Jan Sahas
Social Empowerment Society

SAHARE KE CHOTE ISHAARE

FIRST STEPS OF SUPPORT

TRAINING MANUAL FOR BAREFOOT COUNSELLORS

phf Paul Hamlyn Foundation

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FOREWORD

It is with immense pride and hope that I write this foreword for the Training Manual of Barefoot Counselors. This manual stands as a testament to the resilience, courage, and commitment of the countless individuals in our communities who have taken it upon themselves to bring about meaningful change. In the face of adversity, where mental health is often marginalized or misunderstood, barefoot counselors have emerged as the true pillars of support, providing a compassionate and grounded response to the struggles many face daily.

As we know, mental health challenges are not confined to urban centers or those with access to specialized care; they affect our rural and tribal communities, often compounded by socio-cultural factors such as caste-based discrimination, gender-based violence, and poverty. Yet, despite these challenges, our communities have an innate strength and resourcefulness that we must harness and nurture.

The barefoot counselors are the heart and soul of this change. By training individuals from within the community, we not only provide a critical support system but also empower those who understand the local context and speak the language of the people. These counselors do not carry formal degrees or certifications, but they bring something even more invaluable–the trust, the connection, and the lived experience of those they serve.

This manual is not merely a guide; it is a reflection of our collective vision. It embodies the belief that mental health support must be grounded in community, that healing is as much about emotional connection as it is about therapeutic techniques. The barefoot counselors, trained with empathy, practical knowledge, and deep cultural understanding, will help bridge the gap between what we know and what we must do to heal and support our communities.

As you turn these pages, remember that this work is not only about individual healing but about creating a ripple effect of change. It is about fostering a society where mental health is as integral to well-being as physical health, where every individual has access to care, dignity, and the opportunity to thrive. Together, through the work of barefoot counselors, we are building a future of solidarity, empowerment, and hope for all.

Let this manual be a guide to the essential work ahead, a work that will transform lives, heal wounds, and make our communities stronger.

In solidarity and hope,
Kranti Khode

ACKNOWLEDGEMENTS

The *Sahare ke Chotte Ishaare* project, by Jan Sahas Social Empowerment Society, was made possible through the generous support and partnership of the Paul Hamlyn Foundation (PHF). The initiative to develop this training manual began with PHF's shared commitment to addressing the mental health care gap in rural and remote communities across Madhya Pradesh. We are deeply grateful for their trust, guidance, and the collaborative network of mental health professionals, including those from the Jan Sahas Foundation, who helped bring this vision to life.

It is a delight to finally present 'First Steps of Support', training manual for barefoot counsellors; and as excited as we are to see it aid for the training of more barefoot counsellors, this is also a moment to appreciate the efforts of so many passionate and driven people who all continue to aid and transform the landscape of mental health in rural India.

This training manual for barefoot counselors is a culmination of our shared efforts to create a practical, accessible resource for grassroots organizations. Our goal is to provide tools that initiate meaningful conversations and understanding around mental health, enabling these organizations to incorporate mental health awareness into their work and communities.

Designing training material systematically for new barefoot counsellors that is digestible and adaptable to contexts that the mainstream language of mental health fail to conceive convincingly is a challenging task, and for every chapter, every endeavour undertaken towards structuring and polishing this training manual, we have the members of Mental Health and Psychosocial Support team to be grateful for. The chapters in this manual has been the the combined efforts of many team members over the years, and their unique and diverse insights and voices shape the pages that fill this manual.

The barefoot counselors themselves, whose unwavering dedication, resilience, and compassionate work are always the beating heart of our work. Whatever understanding we have taken to shape this manual would not have been possible without the efforts of and insights our barefoot cousnellors have provided from their work and understanding of our communities.

This training manual has been a combined effort of Jan Sahas Social Empowerment Society and its partner organizations. And we would like to sincerely extend our gratitude to our partners who have always been supportive and collaborative, and without them, neither this manual nor the work we do in mental health would be where it currently is.

Finally, it is the the communities we work with that always shines as our guiding light. Any and all our efforts to work towards transforming mental health in rural communities is made possible because of their collaboration and resilience they share with us. Their stories, their courage and their knowledge drives and shapes our understanding of mental health in rural India, and our hope that to contributing a change in the understanding and work with rural mental health is thanks to them.

EDITOR'S NOTE

The creation of this Training Manual for Barefoot Counselors has been a labor of love, collaboration, and persistence, shaped by years of evolving experiences and perspectives. The mental health team that has contributed to this manual is not just a group of professionals; it is a collective of passionate individuals who, despite their different disciplines and approaches, share a common vision: to bring mental health support to the grassroots level in a way that is accessible, relatable, and effective for all.

Over the years, the mental health team has grown and changed, with each professional adding their unique expertise to the process. The team comprises psychotherapists, mental health social workers, psychologists, and clinical psychologists– each with their own distinct approaches and tools. Together, we have spent months designing these training sessions, focusing on transferring knowledge and equipping barefoot counselors with skills that are not only relevant but grounded in the realities of the communities they serve.

One of the core challenges we faced was ensuring that the principles and techniques drawn from Westernized mental health frameworks were translated into language and examples that felt meaningful and useful in a local context. We knew that the success of barefoot counselors depended on their ability to connect with the people they serve, to speak their language, and to offer support in a manner that was rooted in the community's experiences and values.

Each mental health professional brought their expertise and dedication to addressing the barriers that often accompany the dominant, expert-led models of mental health care. We worked hard to ensure that this manual was not just an academic document, but a tool for empowerment. We sought to break down the walls of expertise and create a space where knowledge is shared and accessible, where community members are not passive recipients but active agents of change in their own healing processes.

These training sessions were not created in isolation; rather, they were delivered, evaluated, and continuously refined based on feedback from the barefoot counselors themselves. After each training cycle, we would return to the drawing board, revisiting and redesigning parts of the curriculum to better address the specific needs and challenges faced in the field. This iterative process–of designing, delivering, gathering feedback, and redesigning–ensured that the content was not only relevant but truly effective in real-world applications.

