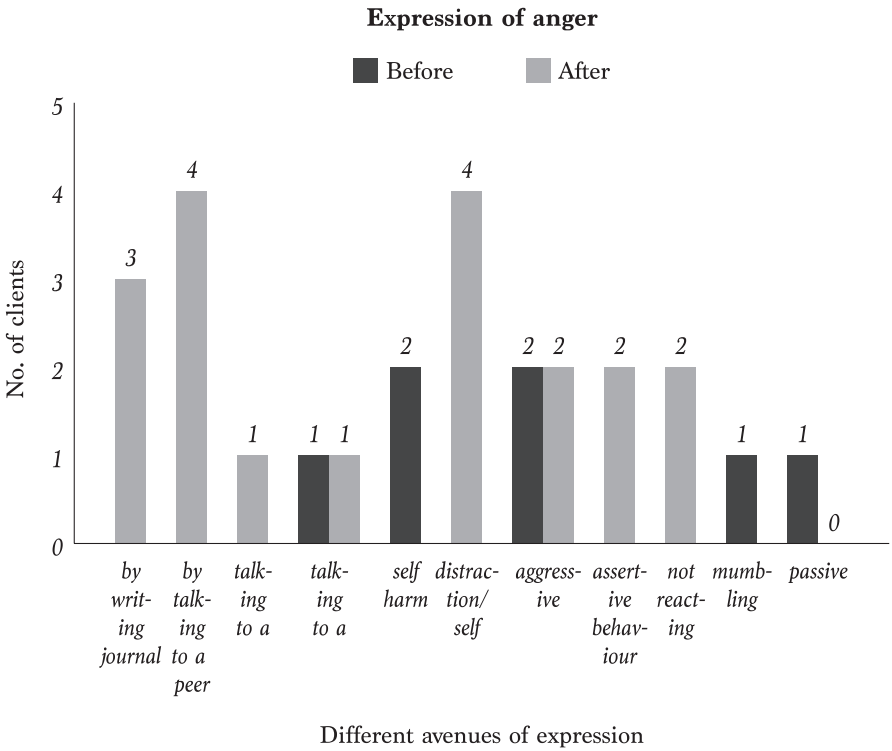
These testimonials show the journey of self-awareness that the clients have embarked on – they are able to identify emotions, manage them but at the same time are aware of their current triggers. While clients could confidently articulate the reason behind the shift they were ambiguous about time-frame in which they starting noticing the shifts in themselves. While 2 of them said they could see change in themselves in six months, one client said the time span was three months and 1 year respectively; the others felt it was a gradual process with no marked beginning. As one client puts it beautifully:

*"I can't tell you exactly when the change started happening...with each day I became anew, with each mistake I learned something new...it happened gradually and slowly".*

## B.1.2 Acquired skills in handling emotion




*Graph 13: Expression of Sadness Pre and Post session*




*Graph 14: Expression of Anger Pre and Post session*

Expression and management of emotions (anger and sadness) is an arena that trauma survivors struggle with (as mentioned in the earlier section on group sessions). Clients who have received individual therapy show using positive avenues of channelizing their difficult emotion – writing a journal, using self-soothing/relaxation techniques, having the counsellor, peer and caretakers as resources to fall back on, developing assertive behavior to communicate their anger and sadness. This shows a movement from prolonged crying spells, angry outburst, self-harm behavior like not eating, wrist slitting, suicide ideation and sulking. The clients themselves realize these shifts in themselves and that becomes the source of their empowerment.

As clients presently undergoing therapy talks about this shift:
*"Earlier I didn't understand what I was feeling. So I just used to shout at others to feel better. I used to cry a lot. Counselling helped me understand myself in a much better way. I have more control over my feelings. Especially my anger. Now I know what I feel so I can tell it in a better way. My relationship with my peers here and with the sisters has improved a lot. Even though I don't talk to my family anymore, I am able to come to terms with my anger against them" – Client undergoing individual therapy.*

*"Earlier I used to take it out on others or ignore my feelings. Now I know different tactics of dealing with my sadness. I tell myself that it's ok to be sad and that it's not my fault" – Client undergoing individual therapy.*

While the clients undergoing therapy are articulate about their transformation; clients who have been in prolonged therapy and had closure moved a step further. Thus the articulation of this ex client (quoted below) not only talks about transformation but her language and perception of others talk about the internalization of the therapeutic principle in her everyday interactions. Here, far from being a victim of sexual abuse she emerges as a survivor who is ready to carry on with her life. These movements, no doubt, take on further meaning when we place them in the context of the presenting concerns with which the client embarked on the journey of individual therapy; however this level of self-awareness and empathy even in itself is noteworthy.

*"Earlier .... (She laughs)…when I was sad I did not understand…I did not understand what I am going through; I used to run away from my feelings. I used to fight with people, get irritated at the slightest things, did not speak to anyone. When I was angry I used to harm myself, I have done that often, I even tried to commit suicide by turning on the gas; I did not want to stay in this place. So I was angry and used to blame myself. I used to ask "why did it happen". But nowadays I don't*

*do all these. Sometimes thoughts do come, but then I talk to myself, I listen to music, I dance as it's my passion, I write journal and all of these settle me. Before counseling if someone was angry with me I would be also angry with that person and will get into a fight. My counsellor used to always tell me that if someone is angry there is always a reason to it; maybe she is anxious or scared deep down; she is angry because of different circumstances; she is not doing it intentionally; that has been a leaning for me. So if now somebody is angry and I feel anger too; I don't react immediately; this is not to say I never have fights; but largely I understand she is not angry with me, may be the reason of anger is in her past and deep inside her. I can do this because now I understand every human being has these feelings and all feelings are normal; I realize we need not run from our feelings, we need to face our feelings as feelings surface to keep us safe; If we run from feelings then they will surface further; and if we suppress and silence them, then we might end up taking wrong decision and commit wrong action; but the feelings surface to keep us safe so we need to face them and need to hear them and we need to express them to others safely".*
– Ex client having undergone therapy for 2 years

### B.1.3 Acquired skills in communication and expressing need

The clients expressed that communication of their needs to peers and caretakers has been another arena where they perceived the therapy process to have impacted them the most. While all clients said they were scared of caretakers before therapy and did not perceive them as helpful (For detailed discussion on this refer to group sessions analysis) so communication of needs was negligible; their communication with their peers was mixed – aggressive or passive as they were either scared, frustrated, confused or angry.

4 of the 8 clients said they have become assertive in their communication with peers; while the rest felt that they are still working on it and tend to oscillate between being aggressive – passive and assertive.

*"When I live with other girls and if there is misunderstanding with someone in particular, I can communicate to her saying, "You did that to me I felt really sad". Earlier if anybody would have told me anything I would have verbally abused her and got into a fight; I would have been angry and reacted immediately". – Ex –client having undergone therapy for 2 years.*

2 out of 8 clients claimed they are 100% assertive about their needs to the caretakers.