As editors, we faced the complex challenge of synthesizing these trainings modules, many of which span across diverse perspectives and creative choices tied to the creative minds behind it across iterations, and respective lenses and points in time that the work itself evolved through. The result is a product that reflects both the diversity of thought within our team and the unity of purpose that binds us together. This manual is more than just a guide for training; it is a reflection of our collective commitment to making mental health care more inclusive, more grounded in community, and more aligned with the lived experiences of those we aim to support.

We hope that this manual serves as a valuable resource for all barefoot counselors, equipping them with the knowledge and confidence to make a meaningful impact in their communities. It is our belief that, with the right tools and support, every community member has the potential to be a powerful force in the mental health landscape, and this manual is one step in that journey.

With gratitude and hope,
Abhijith S, Keerthi Rangarajan

HOW TO USE THE MANUAL

The contents of this manual are aimed to be the modules that facilitate as training sessions for barefoot counsellors. Anyone who oversees the training of barefoot counsellors and has technical knowledge as a mental health professional working with communities, would make the best use of this manual.

Each topic in addtion to its contents and outline have alongside it, a few words from the current MHPSS team members who add their own reflections and insights regarding the chapter, the context of the development of its contents, and the various perspectives over the same chapter that may not have made it the particular iteration of the chapter, but can nonetheless be relevant.

It is also important to keep in mind that the relevance of different choices of perspectives and examples showcased in this manual can change from context to context. Mental health if anything, is deeply contextual and we hope that whoever may use this manual may use it to enrich the understanding of mental health in communities and not shut down discussions, disagreements and diverse perspectives on approaching the same problems that we are all trying to work towards solving.

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I Basics of Counselling

1 Introduction to Mental Health

A word from the team

This topic aims to introduce field counsellors with a basic understanding of mental health and its components and provide them with the information to spot signs of distress.

Discussion

Since conversations on mental health could be fairly new, people may immediately limit their understanding of mental health to severe mental illness. To build towards a holistic understanding of mental health, facilitators may start the discussion with the following questions:

- What is 'health'?
- What are the different ways in which we take care of our health?

Myths and facts about mental health

Before trying to understand "What is mental health", let's attempt to figure out what we already know about it.

Activity

The facilitator will present some ideas around mental health to the participants, who will share whether they agree with these statements or not and why. After listening to what they share, the facilitators will also share the facts surrounding each statement - which are shared alongside the statements, below.

- **Mental health issues are very rare/uncommon in people**

1 in 4 people worldwide will be affected by mental health issues at some point in their lives. Mental disorders are one of the major causes of ill health and disability worldwide. Concerns related to mental health are as common as any physical health condition. Because we often don't know how to recognise mental health concerns, we become incapable of seeking help for them.

- **People affected by mental health problems cannot work**

It is true that people struggling with serious mental health problems may find it difficult to concentrate on their work or may occasionally face challenges in their daily routines. However, this does not mean they are incapable. In fact, many individuals dealing with mental health issues can be just as productive as others. Just as people continue to work even after experiencing serious physical illnesses, similarly, if someone has a serious mental health problem or illness, with the right treatment and support, they can work effectively.

- **Mental health issues are a sign of weakness**

Saying this is like suggesting that a broken leg is a sign of weakness. Mental health issues are not a sign of weakness; in fact, it's quite the opposite: it takes a lot of strength to confront mental health conditions. There is no connection between being lazy or weak and mental health problems. Many factors contribute to mental health issues, such as genetics, physical illness or injury, life experiences like trauma or abuse, or a family history of mental health problems.

- **People with mental illness are violent and need to be hospitalised**

Most people with mental health issues, including those suffering from serious illnesses, are not violent. The likelihood of a person with a mental illness becoming a victim of violence is higher.

- **Children do not have mental health problems**

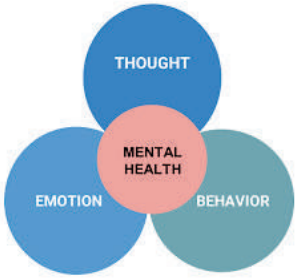
Early signs of mental health issues can appear in very young children. Many mental health conditions show their initial symptoms before the age of 14.Every individual has the capacity to think, feel, and behave; they have mental health, whether they are young or old.

What is mental health?

Mental health means how we feel, how we think, and how we behave.
Just like feeling sadness, anxiety, and worry is a part of mental health, feeling happiness, enthusiasm, and contentment is also a part of mental health. Experiencing any or all of these emotions is not a bad thing.

- Mental health is an individual's psychosocial well-being.
- It encompasses our emotional, cognitive, and social mental state.
- Mental health affects how we face challenges, form relationships, and make decisions.
- It can influence daily life, relationships, and physical health.
- Just as feeling sadness, anxiety, and worry is a part of mental health, feeling happiness, enthusiasm, and contentment is also a part of mental health.

Thought, emotion, behaviour



Our thoughts, behaviours, and emotions collectively shape our mental health. Mental health problems can arise due to various reasons, and sometimes these causes may not be immediately apparent. Mental health is also influenced by our interactions with others and the socio-economic-political conditions happening around us.

Activity

In the following situations, reflect on what might be your thoughts, emotions and behaviour.

Situation 1: Your friend has not been answering your call for hours.
Situation 2: A girl from your family has topped the entire district in the 10th grade

We are providing these two scenarios to help us understand that mental health is influenced not only by traumatic events but also by situations that bring satisfaction.

Discussion

You have a 3 day holiday from today. You planned to celebrate a 2 day holiday with your 5 friends. You packed your luggage and prepared in the morning. One of your friends was supposed to come with the car at 3 in the afternoon. You were waiting for your friend but it was 3:45 and your friend who was supposed to bring the car was neither talking nor picking up the phone. If you were in such a situation -

What would you think?
What would be your feelings?
How would you behave in such situations?
What changes would you feel in your body?