*"I can ask for help. But somewhere there is fear as well. The fear is whether they will give or not; whether they will scold or not; so need to prepare myself before asking; then I can gain that much courage to ask. Earlier also I used to ask; actually I have that in me to seek help; but earlier I did not have the skill to express it; so misunderstanding used to crop up". Now I can. – Ex –client having undergone therapy for 2 years.*

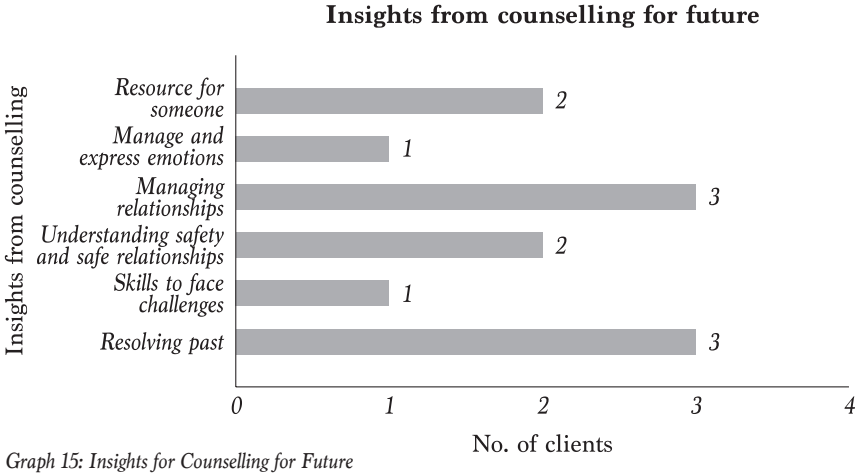
*"Earlier I didn't think I would get what I need. That used to frustrate me. Now I know I have the right to express myself and get what I need. When I had slit my wrist, sisters explained what I did was wrong. I felt really nice that someone cares enough about me to explain this to me lovingly". – Client having undergoing individual sessions.*

6 others felt they would be able to express themselves 50% -75% of the time as they feel little scared at times.
*"Earlier I used to be afraid that I would be blamed for expressing myself. I thought people would judge me because of my history. I am still a little scared of them. They are our elders. You can't tell them everything". – Client undergoing individual sessions.*

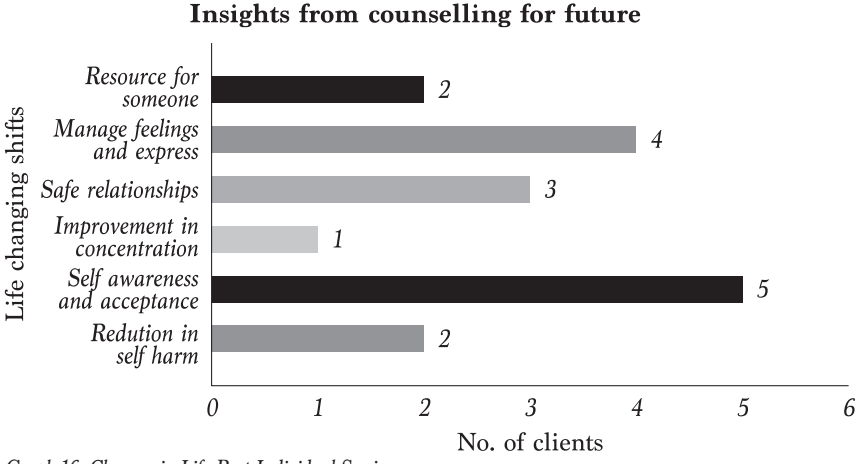
However, what came up in the narratives of the ex-clients was that their expression of needs to adults, especially caretakers, depends on the latter's receptivity. Thus, it suffers a blow when the caretakers are

not receptive enough because of their own understanding of the issue, their perception of sex work and their lack of skill in taking care of traumatized children. This became evident as clients mentioned that once they moved out of the present home they suffered a blow while expressing their needs and have gone through momentary setbacks. This flags the importance of skill building of caretakers as an important arena of work in the institutional set up.

### B.1.4 Instillation of hope and goals for the future




*Graph 15: Insights for Counselling for Future*




*Graph 16: Changes in Life Post Individual Sessions*

Once the rehabilitation is complete or the child reaches 18 years, the child will have to move into the outside world, which does not offer as secure an environment as a rehabilitation institution. The child may have to deal with attempts of harassment and exploitation, trafficking, rejection from some members of society, or persistent probing into her past. She has to learn to deal with all of these situations, learn to identify people with whom she could make friends and share confidences; and protect herself from those who may threaten her wellbeing. Hence, the focus of individual therapy is also to address these issues, simulate such situations and inculcate skills that would make the child better prepared to face the outside world.

The analysis of the above graphs on the insights gained from counselling for the future and most critical shifts in their thoughts, feelings and actions after counselling brings out clearly that self-awareness and acceptance is the primary shift as assessed by clients themselves.
This gets manifested in children acquiring better judgment of safe relationships, having avenues to channel difficult emotions positively leading to impulse control and lessening of self-harm behaviour and improvement in concentration. The fact that therapy has aided them to stand up and face life head on from a position of hopelessness, despair, sadness is evident in the clients' narrations:

*"I have learnt about EMDR. I also learnt tactics like tapping, imagining situations and the associated emotions. These tactics have reduced my anxiety about how to deal with problems. They help me focus on my studies. Because of the counselling sessions, I can understand myself better. I know what the good things about me are and I also know what skills I have! I know I am good at cooking and stitching. I appreciate these things about me now". – Client undergoing individual therapy.*

*"For me counselling has been helpful in all aspects. Not sure how to talk about them.*

*My counsellor was never rigid that we need to talk about my past; but even anything that was disturbing me in the present I could discuss. I have learnt a lot through this process - how to interact with my family, elders, how to make friendship; my feelings, relationship. The counsellor shared an example- there was a girl who was kidnapped by a boy; the boy used to torture and rape her continuously; however, when the boy was arrested the girl was ready to forgive him and stay with him; so she explained that this girl was not acting strange but this is what attachment is about. To her the comfort was to stay with this person and hence she was drawn towards him; it was at that point the only thing that she could do; so she was not wrong; but when we are out of that unsafe situation we realize that we don't need it [such abusive relationship] any more. Earlier I used to be very attached to my family; but now I have understood that they are not safe for me; hence I rarely talk with them. Without counselling, I would not have known myself; like my counselor often tells me that couselling is like a mirror ; earlier I used to run from my feelings, now I stop and converse with it; without couselling I would have been still running from my feelings and have never known me. In the future my counsellor will not be with me but the learnings will support me. – Ex-client undergone therapy for 2 years.*

While this client talks at length about psycho-education of attachment patterns, managing emotions and relationships and skill building for self-soothing; there are others who talk about the way therapy has helped them develop skills for impulse control – be it for stealing or craving for sex.

*"Earlier I wanted to have sex all the time. I kept thinking about it. The counsellor told me it happens when I feel tense about something. She gave me different ways to cope with my stress so I wouldn't think of only sex." – Client undergoing individual therapy.*

For some others counselling has helped them move from the past to the present.

As one of the ex-clients re-counts,
*"I was locked in my past; I used to blame myself for what happened in the past; I thought I was responsible; he [boyfriend who trafficked her] is behind bars now; not because of me but another girl; but I used to feel responsible; counselling helped me to get out of it".*

In addition, counselling has instilled hope for the future as they assess themselves to have better skills in dealing with life challenges. This hope has made them aspire for a life with a new identity – whether it is in the nature of goal setting for self-care or the confidence to achieve everything; or more specific aims around becoming a head nurse, lawyer, bank assistant or a counsellor.

*"I want to do my graduation and then I want to become a counsellor; earlier I used to think of becoming a social worker; so I am not sure if I will think of something else in the future. This way I will finally arrive at what I want". – Ex client undergoing therapy*

Thus it becomes clear that these girls are shaping up new identities and healthy attachments. They want to move far away from the themes of trauma, abandonment, and disruption which had otherwise dominated their narratives.

### B.1.5 Catalyst of change

6 out 8 clients believed that change through counselling is inevitable; whereas 2 believed that it is possible at the level of 4 in a scale of 5. The clients communicated that having seen drastic shifts in their thought process they are convinced that therapy can work wonders. However, they do not want to stop at that; but they want to become the catalyst of change in someone else's lives. Thus clients mention being a 'resource for someone' as one of their greatest insights through counselling and the critical shift in them.