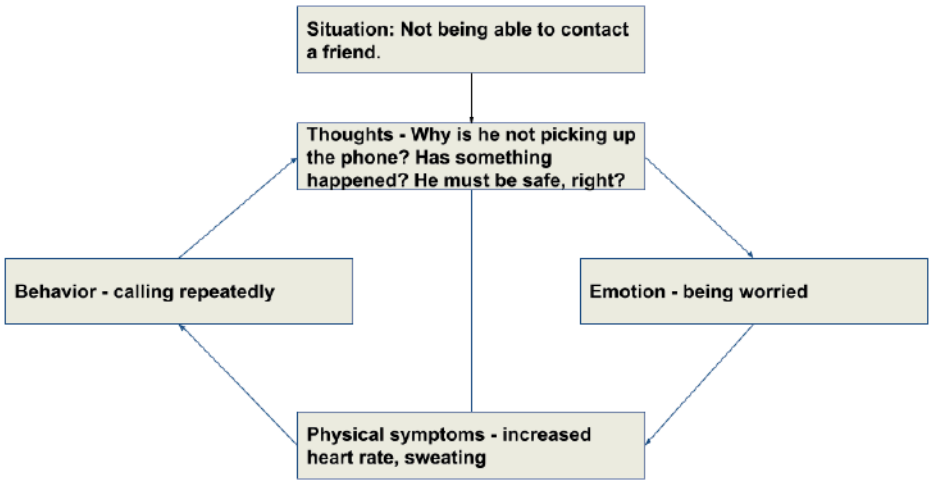
Thoughts
Thoughts are our interpretations of situations. Usually this is understood as the verbal commentary inside us. But apart from words, sometimes thoughts can be non-verbal, and present themselves as images in our minds.

Emotions
What we feel in any situation is an emotion. - While feeling an emotion, sometimes we also experience physical sensations - like if we feel sad or bad, then we feel a little heaviness in the body, a little heaviness on the chest, if we are very happy, then we feel excitement in the whole body.

Behaviour
Behaviour means what we do and how we act in a situation. In some circumstances this could also be looked at as what we are unable to do, or choose to not do.

Physical Symptoms
The effect of what we think on our body - for example, if we become very worried, our hands and feet start sweating.

We observe a situation - we think about the facts of the situation and make a feeling - we react to the situation based on our feelings - we engage in behaviours that in turn affect the situation (it can affect the situation in a positive or negative way) - and this affects our body.

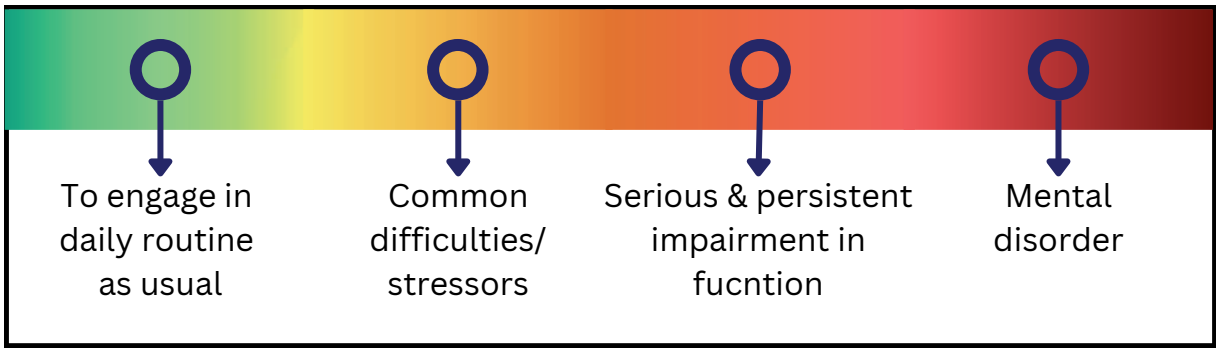


Discussion

A 17-year-old girl used to go to the fields with her parents every day. One day, the girl's parents left early for some reason and the girl finished her household chores and went alone to the fields. While going, some boys from the village molested the girl. Somehow, the girl defended herself and reached the fields to work, but she did not tell anyone about the incident.

After understanding the above situation, answer these questions:
What thoughts would come to the girl's mind?
What feelings/emotions does the girl have?
How would the girl's daily behaviour be in such situations?
What changes can the girl feel in her body?

Mental health continuum



Regardless of where someone currently, in this spectrum,
they can always focus on your mental health and seek help for it.

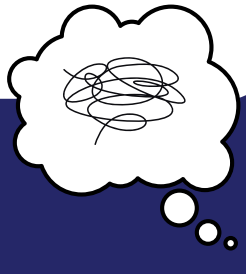
It is evident from this continuum that at different stages of our lives, we can place ourselves anywhere on this continuum, and we never stay in one place forever. Life has different phases and ups and downs; we can be in any part of this continuum based on our internal and external circumstances. These fluctuations are normal in everyone's life.

Sometimes, a group of signs and symptoms that persist for a significant duration, or with stronger intensity and impairs the daily life of a person. Such situations may be where we consider these signs as possible signs for mental illness.

Symptoms & Signs of distress

THOUGHTS

- Excessive worrying
- Suicidal Thoughts
- Negatives thoughts regarding self and the future
- Feeling a lack of control over everything
- Difficulties related to attention



EMOTIONS

- Tension
- Sadness
- Restlessness
- Nervourness
- Fear
- Irritability
- Anger

BEHAVIOUR

- Lack of interest in daily activities
- Frequent desire to cry
- Excessive consumption of harmful substances
- Outbursts of anger - getting into arguments frequently

PHYSICAL SIGNS

- Changes in sleep and sleep patterns
- Physical pain without any apparent physical cause
- Constantly feeling fatigued

Signs of mental health distress related to thoughts

- Excessive worrying
- Suicidal Thoughts
- Negatives thoughts regarding self and the future
- Feeling a lack of control over everything
- Difficulties related to attention

Signs of mental health distress related to emotions

- Constantly feeling sad
- Feeling extremely anxious, afraid or sad.
- Feeling helpless
- Feeling worthless
- Feeling extremely hopeless about the future

Behavioural signs:

- Crying frequently
- Self-harming
- Using excessive substances
- Using harmful methods

Physical signs:

- If you experience unexplained pain and other physical symptoms
- Feeling extremely tired
- If you notice extreme changes in your sleep or appetite

Other signs of mental health distress:

- Mood swings, sometimes suddenly feeling very good and then suddenly feeling very bad.
- Difficulty concentrating.
- Feeling a lot of emotions like sadness, stress, anxiety, restlessness, guilt, anger and not being able to control them.
- Difficulty meeting family or friends or having difficulty in maintaining any relationship, feeling like staying away from people.
- Feeling very tired or having less energy, body or headache.
- Even everyday tasks seem difficult like cooking food, bringing vegetables etc.
- Increase in alcohol consumption, excessive anger or violent behaviour.
- Changes in sleep. Changes in appetite.
- Hearing strange voices or seeing things that are not there (names, places, days and dates).
- Having suicidal thoughts or having any injury marks on the body.