As one of the client articulates it:

*"I have fallen down many times; I have stood up as well. There are many girls in my situation who think there is no way out and they commit suicide. I think even God gives us many chances to get up and we should not give up. I feel this strongly. Whenever I look back at my life …I have seen drastic changes in me. At times I can't even believe that this is what I am today. I think some miracle might have happened. At times I think – I am a girl coming from slum and today I am working with an organization. Sometimes I ask myself is it a dream…has some angel come in and changed my life with the swipe of her wand; but at other times I know I have been witness to this gradual process of change…I have contributed some…some have been contributed by adults around me through their support. This has made me realize that every individual has the ability in them to recreate and reshape their life". – Ex-client undergone therapy for 2 years.*

It is this conviction about the life changing quality of counselling that prods these children to be the resource for someone else and even suggest therapeutic intervention for other children. Clients communicated to have shared their learnings of therapy to as many as 1 to 12 people in their lives in order to help them. The clients primarily shared their learnings with parents, siblings, home mates and friends. The primary reason for sharing was to help them resolve their past, help them manage their emotions and reduce self-harm behaviors and facilitate positive change in them.

*"I have been able to build trust in my younger sister so that she can share everything with me and I will never judge her or point finger at her; or blame her if anything goes wrong; I can hear her out and understand her; so I think it will help me and my family; earlier my sister did not share anything with me but now she has opened up; I tell her it's not her fault; whatever happened is not pleasant for sure; but you are not at fault; don't listen to your family and don't blame yourself. – Ex-client undergone therapy.*

*"I have gone from Advait and still had the opportunity to undergo couselling sessions … I am recovering slowly. But there are many girls who did not receive counselling. I think all of them should get an opportunity. It's |Therapy| a great support structure. I was very involved with my past. I kept blaming myself for everything. I just want other girls like me to go through the sessions. I want to help more people like me so they don't blame themselves or ruin their lives".*
*– Ex-client undergone therapy for 1 year.*

### B.2 The parameters used for mapping counselling process

The parameters used for mapping the counselling process by the client was usefulness and uniqueness of the service, acceptance in the counselling process and comfort with the counsellor.

All the clients except two mapped the service to be useful to them and effective at the level of 4 in a 5 point scale; two client's, one presently undergoing therapy and another ex-client, marked effectiveness and usefulness at the level of 5 in a 5 point scale. They rated the key component of the usefulness in a varied manner – for 1 of them meeting the counsellor was the driving force as her presence was thought to be calming and relaxing; 2 others communicated that they looked forward to the learnings and information that they receive; according to 2 clients, they looked forward to the weekly sessions for resolving their issues; the remaining 2 out of 3 verbalized that they look forward to talk to the counsellor; the remaining one client said for her it was all these reasons at different point in time which made her aspire for the session.

As this population has been part of both group and individual sessions, they were also forthcoming in communicating whether they benefitted most from the individual sessions or group sessions. The clients were mixed in their response – while some felt they benefitted from both equally; others opined that individual sessions were most effective.

As one ex-client narrates:

*"To me both were different and important; in the group session everyone shared their view so you get different ideas; you get encouragement from their stories; the counselor also share her story which gives you inner strength; but you cannot talk about your past in the group session as you are not comfortable which you can do it in the individual sessions".*

Irrespective of their preference, the clients listed out the following parameters which make group and individual sessions unique in themselves:

| Stakeholder group | Continuing of psychotherapeutic service |
|---|---|
| Can learn from others mistakes and experience | Can talk openly and freely about your past |
| Create trust between peers and they become one's support system | Have more trust in the process |
| Helps to resolve issues among peers | Build skills to make you strong before you disclose your traumatic past |
| Space for learning and getting information | Safe space to resolve past issues |

*Figure 14: Factors contributing uniqueness to individual and group sessions*

All clients said they felt 100% supported during the sessions. 4 of the 8 clients rated their comfort to be 75%; whereas 4 rated it to be 100%. As one client narrates,

*"The very first day I went for counselling, didi |the counsellor| told me you can talk about anything here; without thinking what will she think or whether I am wrong ; if I want to cry that's also completely normal as it will help me; I used to go on Fridays for my individual sessions; so I would eagerly wait for Friday to come; even*

*on Tuesday when didi [the counsellor] used to come to take group session; I used to tell her I am eagerly waiting for you as I would have loads of question in my mind; two of us used to go together and I would mostly be the second to go for counselling; sitting there for one hour I would look at the clock and think when will my turn come; She is only adult who would listen to me; not like others who would pay half attention and will be busy doing their work" – Ex-client undergone therapy for 1 year.*

*"I was eager to talk to her, I would also wait for her to share my problems, I could not remember them all during the session; so my counsellor asked me to write it down during the week; I would also wait at times to take any big decision; I would think let me discuss with my counselor and then maybe I will get an answer. I am comfortable with her but at times I hesitate. It's nothing to do with her; but because my counsellor is very professional which I have learnt from her I used to think what am I saying? Is it worth mentioning? So I used to think that she won't think this to be 'bakhwas' [making no sense] before verbalizing. When the session used to go on at times you would judge that she did not understand me today, but now when I am not going for sessions and I replay those session/s in the screen of my mind, I think she understood me 100%. – Ex client undergone therapy for 1 year.*

The self-assessment of clients along with their rating for usefulness and effectiveness of therapy clearly point to that fact that the therapy process has been empowering and emancipating for them. This has made them craft their own definition of counselling which, far from being a textbook definition, brings out the essence of therapy in the life of the clients. Two definition of counselling by ex-clients are reproduced below which at times overlaps but also craft out two different trajectories and self-realization:

*"Like we need water and food for survival, I think in the same way every human being needs counselling; everybody has feeling but nobody learns what to do with them; somehow I think everybody needs it".*

*"Counselling is a space where I can cry, where I can share everything that's in my heart; I know for sure what I have shared there, will never come out of that room. I have so much trust. I can't trust anyone else like that; if I want I can leave aside studies for one day but not counselling".*

### 4.4 Outcome of therapy from the organization's point of view

*There was one girl from Bangladesh trafficked via marriage. But it's such a smart operation that the girl never knew that the man who married her also sold her after having sex with her for 20 days. So she believed that her husband must be searching for her. That is probably the only faith that she was left with. When she went to the court and saw this man along with other accused she turned hostile. The case was adjourned and on her way to the institution and for almost two weeks after that she was only vomiting. She was betrayed and so broken. During that time therapy supported her and gave her some semblance of what was happening. It meant a lot for that girl to come back to her normalcy and fortunately she's gone back to Bangladesh very rationally and equipped to face the reality. But it was a struggle. More for her than for us but even for us.*

*Figure 15: Progress of client as mapped by organization - Advait*

The outcome of the group and individual sessions is not only captured by the therapist and the clients themselves. However, the management and the caretakers of the institutions are also witnesses to these shifts though they do not necessarily make a distinction between outcome of group and individual therapy. Thus they are vocal about how psycho education on safety, sexual urges, boundary settings, neurobiology of brain, emotions have given children the knowledge which they did not have access to. They believe there is a lot of positive energy in the house because of the sessions. They claimed that the clients now know in which areas they need help and when they need help, they ask for it. They share about their interactions, they are more mature, and

they are now able to respond to disappointments better. As one of the caretaker recalls,

*"In the beginning when they come they need someone to talk to, listen to, and understand. And I think the counsellor plays a very important role in that".*

They also talk about clients whose movements and transformation have stayed with them as they take up a new identity,
*"One girl who has gone from here it was very difficult to convince her initially to go to the psychologist … but then the way that girl is today… She's gone home and she's is working. The other day she called me and said she needs to go to counselling. This was a girl who couldn't even take care of herself but today the way that girl is keeping up, the way she understands things is completely different."*

This confidence in the therapy process and the unflinching support evolved through a process. As the coordinator accounts,

*"And now over the years, that confidence is there among clients. They know if I talk to the therapist, she's not going to tell anyone and she's going to understand me and no one is going to judge me. This confidence amongst the girls and building of our own skills have helped. Our mapping is mainly based on how the girls are… the assessment of how far the girls are able to go from here and how they are seeing themselves – their situation and their other social relations in future."*