2 Introduction to Counselling

A word from the team

This topic is aimed at introducing the concept of counselling to field counsellors, characterising its core values and various goals, as well as dispelling misunderstandings surrounding it.

Discussion

At the start of the session, asking the participants if they're familiar with the term 'counselling' or ever heard of it, and having a discussion about what they know or have heard already about counselling would help set up a baseline understanding of the participants knowledge.

What they have shared may be referenced during later parts of the topic, when discussing characteristics, goals, or dispelling myths and misunderstandings about counselling.

Counselling is a professional relationship that empowers various individuals, families and groups to meet their mental health goals. It is not a method to give suggestions or advice. In counselling, we do not tell anyone right or wrong, nor do we take their decisions for them, ourselves. The aim of counselling is to empower.

In the process of counselling, we specifically work on three areas, encouraging the survivor to bring about some changes in their thought process, behavioural patterns and emotions so that they are capable of making decisions for themselves.

What's unique about counselling

- Counselling can be used for both personal and interpersonal problems. In counselling, we not only talk about improving the relationship between two people, but also work on the mental health concerns a person may face.

- Counselling is conducted in a variety of settings, such as individually, within groups, and within families.

- Counselling works on different types of problems and is not based on any one culture. It respects all cultures and does not discriminate against any person based on religion, caste, tradition, language, etc.

- It is a dynamic process. In counselling, we use different techniques and methods aimed at helping a person reach their mental health goals

Characteristics of Counselling

There are many characteristics of counselling but here we will talk about the main 5 characteristics:-

1. Acceptance - We should accept the person completely as he is, without judging his thoughts or feelings.
2. Respect - It is essential to respect the person who comes for counselling. We have to first see the person who comes for counselling as a respectable person who is not inferior to us in any way.
3. Confidentiality - This is a special point of counselling. During the counselling process and even after it is over, we have to take special care that the identity of the counselee should always remain confidential. Especially if we are discussing this case somewhere or making a report, then we have to keep in mind that the name of the person or any such information which makes his identity clear should always remain confidential.
4. Reality - This means that during the counselling process you will always maintain honesty with the counselee and will not use lies. We will not keep the person in any kind of confusion.
5. Empathy - This means understanding the feelings of the person who has come for counselling and understanding in such a way that you can put yourself in the person's place and see and understand his point of view. You can feel whatever the person is going through.

Goals of counselling

- Providing psychosocial support to the survivor means that we have to help the counselee to maintain both mental and social health.
- Reducing the impact of mental stress and problems on the survivor to some extent through counselling. We have to try our best to help reduce the mental stress of the survivor through counselling.
- Increasing the insight of the survivor's feelings and thoughts so that he takes rational, realistic decisions. Often when an incident happens to a person or someone feels mental pressure due to excessive stress, then his insight or ability to deal with that problem decreases. At such a time, through counselling we can help the person to increase his insight about his thoughts and feelings so that he is able to deal with the problem.
- Counselling is a safe place for the survivor where he can vent out his agitated feelings. If the person is assured that counselling is a safe place, he is able to express his feelings and feel lighter. Also, he is able to talk about his stressful thoughts and feelings in the session.

- To make the survivor aware of his personal strengths so that he is able to take his own decisions. An important goal of counselling is that the counsellor not only discusses stress, but also helps the counselee to understand his strengths. For example, if you feel from the conversation that the person has a very positive thinking, then you will try to bring this strength to his awareness and also help in the process of how he can use this strength to find a solution to his problems.
- If the survivor is facing any obstacle or hindrance in using his personal strength, then identify it and help him. To help the survivor become aware of their strengths and overcome any obstacles they are facing.
- To help them identify how they can improve their current situation. To make them aware of all the options available to them to deal with their problem.
- To help the person reach their personal goals. To help them reach the goals that the counselee has set for them, through counselling.
- To encourage behaviour change, through counselling. To help the counselee change any behaviour or thought process that is causing harm to the person or those around them or that is hindering them from reaching their mental health goals.
- To increase the self-awareness of the person and help them improve mental health. Through increased self-awareness, the counselee comes to know about his/her strengths and weaknesses and also about the right ways to deal with emotions that work for the individual, coping skills, etc. All these things together improve the mental health of the individual.
- Helping in the acquisition of social skills. To teach the counselee the skills to form or resolve social relationships so that he/she can build healthy relationships in the society.

What counselling is not

In this section we will look at what counselling is not, things that people may misunderstand counselling to be but in reality, counselling is not.

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- The power to change others. Many times people think that through counselling we can change a person or tell him what is the best option for the person but, in counselling our aim is not to do anything like that. Our aim is only to help, to empower the person, in the end the change will come only from the person himself.
- Method of extracting information from a person. Counselling is not a process of extracting information from a person. Maintaining confidentiality at every step is a special requirement for the counsellor.

- Immediate solution to any problem. Counselling is a continuous process and it takes time to see the benefits, so expecting that we can help the counselee immediately is futile. There is no immediate solution to any such problem, it may take time to change things at an intellectual or practical level.
- Giving any kind of advice or suggestion. We do not give any kind of advice or suggestion to the person who comes for counselling, nor do we tell him what is the right option.
- It is just a place where there is a conversation, a person only speaks and at the end the counsellor gives his decision. counselling is not just a place for conversation. It is a goal directed intervention where mental health related interventions are used. The counsellor is not a judge and neither does he take any kind of decision.
- The counsellor is a person who has all the answers to the questions or he knows the most. As counsellors, we always have to remember that at the end of the day, we ourselves are also a human being and no human being has the answers to all the questions. At any time, if you feel that the counselee is waiting for an answer from you, then you should explain this to him. Also, it is important to remember that neither we are more intelligent than the counselee nor do we know more. We need to respect and honour every person equally.

3 Counselling Skills

A word from the team

This topic will cover some of the different skills that are necessary for counselling. The practice of counselling is about effectively using these cluster of skills. The topic also aims make trainee field counsellors aware that these are not completely alien skills, we already practice some of them, to some capacity in our personal lives. And thus, it is possible for us to do to understand and pick up on these skills.

The content was conceptualized keeping in mind the importance of understanding how it feels like and looks like to put these skills to practice rather than just theoretically making sense of it.

Genuineness

Genuineness creates consistency between you and your words. It is important to remain genuine in all counselling techniques and verbal and nonverbal cues. Do not make any emotional promise which you cannot fulfil.

Discussion

The facilitator may ask the participants to think of examples where they might feel challenges or doubts regarding being genuine.

Empathy

If we take Yalom, then empathy is to look out of the other person's window. There are other authors which Yalom quotes who say, through empathy a human attempts to experience to a relative extent the experience of another human being. Rogers says empathy is to feel and think with the client and not for the client. Etymologically empathy literally means to 'together + feel'. To feel together. In Hindi the closest translation that we could arrive at is 'समानुभूति'. Which defines as: 'दूसरों के कष्टों और संवेगों (Feelings) का अनुभव करना और समझना'. Empathy is one of three tenets which Rogers proposes as crucial for healing in any therapeutic relationship.

Activity 1: Empathy

The following activity attempts to express the essence of empathy: the effort to look at the world from other's eyes and to attempt to feel it within by creating a similar inner-experience which comes as close as a second-hand experience can in terms of similarity.

Materials needed:

- 4 crayon packets
- 8 chart papers
-

Division of space:

Equally amongst groups. In a manner in which groups cannot view each other's chart papers.

Steps:

- Members are randomly divided in 4 groups of equal size. (2mins)
- Each group is given a packet of crayons and a chart paper. (2mins)
- Each group is told that they cannot see the other group's chart paper until the end of the activity.
- Each group is told to discuss what they like most as a group and each participant chooses a colour which tells how they feel about the thing they like.
- Each group creates a picture of their feelings using their feeling crayons.
- When all the groups are done drawing, group A guides group B to create the picture they have created without using the **names of object** painted in their chart paper. Each time the colour changes the guiding group tells which feeling this colour is. Group B guides Group A to create the picture which they have created.
- Group C and D follow.
- The paired groups show each other their paintings.

Questions for large group reflection:

1. What were you trying to do when you were painting your own group's picture?
2. What were you trying to do when you were painting the picture which the other group painted?
3. Were the colours assigned to a feeling similar to the feelings which you assigned?
4. Did each group get an idea about what the other group feels about the activity they like?
5. What would you like to call this skill of yours in which you try to feel, think and behave like the other person?

Listening skills

In this section, we will explore various skills and aspect of listening through several activities.

Activity 2: Try not to listen

Objective: Demonstration of Active Listening

Steps:

1. Ask the participants to find a partner to work with. Divide them in partner A and B. A group are talkers and B group are listeners.

2. Group A will talk about a dish they like. While group B will be told to not listen secretly (they can be instructed to look around or shuffle or check their phones). Group A talks for 2 minutes and B demonstrates not listening and cannot say anything.
3. They then swap around and it is B's turn. Group B now will be told to listen actively and attentively.

Expectation from the activity: Group A participants will dry up before the 2 minutes and feel off about talking. Group B will feel they are respected and what they are talking about matters.
It is difficult to keep going when someone isn't taking any notice of you. This is a light-hearted start to the activity, so if it disintegrates into humorous chaos, it doesn't matter, the points will nonetheless be made.

When both A and B have had their turn, ask them how group A felt (not listened to) and how group B felt (listened to). Discuss and write up their immediate reactions on the board.

Then ask what behaviours they observed in the person who was not listening to them and in the person who was listening.

Activity 3: No questions session

Objective: Significance of verbal & non verbal cues

Participants are given roles of counsellor and counsellee. Counsellors will be instructed to complete a 10-minute counselling session in which they are not permitted to use any spoken words for the first 5-mins. Last 5-mins they can use words. In the first five minutes counsellees can talk about what all do they like in the world and in the last five minutes they can talk about what all do they do not like in the world.

Through this, counsellors will get to know the importance of verbal skills such as encouragement, acknowledging and reflective listening.

They will have an opportunity to see how they can make connections with clients by using these skills, and they will also learn that they do not need to rely on questions to propel a counselling session forward. Brief feedback from the counsellee may be offered after the session.

Following the "No Questions" Sessions, there is debriefing and discussion of what the experience was like.

Activity 4: Selective Listening

Participants form pairs, one participant is A and other B..
Participants A are listeners and Participants B are storytellers.
Listeners are instructed to pay close attention to the storyteller's story.
Listeners are instructed to note the number of times the story teller says 'फिर'/'then', 'umm' and 'और'/'and.'

Storytellers are instructed to tell a fun story from their life or imaginary.
Switch roles. Storytellers become listeners.

After both the participants are finished we ask how many 'then', 'umm' and 'and..' they counted. Facilitators shall try to make it look like a competition. Then, all the participants are asked to write the stories which the other person told them and ask the other person if the story is correct. Participants shall find how focusing on specific words or having expectations reduces their ability to follow the story fully. This game shows you the different types of listening and how it works.

Activity 5: Employing Listening Skills (Practicum)

Devide the participants into 4 groups. Each group will be given a case study (refer to the end of this topic) which they will read and try to answer the following questions (15 min):

- Did the person utilise active listening techniques at any point in this conversation?
- Using the above example, incorporate active listening skills into the conversation
- How do you think active listening skills would have benefited both persons in this case?