### 4.5 Capacity Building Sessions with Caretakers

Establishing physical and psychological safety is considered a pre-requisite in working with victims with trauma histories. This means collaboratively assessing the current level of client safety and together developing plans to make them safe. It also means designing each component of service to prioritize safety. This premise flags that safety cannot only be maintained in the therapy session nor can it be limited to the therapist. In order to achieve this, it is important to educate and

train the staff working directly with clients. To meet this requirement which surfaced with the onset of therapy with clients, caretaker sessions were started. Education of staff included training on the complex interactions of trauma, emotional disorders; as well as basic safety issues in working with victims and approaches to treatment. Training also included helping caregivers understand the experience of being trafficked, the impact on victims, and what a path to recovery can look like. The need for training was further felt as the caretakers were not skilled professionals to handle children with trauma. Moreover, there was a lack of understanding that individuals who take care of children with traumatic background need special training rather it is understood as a job which any adult, especially adult females are capable of doing. Breaking this myth is critical as adults who end up taking care of children with trauma do not necessarily have the knowledge and understanding regarding sexual abuse as well as symptoms of trauma.

While working with victims of trauma, it is not unusual to have a whole range of different feelings. It can range from exceptional empathy and the wish to do anything for them (even going even beyond what one's professional role entails); to strong negative emotions and wish to find an exit from such a situation as soon as possible. If caretakers succeed in accepting and understanding their emotional reactions to the victim's story and behaviour, as well as in differentiating between children and their behaviours then the caretaker-child relationship has the potential of becoming therapeutic and trauma free. For caretakers, it is exceptionally important to have inner boundaries which are strengthened by capacity building sessions and self-work. The process in which the caretakers can be stable and hone their capacity to contain feelings represents the key for forming an environment where the mistrusting person starts to rebuild trust. The caretaker's role in dealing with mental health ranges from being

non-judgmental and non-moralistic, to communicating and having a caring attitude towards the children. Such interventions could be a good starting point to relieve a child of her anxieties while also serving as a continuous process of coping with past experiences – thus giving the client wholeness and perseverance. In this way, the caretaker can complement the counsellor's effort to design successful rehabilitation in terms of mental health.

The objective of the caretakers' session as communicated by one of the caretakers:

*"First thing is supporting each other. Second thing is giving us understanding about the trauma of the girl, giving us education about their feelings, their behaviours. So how can we take care not only of the girls but of ourselves too?"*

This sums up the objective of the caretakers' session which is to build capacities of caretakers so that they are better equipped to deal with clients as well participate in their own self-care. The articulation of the caretaker also brings in focus that the key component for the capacity building session for them is to have the support of another person – a non-judgmental space where they are not reprimanded for their mistakes but given opportunity to learn from. This is also echoed by the facilitator of the session,

*"Caretakers sometimes want somebody to tell them that they are not bad people. They know at times they have not done a good job of handling clients but then they want someone to tell them it's alright we all make mistakes. And I think that gives them a boost … I never realized it but one of our caretakers keep telling me, "you know what… what I like about our counsellor is that… she's very encouraging". And then I realized what I was doing unconsciously, was validating. I tell caretakers, "How would you know? You've never worked with trauma… So it's absolutely OK and you know you are going to fall and you are going to get lost and it's alright so when that*

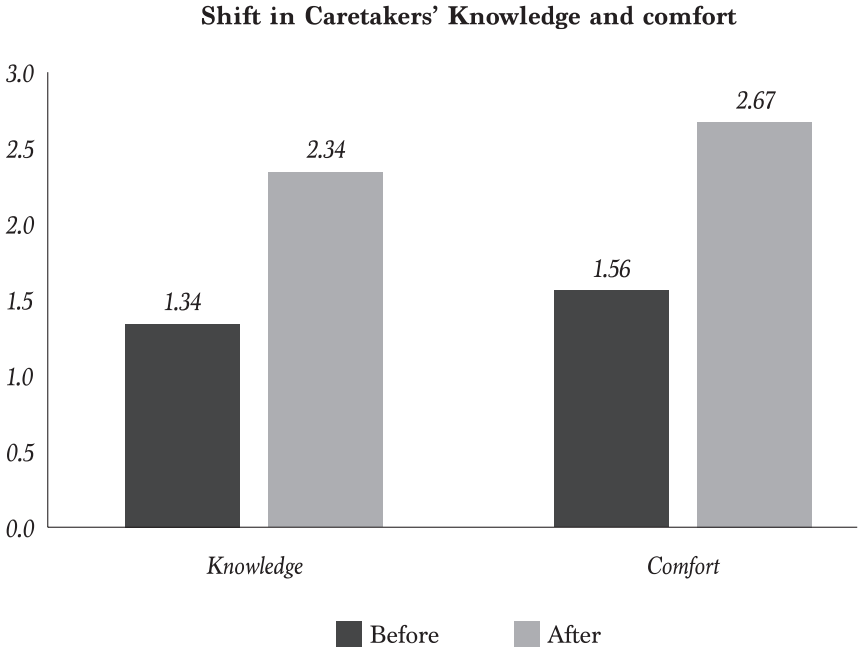
*encouragement is given… then they feel more empowered".*

The capacity building sessions with caretakers thus focus on 3 components – building capacities by imparting psycho-education and inculcating new skill set, providing feedback to the caretakers on their day to day handling of clients and validating them. The topics for capacity building in the past years encompassed the following components:

| PSYCHO-EDUCATION | SKILL BUILDING | FEEDBACK |
|---|---|---|
| • *Roadblocks to individual therapy*<br>• *Individual therapy – do's and don't at organizational level*<br>• *Dissociation*<br>• *Child development*<br>• *Feelings and thoughts*<br>• *Factors that facilitate individual counselling*<br>• *Transferences issues*<br>• *Understanding self*<br>• *Dealing with projection*<br>• *Trauma and its impact*<br>• *Discipline for teenagers self care and burn out*<br>• *Attachment*<br>• *Memory*<br>• *Neurobiology* | • *Need identification*<br>• *Difficult emotions and how to deal with it*<br>• *Alternative to punishment (setting limits)*<br>• *Providing help to troubled girls on a daily basis*<br>• *Problems with clients and how to deal with it*<br>• *Problem solving with girls considering trauma symptoms*<br>• *Insights into symptoms of new clients*<br>• *Decision making*<br>• *Linking weekly issue/s to trauma symptom* | • *Feedback on client's progress and concern*<br>• *Sharing of group's progress*<br>• *Caretaker's challenges*<br>• *Client's rehabilitation plans* |

*Figure 16: Concepts covered in Caretakers' sessions*

### 4.5.1 Outcome of Capacity Building Session/s at the level of the Caretakers




*Graph 17: Enhancement of Caretakers' Knowledge and Comfort before and after sessions*

The ongoing caretakers' sessions have helped the caretakers understand the clients as well as themselves. The escalation of knowledge on sexual abuse, trauma and their comfort in handling the victims with trauma as shown in the graph is evident of this shift. The sessions have helped them to understand multiple mental health constructs. Some of them mentioned by caretakers' include understanding of:

- An adolescent client who behaves like a 5 year old as whenever there is a trigger she regresses to that age;
- Overeating of the clients as an indicator not of physical hunger but their mental emptiness;

- Reptile brain and the fact that clients though seem to have option to resist the abuse actually have only three options – freeze, flight or fight.