Reflection on Case Studies (30 min) Each group will act his case as written, then discuss with the others the mistakes done in the conversation, and then re-act the case using the Active Listening tools [eye contact, no distraction, empathetic listening, facial expressions, summarising, paraphrasing].

Unconditional Positive Regard

When we accept counsellees without any demands, they:

- Feel respected.
- Trust develops in you due to which they are able to open up.
- They feel accepted.

Skills from everyday life

Discussion: What's valuable in a therapeutic relationship?

Our endeavour will be to share these important values of counselling in a spirit of friendship. Through group discussions we will explore the qualities, values and emotions of a good friendship and connect it to the counselee-counsellor relationship.

"Today we will talk about friendship."

1. Prompt: What is friendship?
2. "I request all of you to think of a good friend. Write their name in your notebook. Why is this friend important to you?"

3. "When was the last time you had a conversation with this friend? Would you like to take 5 minutes to send them a message or call them?"

4. Discuss the following points:

- What qualities does a good friend have?
- What kind of conversations take place in a good friendship?
- In a good friendship, what kind of feelings do both individuals have for each other?
- What kind of trust forms the basis of a good friendship?
- What does a good friend do in a difficult situation?
- What does a good friend expect from you?

5. After discussion: Can you tell what similarities you can draw from our discussion between friendship and counselling?

Cases for Activity 5

Case 1:

Ravi and Reena have been married for 8 years, and they have a daughter and a son who are already in school. One day, while the children were doing their homework in their room, Reena was standing in the kitchen preparing dinner. At that moment, Ravi comes into the kitchen to get a glass of water, and they had the following conversation:

Reena: Ravi, you don't talk to me anymore.
Ravi (Turning his face to the refrigerator and showing his back to Reena): What do you mean by not talking to you, I am talking to you right now.
Reena: I'm not talking about this kind of conversation.
Ravi (Looking at his mobile): So what do you want to talk about?
Reena: I mean talking about important things.
Ravi (Still busy with his phone): Like what?
Reena (With tears in eyes): Anything…like how I am feeling…or how you are feeling…anything.
Ravi (Looking at her with anger): Fine, I think you are bothering me… I don't know what you really want from me… I have work to do right now… Alright!!!
Reena (With tears in eyes): Am I bothering you? Fine, forget it, I'm sorry I asked you to talk!!
Ravi (Putting his phone in his pocket, with a bored expression): Alright Reena, talk, I am listening.
Reena (Angrily): I don't want to talk… let it be.
Ravi: Why are you crying now?? I don't understand what has happened to you? Do you want to fight? I have to go out, I don't want you to be sad all the time!!!!

Case 2 :

When Jeevan was in college, he was an active volunteer working with communities on mental health. After completing his studies, he got very busy with his new work and he also decided to get married, it took him a lot of time to complete all the rituals of the marriage. After a few months of his marriage he was sitting alone and reflecting on how much he missed being a volunteer and felt bad that no one from the organisation was asking about him. He decided to meet and talk with the field counsellor on the next day. This was the conversation:

Jeevan: Hello Mala ji, do you recognize me?
Mala: Hey Jeevan!!! How are you? It's been a long time since we met.

... Cases for Activity 5

Jeevan: Yes Didi, I miss you and this work a lot... Can I talk to you for a while?
Mala: Yes, of course... Just a minute, let me explain some tasks to my colleagues and I'll come back then.
After some time...
Mala: Hey Jeevan, I also miss you a lot.
Jeevan: Well, if that were the case, you would have at least tried to contact me once!!
Mala: (After talking about work with someone): Sorry, what were you saying??
Jeevan: I was just saying that it feels really bad that no one from the organisation was in touch with me.
Mala: (After answering a phone call): Jeevan you are being very harsh on me, I was hoping especially you would never say something like this, you were very close to me and you know how tired and busy I am with the different services I am involved in. Sometimes I don't even have time to go to work.
Jeevan: I thought I was someone special to you and not just one of many!!
Mala: (Busy following up on the activities of other colleagues): Everyone and every service is special to me, Jeevan. Anyway, I need to leave now for Abuna and meet
someone. You are always welcome to rejoin as Man Sathi anytime. Alright, you can call me whenever you feel like getting involved again!!
Jeevan (Gets up to leave): Thanks for your precious time, I'll think about it.

Case 3:

Lora is a teenage girl , one day she was back from her school , she dashed into her home and searched for her mother who was busy in the kitchen preparing the lunch for the family .
Lora threw her school bag at the floor and cried angrily : I will never go to this school again
Mother (was facing the oven and testing the food) : Lora go out now I am busy
Lora (kicking the chair with her foot) : I am talking to you , can you look at me
Mother : Don't you see I am busy
Lora : I am more important
Mother (still busy) : I must finish the food before your father comes , GO OUT

... Cases for Activity 5

Lora (screaming) : I hate my life , I hate the school ...AND I WILL NOT GO TO SCHOOL AGAIN
Mother (throwing the spoon to the floor) : Nonsense, you always say same thing and then you go , you just love to bother me
Lora (crying and dashing out of the kitchen) : Nobody understands me
Mother (shouting) : Nobody is helping me in this house , I am exhausted

Case 4:
Riya is a teenager. One day, when she returned home from school, she ran straight inside and started looking for her mother. Her mother was working in the kitchen at that time, preparing food for everyone. Riya threw her school bag down on the floor with a thud and began to cry, saying that she would never go back to school again.

Mother (facing the stove and tasting the food): Riya go out now, I am working.
Riya (kicks the chair): I am talking to you. Please look at me.
Mother: Can't you see? I'm busy right now!
Riya: But I am more important.
Mother (still busy): I have to cook all the food. Go out now, before your father comes back.
Riya (Shouting): I hate my life, I hate school, and I'm never going back to school!
Mother (Throws the spoon on the floor): Stop talking nonsense! You always say that and then go back! You just like to bother me!
Riya (Cries and runs out of the kitchen): No one understands me!
Mother (screaming): Nobody helps me in this house, I'm tired!

4 Ethics in Counselling

A word from the team

This topic aims at introducing some ethical guidelines, establishing the importance of ethics, and discussing some dilemmas so the FCs are able to make better decisions in counselling practice.

Discussion : On Ethics

The facilitators may discuss with the participants on what they understand by ethics.

Can we think of some examples of ethics in various professions?

Following the discussion and establishing what ethics is, the facilitators may ask the participants on why they think ethics is important in counselling.

"Ethics guide us to make
better decisions in counselling practice."

Counselling Ethics

1. Acknowledging agency, and empowering the counsellee

This ethic emphasises that you as a counsellor should empower your client to make their own decisions or choose what they want to do in counselling or in other aspects of life. You can help the client understand their choice better (what are the harms or benefits of their decision) but ultimately the decision is of the client. And we have to avoid changing the decision of the client.

Help the counsellee make their own decisions.
Help the counsellee better understand the chosen decision (benefits or disadvantages).
Examples - if the survivor/client is saying that they cannot come to the office for counselling, do not force them to come. Instead look for some other ways of providing counselling like telephonic counselling. Counsellees may request counsellors of the same gender and have the right to change counsellors or ask for another counsellor at any time.

2. Refrain from doing harm to the counsellee

This ethics means not to harm the client in any way (knowingly or unknowingly). If there is any work that can harm the client, then the counsellor should not be involved in such work nor should he do any work that harms the client. This harm can be sexual, financial and emotional or the counsellor may lack quality, in such a case the counsellor should not counsel that client. It is the responsibility of the counsellor to try to ensure that the client does not suffer any harm or at least it is minimised.

3. Beneficence

Beneficence means doing good for others and promoting the well-being of the survivor/client. It is the counsellor's responsibility to ensure that whatever he does is in the interest of the client and for the betterment of the client and to protect the client from any harm as much as possible. For example, suggesting interventions that can be easily done by the survivor/client.

4. Justice

This ethics means that counsellors must treat all their clients fairly and impartially. Counsellors must respect the dignity of their clients and their human rights. We have a responsibility to provide appropriate services to all survivors/clients. Everyone, regardless of age, gender, race, ethnicity, disability, socioeconomic status, cultural background, religion or sexual orientation, deserves equal access to mental health services.

5. No false or misleading statements

We must not make false or misleading statements about our positions, functions, training and services.

6. Informed consent and voluntary participation

Informed consent is a collaborative decision-making process in which a counsellor provides sufficient information to the client so that he or she can make an informed decision about entering into a counselling relationship. The language of this informed consent should be such that both the counsellor and the client can easily understand it.

For example- telling about the duration of the counselling session, whether it will be face-to-face or telephonic, timing of the counselling session etc.

7. Confidentiality

Everything discussed in counselling is kept confidential. Case details must not be shared with your friends or family. Do not take their name, or share other information while discussing their case. Take counselling sessions in a place where there is no one else to hear the conversation between you and the survivor. Do not click their photos or make videos of their place or where they live.

However, there are the following exceptions to confidentiality:

- When disclosure is needed to prevent clear and imminent danger to the survivor;
- When self-harm (wrist cutting, suicide) or harm to others is at risk;
- When legal requirements demand that confidential material be disclosed;
- When the child needs protection.

8. Anonymity

To provide better services, while discussing the case, avoid mentioning their name, place of residence or any other information that may identify them to others.The person should be informed with whom their information will be shared and how much information will be shared. Sometimes it becomes important to discuss the case with other stakeholders to provide better services to the survivor/client. In that case, make sure you share only case information with others and avoid taking their names, the place they live or any other information that may give their identity to others. The person should be informed with whom their information will be shared and how much information will be shared.

9. Other things to be mindful of:

Avoid substance abuse.

How to sit with a counsellee - (Be culturally appropriate & professional, but the main intention is to make them feel safe enough to share, body language may be 'keen').

Respectfully accept the counsellee's decision even if you do not agree.

Avoid making promises e.g. if you take counselling, all your problems will be solved.

Discussion: What would you do?

Discuss the following scenarios with the participants and as a group, reflect on their responses in light of what has been discussed in the session.

1. Your superior wants you to tell him whatever you shared with the counselee in the counselling session, what will you do in this situation?
2. Counsellee has shared with you that he tried to attempt suicide once and he may try to do it again in future, he does not want his family to know about this.
3. You need to discuss a case with a professional counsellor, how would you discuss it ethically?

II Counselling Process

5 Counselling Process

A word from the team

This topic outlines the structure of counselling for field counsellors starting from fact finding to follow up and termination, and provides a basic understanding of each of the steps in this process.

It must also be acknowledged that questions of safety and uncertainty may persist when working in low resource settings. Counselling in a community setting might need some flexibility and rigid flow may not always be possible.

Structure of counselling process

1. Fact finding

During the fact finding process, it is important that the field counsellor introduce themselves to the survivor's family and to the survivor. At the same time, they should also inform the survivor's family about their work. At this point, you should provide information about your name and the program, followed by an explanation of your role. While providing information, be sure to mention that you work on mental health, and you will discuss the impact on the survivor's mental health after the event.
How do you explain mental health to survivors and their families?
Mental health means a person's emotions, thoughts and mental state. Like how a person thinks about situations and how they react to any situation. How a person reacts emotionally to different situations and what effect it has on a person's mental state.

Why is counselling important?
With the help of counselling, we help the person to get his life back on track.
Helps a person to know his inner capacity to cope with situations.
It helps a person to understand their inner weaknesses and strengths, and assists them in becoming a better individual.

Why is family counselling important?
This helps the family to know the survivor well and to talk to the survivor for the first time.
It also helps us to understand from the family what has changed in the behaviour of the survivor after the incident that happened to the survivor, and what effect the incident has had on the family.
Family counselling helps in assisting the person outside of counselling sessions. This helps the survivor trust you more easily, and in the future, when you have follow-up sessions, it can provide information about what changes are happening in the survivor with the help of their family, and which aspects of counselling are working.