This understanding and skills have equipped them to handle the different mentalities and temperaments of the girls, their moods wings, their fights, their violence, their nightmares as well as their background, mindset, emotions and their struggle. As the caretakers articulate:

*"I'm not a professional but I feel I also have improved a lot… the way I understand the girls today and the way I look at the girls today is different from the way I looked at them five years ago… I wouldn't even talk to them when I came in the beginning but now I meet them regularly, I talk to them. What I get from these sessions, I try to apply with girls - to tell them it is ok to remember your home people. Instead of putting them in shame, it is important to give them hope to look at the life ahead. It helps us to understand the girls better, it helps us to take care of the girls and at the same time ourselves… otherwise what happens we shout at them and then we feel bad… So that gives us courage, there is a support.*

As another caretakers communicates:

*"For me … in the beginning…it was too hard to understand this whole situation … What is trauma was out of my knowledge … and then I came… I was completely feeling like I'm not doing anything for them you know… but as we started our group sessions slowly we also started to understand what it is. For me personally, it has huge impact on my day-to-day life also…. In the beginning I used to feel by only shouting at them, punishing them and maybe scolding them or giving them some hitting it would be enough to control them. I am now able to help by talking to them, sitting with them, looking at their view, and make them see my viewpoint to help them understand what I meant. I feel today that those beliefs have gone from me… shaming them, insulting them or hitting them do not change the person but by understanding them, respecting them and accepting*

*them as they are… [We can usher in change]".*

The caretakers also have learnt skills to intervene in crisis situations and have a clear understanding of protocols as to when to escalate the matter to the therapist and other authorities. For example, if a girl is involved in self harming behavior like cutting her wrist, the caretakers are apt to respond to it with medical support. In addition, the caretakers immediately contact the therapist so that she can support the client through this phase. They have also developed skills to respond to certain crisis situation, for e.g., a case of two clients being sexually involved and the other girls were labelling them. The caretakers asked the clients to discuss this in the evening house meeting as well requested the therapist to take it up in the group session. In another situation, when a particular client was being threatened by others because her current boyfriend was the ex-boyfriend of another client they addressed it in the group to sort out the group dynamics and bullying of the client.

However this process of questioning and challenging one's own belief system about disciplining, trauma and mindset about the target group and simultaneously to learn and unlearn have not been a smooth and easy process. As one of the caretakers who has been part of the sessions eloquently says:

*"Sometimes we find it difficult to accept and to understand the traumatized mind of the girl. It is difficult. Now I understand more about myself… I understand more about girls… and also what attachments makes us."*

According to the facilitator of the sessions, this is inevitable and hence prolonged capacity building sessions in a consistent manner are a necessity. As she communicates through a metaphor:
*"The difficulty comes from this as caretakers are not trained. I always give them*

*this example that if I ask you to do electrician work would you be able to do it. They said no. I said why not? They reply saying that we are not trained. So I said absolutely. So if you cannot do electrician work because you are not trained but you are expected to do trauma work, although you are not trained. So how is it fair? It is not. So if you start doing electrician work without training there are going to be sparks happening. Because you don't know which wire connects? Same things going to happen here as well".*

In spite of these hurdles, according to the facilitator of the sessions the caretakers have shown critical shift in terms of language used, level of tolerance and acceptance of negative emotions which is exemplified in the improved relationship between the caretakers and clients. It has also helped caretakers profoundly to have realistic expectation of the therapy process and understand that miraculous shifts are not possible after 6-7 sessions. The caretakers thus have become a resource for the clients. They feel safe while talking to them which has been the goal initially. Even the girls who have moved out of Advait confide in the caretakers. As the facilitator recalls:

*"A client was not willing to go for counselling sessions. She was upset and she said I don't want to go for individual counselling. The caretaker responded saying, "Even if you go to the counselor or you don't go, but I want you to know that our relationship will not end". That was a big thing to say… for that caretaker to that girl… Just imagine the relief of the girl to know that the caretaker will not punish or judge her. To know that the caretaker accepts her unconditionally, irrespective of her relationship with the counsellor". [Excerpts from interview with Ms. Sandra Farel]*

### 4.5.2 Outcome of the Capacity Building sessions at the organization level

The positive outcomes of the therapy process have not been limited to clients and caretakers but have been instrumental in shaping organization policies so as to better ensure a trauma free environment

for clients which will be conducive to recovery. Some of those evolved policies are:

- In the initial years, clients were not allowed to connect with families in order to keep them safe from unsafe environments. Though this policy was formulated with good intentions, it was proving to be counterproductive. This became clear when Arpan initiated the psychotherapeutic intervention. Through the capacity building sessions and their exposure to attachment theory, they were made to realize that this forced separation is leading to attachment cry and idealization of parents which is hindering the therapeutic progress. They were assured that the counsellor and the caretakers' goal is the same – to ensure the safety of the children However, this goal can be achieved by addressing their attachment needs, educating them about safety and inculcating skills to protect themselves when the primary caretakers failed to protect them; rather than separating them. So now, it has become a practice – as soon as clients come and settle down, the caretakers within two weeks start getting in touch with their families and family members come to meet them; and if the families are reluctant to come then the therapist start preparing the girl accordingly.
- Earlier when the parents used to come and meet the girls, they would make them speak to other family members over the phone. However, it came to the therapist's notice through conversation with clients, that some of the unsafe parent (perpetrators) would make them speak to 'so called boyfriend/pimp" because they wanted them to stay connected to those pimps. This was brought to the caretakers' notice without compromising the confidentiality of the clients. Hence, a policy was enacted which allowed clients to talk only to immediate family members so that it can be monitored that parents are not helping the girls to keep in touch with unsafe people.
- When parents meet children or call them, they often end up

discussing their difficulties at home. This leaves clients feeling traumatized and responsible. This too was brought to the caretakers' notice. After this, parents are informed that their job is to check the girls' welfare and show interest in girls' life and learning when they contact the girls. They need to avoid discussing problems at home with children and use other adult resources to meet their need to vent.

- The therapeutic intervention has also changed the disciplinary techniques followed at home. Rather than using authoritative disciplinary techniques, the house is evolving to be a space where children feel safe to express their negative emotions and are not reprimanded for their shortcomings.

## Section V

# Challenges and Bottlenecks

### 5.1 Challenges for therapeutic intervention at the organizational level

- Different Non-Governmental organizations rescue children and place them at Advait through CWC (Child Welfare Committee). Each of these organizations quite naturally feel strongly for the girls they have rescued and advocate for the prioritization of their individual therapy. This at times is not in sync with either therapist's clinical assessment or the protocol developed by the therapist and Arpan.
- NGO's who rescue girls often seek details of therapeutic intervention through caretakers and therapists for their internal and external reporting requirements. However, in situations where the caretakers and therapists have to withhold information for ethical considerations and the mental wellbeing of the clients – often this is not accepted in true spirit. This often and leads to organization dynamics and labeling of concerned individuals as "non- co-operative".
- Many volunteers come forward to participate in the healing work of the rescued minors at Advait. In the past some of their work had proved counter-productive as they led to re-traumatization of the clients aggravating their symptoms. It becomes challenging to provide an apt balance in which their enthusiasm and passion is not dampened and on-going therapeutic intervention is not jeopardized.

### 5.2 Challenges in group sessions

- In the last two years there has been frequent shifting of clients in and out of the institution. This had started to impact the effectiveness of group sessions and the nature of it as the requirement and need of new clients and older ones were different. In order to respond to this challenge, the senior housemates and the newer ones were separated in two groups, namely, 'Asha' and 'Khusi' based on their differential need. In spite of this, continuous movement of clients lead to a lot of repetition of basic nonnegotiable concepts leaving little space for other evolved discussions.
- This division of groups, however, had its own challenges. There were fights between both the groups and they would address each other as 'new' and 'old' which was not healthy. The senior girls would taunt the new girls and would be critical and judgmental about them. Once they started spending time in one particular group, they tend to bond with group members which started interfering in their relationships with members of the other group. This led to more concentrated work on group dynamics and inculcating skills on how they could be loyal to their own group members' trust issues yet share close relationship with members of the other group.
- In case of clients attending both individual and group sessions, there is a probability of transference issues surfacing. As clients in individual therapy develop a unique therapeutic alliance with the therapist it is a transition for them to interact with the same therapist in a group setting. This is because the role of the therapist in the group sessions is also significantly different, in this space she is more of a coach to a group of individuals. This can lead to issues in group dynamics as clients from individual sessions can assume and portray they are closer to the therapist as well can make conscious and unconscious reference about their conversation in individual therapy.

- From the clients' perspective, at times in spite of their comfort and willingness to share their past with the counsellor, they cannot do so in a group session – either because they are not comfortable with all group members or they feel their sharing might trigger others.
- Some of the clients also brought up language as a challenge for them to benefit completely from the group sessions. As the group session is conducted in Hindi, children who are not familiar with the language face a challenge to communicate their view point and follow the therapist.

### 5.3 Challenges for individual therapy

- All clients who need individual therapy as per therapist's clinical judgment cannot be accommodated for sessions due to other legal issues. For example clients who are under psychiatric treatment or have a high run away tendency cannot be taken up for individual session due to safety concerns [because they travel on their own for individual therapy]. In those cases, the therapist has to accept this limitation and work with those clients in group.
- All clients who express the need for individual therapy cannot be accommodated in the sessions as the therapist has a limitation of the number of clients that can be taken up. In those cases the therapist has to communicate to the clients about her limitation and under what circumstances they can be taken in. The therapist has also increased group work so that clients get more input, even if she cannot take all clients individually.
- Individual therapy is resource intensive. As 3 hours of individual therapy benefit only three clients whereas 3 hours of group sessions benefits all 20 girls.
- In the case of individual therapy, safety concerns of client leads to four fold challenges. Firstly, as clients commute on their own for individual therapy, safety concerns of certain clients for example, under psychiatric medication or a runaway

tendency, limits their participation. Secondly as this is only the avenue through which clients have freedom to come out of closed home – this has led to anxiety on behalf of caretakers. The challenge was to take care of caretakers' insecurity and validate that. The third challenge was to ensure that girls are capable of handling the freedom and responsibly given their past trauma and possible acting out; fourth the therapist has to deal with her own anxieties around the safety and freedom of clients as well.

- The individual therapy with clients who in most cases show dissociative symptoms[9] is tremendously tiring and slow paced work. As apparently the movement cannot be seen the therapist can feel tempted to give up. However to sustain this important phase is important as progress is happening but with trauma survivors slow is fast.
- Trust issues with clients in individual therapy also becomes a bottleneck. It needs repeated communication that clients' each and every behaviour is acceptable for the therapist as long as they do not keep secrets because in the past secrets have caused a lot of problems. In the case of clients with dissociative trauma symptoms

*9 Dissociative symptoms means when clients are with the therapist physically but not mentally. The challenges is to constantly bring them back and help them to separate from past and present. So if in the session there is talk about something from past which is even slightly triggering clients start reliving. When clients are in the dissociative field and they are talking about a current issue with rage - the therapist's mind know that this is definitely past… She is re living it in past. The therapist then help them slow down and connect it to past. Why is it feeling so overwhelming? Because maybe there is something. So that becomes a challenging thing because when they are in a dissociative mode they don't want to talk about their past, "Don't talk about my past because this has nothing to do with past. It is about today, how could she talk to me today like that?"*

and splitting of parts[10], to gain complete trust of all the parts is a slow process and the therapeutic alliance is fragile and fluid. Given the tendency of traumatized individuals to resist counselling and to project distrust, the counsellor has to carefully monitor her own countertransference[11] and emotional stimulation and wait for the client and her parts to reconnect. The message that needs to go out to the client is that she will not be punished; and renegotiation of contract involving all parts will help the client's empowered part to take control. This is a continual, evolving process that remains alive during treatment. It often helps counsellors to remember that maintaining trust is the most fundamental and central therapeutic work for the individuals who have been traumatized. At the same time clients test trust and commitment, they can displace their anger onto the counselor trying to help them. Working with traumatized populations thus increases the stress on the counsellor

*10 Instead of developing a SELF, the child develops a system of SELVES. It is a system that is highly adaptive in an unsafe environment. A system of selves must include a part of the personality serving the cause of "going on with normal life:" functioning in daily life, raising the children, being able to provide basic necessities, even enjoying normal developmental tasks or taking up meaningful personal and professional goals. But while one part of all of us is valiantly carrying on normal life, other parts must serve functions of fight, flight, freeze (or fear), submit, and attach for survival or "cling." For example, for a child living with a parent who is withdrawn at some times and violent at others, having a different self or part of self prepared to deal with each of these different challenges is very useful: in response to the panicky alarms of a fearful part (freeze) alerting the individual to potential danger, a caretaker aspect of self (submission) can become the precociously responsible child who tries to protect herself or younger children in the face of the violent behavior, while a "class clown" aspect may try to lift the parent's irritable mood and facilitate relational connection by making him laugh (attach), or a hyper-vigilant aspect of self (fight) may become a kind of bodyguard carefully observing the parent's mood and directing the child's activity to best defend against mood-related "frightened or frightening" behavior (Fisher 2001).*

*11 Transference in a therapeutic setting is the phenomenon whereby the client unconsciously transfer his/her feelings and attitudes from a person or situation in the past on to therapist or the situation in the present. Countertransference is the response that is elicited in the therapist by the client's unconscious transference communications. Reflection from the therapist demands a reasonable level of awareness of one's own thoughts and feelings, and a sound grasp of whether these deviate from good professional behavior (Hughes and Kerr 2000).*

and leaves him or her vulnerable to compassion fatigue[12] and burn out[13].

- Misalignment of goals of therapy for the therapist and the client often becomes a challenge in therapy work. There are very few clients who wanted to come out of their unsafe home; none of them wanted to be separated from their family or boyfriend; they have been rescued and been brought by force. Hence such clients don't want anything from the therapist except her freedom. For these clients, the goal for therapy is to go back to their family; however this is neither the therapist's goal as the home in most cases is unsafe nor does the counsellor have the authority to make this decision. Here the parallel can be drawn with substance abusers who are forced to stay in a rehabilitation centre by their family against their wishes. This resistance represents the degree to which the situation is perceived as a threat. The therapist dealing with resistance will try to name and address the threat and try to minimize the conflict of treatment goals. Hence, despite the seeming urgency, treatment cannot move forward until the resistance is managed.

### 5.4 Challenges in caretakers' sessions

Caretakers need regular input. They also need somebody who has faith in them, who trusts them believes them and is very compassionate with them as this process in itself is therapeutic. In this schema, the

*12 Compassion is defined as a feeling of deep sympathy for another's suffering or misfortune. Compassion Stress is the feeling of tension or demand associated with feelings of compassion. Compassion Fatigue progresses from Compassion Stress and is an overwhelming state of tension and preoccupation with the cumulative trauma experienced by and reported by clients within the child welfare, juvenile justice, and other related mental health professionals. This type of fatigue results in symptoms of distress not unlike the clients who experienced the trauma firsthand*

*13 Burnout emerges gradually and generally involves a state of dissatisfaction with one's position related to work environment factors, career choices and goals, and level of job satisfaction. Compassion Fatigue may be a component of burnout, but is essentially a secondary traumatic stress reaction and vicarious traumatization.*

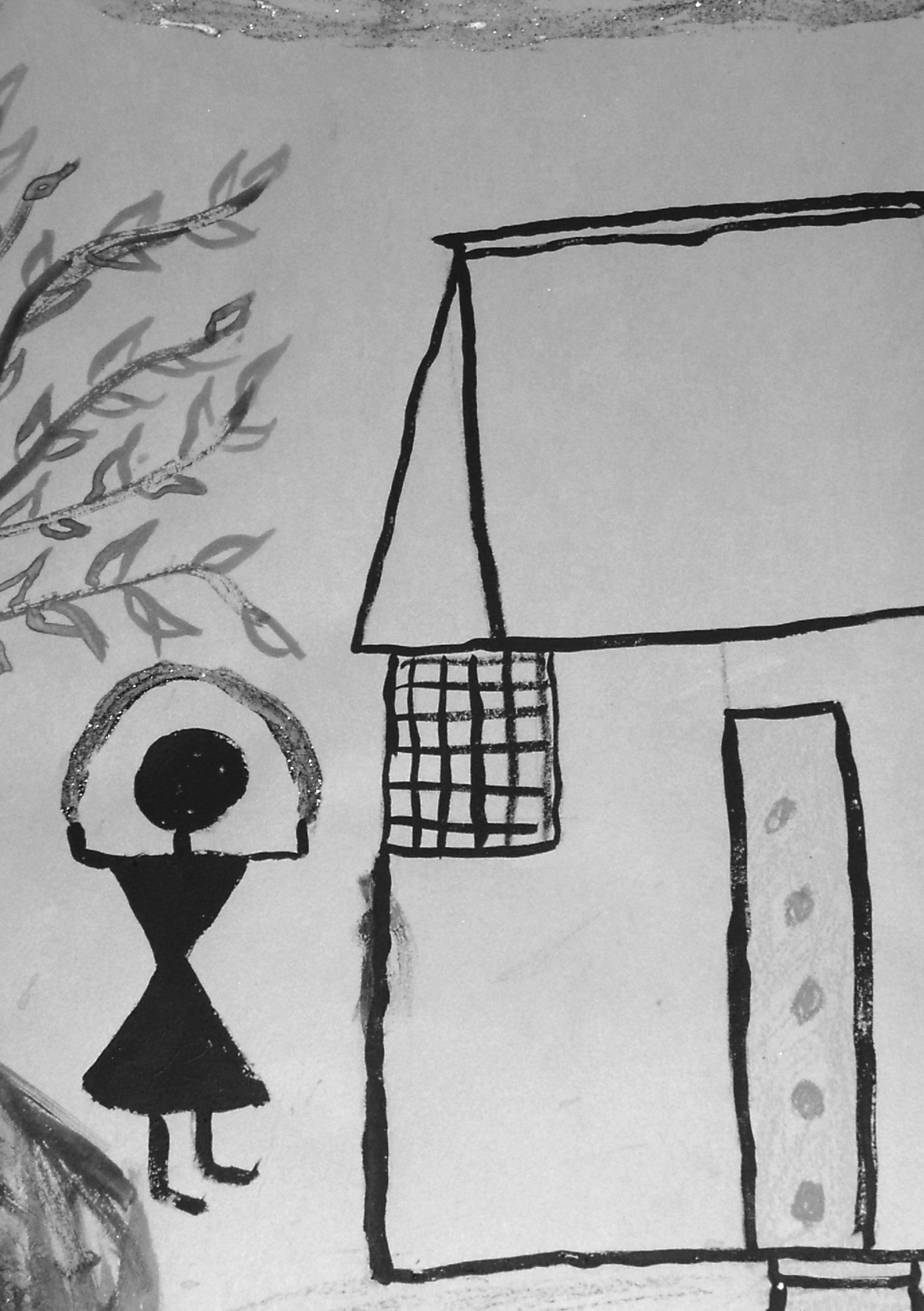
intervention has not been able to arrive at an ideal framework:

- The unresolved challenge has been as to who should conduct the capacity building sessions – the client's therapist or someone else. At Advait, both the options have been tried and both had their share of challenges. For the therapist treating the clients, the clients become the priority and hence the caretakers' session gets sidelined due to time constraints. There is also the possibility of leading to trust issues among clients until they have reached a particular therapeutic alliance with the therapist. Mistrust could surface as clients might perceive the closed door interaction between caretakers and therapists as threatening and assume that what they shared with the therapist will not be kept confidential. In the same manner caretakers in their initial phase have a subtle expectation from the therapist that she will disclose the sharing of the clients – hence the therapist has to strike a balance. On the other hand, if the facilitator of the capacity building sessions is a different therapist then she cannot combine feedback session with capacity building initiatives as she is not well informed about the day to day challenges of the clients. Given that feedback and validation are voiced as key needs of the caretakers as it satisfies their immediate need they prefer the same therapist as they feel this ensures better continuity. For the clients' therapist in order to satisfy this need, feedback sessions on the caretakers' skills in handling daily challenges and crisis takes on larger chunk of time which compromises the capacity building inputs. This leads us to the second challenge.
- Capacity building sessions are important as this will over time make caretakers well equipped and skilled. That is what is ultimately needed and is significant transformative work. However as the caretakers' present needs are getting fulfilled with feedback sessions which provide instant gratification and is effective as a short term measure they often do not realize the long term need of capacity

building. This leads to over dependency on the therapist.

Beyond these fundamental challenges of structuring and facilitating the sessions, there are certain other hiccups as well:

- Rotation of caretakers every 3 -5 years hinders the process of capacity building as consistency gets compromised and repetition with every new entry takes up significant amount of time.
- Dealing with an adult group, individual differences are a major challenge. Different care takers' personalities, belief systems and values about discipline, knowledge about children, past work experience and goals for clients are different and it gets reflected in the way they handle crisis and girls' acting out. So working on this difference and having policies which iron these differences out and evolve a uniform response becomes challenging.
- The inhibition and resistance of caretakers to reading also hinder the process as reading materials on trauma is necessary to become well versed in dealing with victims of trauma.



## Section VI

# Conclusion

The process documentation of the long term Psychotherapeutic Intervention at Advait have flagged that the intervention has been instrumental in supporting the healing of clients as well as equipping the organization and its staff to create a 'trauma informed' service. These have been possible because of accurate reading of a situation, zeal, passion of every stakeholder and beneficiaries. The process documentation thus has been able to bring out best practices that played an effective role in bringing the shifts that were documented in the earlier sections. This has been at the level of the organization providing the service (Arpan), organization receiving the service (Advait) and the key professionals involved in the process; and an effective coordination, trust and alignment of goals between key players as well receptivity to learn and change through experience.

### 6.1 Best Practices followed by different stakeholders

#### 6.1.1 Best Practices followed by Arpan

- To believe that the therapist is an independent agent and practice that the therapist has the sole discretion to decide on the course of therapy. This meant not to treat the therapist as the agent of the court for catching perpetrators or punishing them or get access to clients' lives. The therapist thus had a lot of leverage over the process and had not been confronted with questions such as, "Haven't you started dealing with her sexual abuse yet?" This is significant in psychotherapeutic work as any level of external pressures or influences are hiccups. At the same time, it should not compromise the therapist's accountability.

- To effectively respond to the learnings from the process and integrate it. For example, during the course of the intervention it was realized that a formal need assessment should have been conducted before initiating the programme to understand Advait's vision for the organization and clients. This realization led them to act on it without further delay so that they can involve all stakeholders in the clients' healing journey.
- In a schema where intrusion is minimum a lot of onus is on the independent agent. Hence the choice of the therapist needs to select those who are not only skilled and knowledgeable but conscientious as well. He/she also needs to be open to continuous learning, training and supervision and individual therapy.
- Sustaining the same therapist for 5 years for consistency and greater impact
- To understand that the mental wellbeing of the therapist is critical and hence having a policy which prods all practitioners of Arpan to seek personal therapy.
- Ensuring continuity of funds by tapping the right funders and presenting tangible outcome of the process; in spite of initial challenges of funders to fund mental health issues.

### 6.1.2 Best Practices followed by Advait

- For Advait management, to be a recipient who is ready, willing and open to suggestions and to implement policies that will support the children's healing journey has been one of the key reasons for the success of the project. For the management and caretakers to notice movements in client and the positive environment of the institution after therapy have made them believe that therapy is indispensable and prompted them to create conducive policies.
- Caretakers' openness to reach out to the therapist at times of crisis
- Cooperation of the management to continue with consistent capacity building session of caretakers

- Proactive cooperation of management in streamlining psychiatric evaluation for all clients as this emerged as a need over the course of work.

### 6.1.3 Best practice followed by the therapist

- Setting of realistic goals and boundaries and accepting limitations has helped to achieve targets and stimulate motivation. Thus concentrated focus has been on stabilization so that clients are hopeful about their present and future; before jumping into trauma processing. Through these less stigmatized and stimulating conversations, the counsellor has been able to build trust and work out a protocol based on appropriate pacing.
- To have faith in clients has been empowering. The belief that the clients have handled the worst without therapy and their ability to survive and capacity to do whatever necessary in order to survive has been instrumental.
- Coordination with caretakers to monitor out of session progress has been effective
- Sustaining capacity building sessions parallel to clients' therapy has helped to build skills
- Exposing clients' to prolonged group sessions and psycho education before individual therapy so as to ensure optimum utilization of resources
- To listen to and validate clients' emotions and empower them to resolve their issues with caretakers have helped in defining boundaries; rather than becoming the client's spokesperson
- Boundary setting with the clients and the caretakers also helped to streamline the therapy process. For example, the therapist not taking part in any celebration or festivities in spite of expectation from both clients and caretakers helped to maintain the professional boundary and unambiguous relationship
- To take preemptive steps to combat compassion fatigue and

burnout. This has been achieved by being part of professional circles (Study Circle on Trauma, EMDR study circle). As, in these spaces, support is available from fellow professionals as well as suggestions, advice, and/or consultations from mentors. This is essential, as working in isolation tends to increase the risks of such symptoms and is contraindicated when working with this population

- Looking for avenues for professional development as this stimulates new ideas and interests. Additional training and education helped to remain updated on the evolving literature related to understanding and treating trauma

### 6.2 Recommendations

The project has, no doubt, met the desired goals and has been able to develop systems and protocols which can be replicated. However, suggestions and recommendations which have evolved from the process in order to iron out the challenges are:

- All stakeholders involved with trauma victims need to have or develop understanding of trauma and impact. This will help to review agency policies and procedures at regular intervals and facilitate identification and removal of potentially unsafe ones. Internal reviews, using a trauma lens, can be especially helpful in identifying policies and procedures which can be damaging to trafficking victims.
- Communicating rationale for the initiation of new rules and activities to children and corresponding expectations
- To ensure a minimum length of stay at the facility of at least 18 months. The 18 month stay is recognized as sufficient time to build trust with the girls, provide the necessary therapy to address their trauma, and to begin "working their treatment plan" and rebuilding their lives.
- Each girl is traumatized and has her own way of coping. Being with other equally traumatized girls is becoming more traumatic

for them as they constantly fear emotional outburst from their peers. The forum where clients could interact with other people with less traumatic backgrounds outside the home (without constantly worrying about emotional outburst) on regular a basis is recommended. This exposure through social and occupational interaction outside the home will also give them a forum to test their skills and would provide directions for future planning.

- "Not knowing what would happen next" seems to be theme of the girls' lives especially those who are nearing 18 and is creating either hyper vigilance or withdrawal. Most ex-clients also mentioned having a sudden outburst of complications soon after they moved out. To advocate for continued connection to the program following exit and long-term aftercare services is recommended.
- Create mechanisms to address issues around language challenges of clients.
- To devise mechanisms to map impact more objectively by applying pre-post assessment at the entry point and after intervention at the exit point through social activity scale, distress scale, delusion symptom inventory, brief symptom inventory, trauma questionnaire, adolescent dissociative experience scale etc.
- Develop a sustainable back up plan in case of withdrawal of the therapist and/or Arpan.

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## Annexure: To Do List/Check List for Stakeholders

The 'To Do List/Check List for Stakeholders' is an outcome of our experience and is based on three critical components: Safety, Trustworthiness and Collaboration:

**Organization Providing Therapeutic Support:**

- To start off at a safe, manageable pace, a well-run home where investment of time and energy to ensure other necessities are not required
- To conduct a need assessment with the institutional management to understand their goals
- To maintain clear communication and arrive at a consensus between both organizations on the protocol of the therapy process
- To do a psychiatric evaluation of all clients on entry
- To choose a therapist who is skilled, knowledgeable and conscientious
- To choose a therapist who is open to continuous learning, training and supervision.
- To retain the same therapist for a considerable time span
- To treat the therapist as an independent agent
- To have a policy which prompts all practitioners to seek personal therapy
- To sustaining capacity building sessions parallel to clients' therapy
- To withstand and support the slower pace of progress and to
- identify small successes over the course of treatment

**Partnering Institution**

- Introduce Management and Caretakers to the understanding of Trauma and Trauma symptoms
- To support psychiatric evaluation of all clients
- To ensure continuity of the caretakers
- To ensure the clients are in institution for the minimum

required time frame

- To continue with consistent capacity building sessions of caretakers along with clients' sessions
- To providing spaces for clients to express negative emotions
- To create a space ensuring physical and emotional safety
- To create protocols so that children are in touch with family while ensuring their safety
- To create protocols shunning punitive punishment and avenues for providing positive disciplining
- To propagate a culture which eliminates the use of labels and uses richer language to describe the client
- To have open communication and provide factual information to clients with a lot of support
- To have all support staff cognizant of client's mood swings, acting out, behavioural changes and trauma symptoms
- To develop protocol for staff to seek help during a crisis
- To have platforms where girls could interact with other people with a less traumatic background outside the institution on a regular basis
- To be able to withstand the slower pace of progress and to identify small successes over the course of treatment
- To understand the mental wellbeing of clients is not only the responsibility of the therapist but is a collaborative effort

**Therapist/Counsellor**

- To set realistic goals and boundaries and accept limitations
- To focus on safety and stabilization (care for the self, connections to other people and developing a renewed faith in the universe) rather than on trauma processing. The key questions should revolve around: "Is it safe for you to talk about this? What will happen if you do? Will you feel better or worse?"
- To set up a safety contract with clients - the best approach to contracting emphasizes defining the commitments the client has

to make in order to recover, whether it is to refrain from self-harm, come to appointments consistently

- To have faith in clients – to believe and teach the clients about trauma and in ways that celebrate and emphasize that, if she had the ability as a small child to survive these experiences, then she has all the resources she needs to recover from the symptoms of those experiences
- To coordinate with caretakers to monitor out of session progress
- To define protocols/resources for clients and caretakers to reach out to the therapist at times of crisis
- To accept trust is earned over time and clients will test the relationship until it is established
- To have psycho-education through group sessions as a prerequisite for individual therapy and effective mechanisms for a speedy recovery
- To develop skills to anticipate - each time a patient self-harms or acts out, the first question needs to be, "What was the trigger?" or "Did you notice any early warning signs?" The best way to do it is to look for triggers (that is, reminders, subtle or not so subtle, of past traumatic experiences). Look at what response the patient had to the triggers and how that led to the next step and the next. This will minimize triggers but the expectation is not to eliminate all the triggers
- To teach techniques to calm the mind and body – including breathing exercise and self - talk.
- To inculcate skills to clients for 'staying in the present'
- To support the clients to develop safety nets and resources
- To engage in emotional self-care behavior
- To engage in profession circles and hone skills
- To diversify caseloads, if possible.
- To be honest about the therapist's feelings with his/her client and management

For the last five years, Arpan has been conducting long term psychotherapeutic work with rescued minors living in institutions. Through sustained individual therapy and group sessions, we have seen the girls make remarkable journeys towards healing and self-actualization. This research is an outcome of documenting the process of this change and aims towards providing a model of psychotherapeutic intervention for working with children who have survived trauma and abuse.

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Towards Freedom from
Child Sexual Abuse