Discussion: What would you do in these situations?

1. If there is no communication with the survivor and their family? (The family does not want to seek help; the family is very distressed after the incident)
2. During fact-finding, if the accused's home is found first while looking for the survivor's home, then...?

If there is no communication with the survivor's family during fact-finding, please keep the following points in mind:

- Provide information about the organisation at the very least.
- we go for fact-finding, keep a note with you containing the office address and phone numbWhenever er. If there is no communication with the survivor's family, then at least provide them with that note.
- If possible, you can also take the contact number of their neighbours or anyone who can assist the survivor.

2. Building rapport/making connection

Before starting the counselling process, ensure that the individual is in a comfortable position.

- If the counselling process takes place in a public office, you can offer the person a chair or a place to sit comfortably. Make sure the person feels at ease.
- Before initiating the counselling process, if you feel that the person should be offered water or tea, you can ask if they would like some.

If the counselling process is taking place at the individual's home, consider the following:

- Choose a place where there is minimal or no frequent traffic of other family members or minimal disruptions. This will make it easier for the individual to talk about their feelings.
- When engaging in conversations with the family, ensure that the survivor is not present or does not overhear what is being discussed. This allows the family to speak openly.

If a Barefoot counsellor is meeting the survivor for the first time:

- Before starting the counselling process, the Barefoot counsellor should introduce themselves to the individual. You should introduce yourself thoroughly to establish trust and make the survivor feel comfortable talking to you.
- In your introduction, it is important to mention that you will be working on their mental health. You will discuss any mental health issues they are experiencing.

If you have met the survivor during fact-finding:

- During fact-finding, you can reiterate the introduction you provided earlier. You can say, "You may remember that we met before at your home with my team. I will be working with you on your mental health.“
- Repeating this introduction will help build rapport with the survivor and make it easier for them to engage in conversation with you.

Confidentiality

It is essential to inform the individual about confidentiality before starting the counselling process. While discussing confidentiality, make sure to emphasise the following points carefully:

- Anything discussed between us during our counselling sessions will remain confidential. These conversations will not be shared with anyone else.
- The confidentiality of our discussions can only be breached under three conditions:
  - If the person is planning to take their own life.
  - If the person intends to harm/cause distress/inflict injury upon someone else.
  - If the person is at risk of harm/distress/injury caused by someone else.

Under the above-mentioned circumstances, confidentiality may be breached with the person's consent. These measures are crucial for the individual's safety.

Here, you can also ask the survivor if they believe that someone else should be aware of this process for their well-being and safety.

What things should be kept in mind while building rapport?

We will discuss about the person themselves, how they're feeling, their health and life, rather than the specifics of the event that occurred with the person.
We want to learn more about the person's mental health rather than how the incident happened.
While talking to the person, you can keep a case history format with you, which will guide you on what and which questions to ask. For example, you can begin asking about family, interests, education, or self-care, as part of the case history format.
For example - Do you go to school? or Have you dressed nicely today? Your nail paint looks great. You're wearing a nice jacket. Or anything that the person likes, such as gently pulling their arm or if the person seems very anxious, doing a breathing exercise.
You can provide more examples like these.

3. Defining the problem

Help the person define their problems. To assist, listen to them completely (Active Listening) and understand what they want to say.

Pay attention to their emotions while conversing with them. If they are talking about an event, be sure to ask them, "How did they feel at that time?"
You can use empathy and authenticity skills to define the person's issue. When the person is speaking, pay attention to what they are talking about the most.

Discussion: A little revisit

Can you tell what you have learned in previous training regarding the skills given below?
1. Empathy.
2. Reality.
3. Unconditional positive regard.
4. Listening skills.

4. Setting objectives/goals

After listening to what the person wants to say (use active listening skills effectively), the counsellor and the survivor together establish a goal. The list of goals should be created by keeping their needs in mind.
If the individual wants to make any changes within themselves, they can work on that as well. Once the goal is defined, both of them together determine how it can be achieved based on the resources and abilities available to the individual.

Guidelines for setting goals:

- Set the goal with the consent of both parties.
- The goals should be clear and measurable.
- Define goals that are achievable for the individual.
- Present the goals in a positive manner that motivates the individual.

5. Counselling tools

Counselling tools are a kind of instrument that counsellors use to assist individuals in reaching their goals.
Consider the individual's goals and relevant factors.

Things to keep in mind when using counselling tools:
a) It can be based on the person's interests.
b) It can be based on the person's strengths.
c) It should be socially appropriate.
d) It should be feasible for the individual.

Example:

a. Exploring the individual's past when they were capable of facing the issues they are currently experiencing and allowing them to express their life stories.

b. If a person can write and enjoys it, you can suggest activities like writing poetry, stories, or keeping a diary. However, if they don't know how to write or dislike it, provide suggestions for alternative activities.

c. If a person shows interest in a particular activity, that activity can be used as a means of counselling, such as drawing or singing.

d. If an individual has certain beliefs or perspectives that are causing issues, use questioning techniques.

Note: Do not use any counselling method that is highly inappropriate according to the person's social context. For example, do not advise a man to greet all women in the park with "namaste" if he feels uncomfortable talking to women.

6. Concluding the session

This section will explain how to conclude a counselling session.

- When there are approximately 10 minutes left in the counselling session or when the person feels that there's nothing more to discuss, the counsellor will ask, "Can we conclude this counselling session? But before we conclude, let's discuss what we've done and what we can do in future counselling sessions."
- Summarise the counselling session and ask them if what you (the counsellor) understand is correct or not.
- Assign some homework (counselling tasks) to the individual.
- Get feedback from the individual and schedule a date for a follow-up session.
- Ensure that both the individual and the counsellor are prepared to conclude the counselling session.
- Based on the person's needs, refer them to other professionals or projects.
- **Note**: Always identify the person's strengths and other positive aspects in their life during the summary and let them know how these can help them.

7. Follow-up session

Follow-up sessions are counselling sessions that counsellors conduct with individuals after the initial counselling session.

- Discuss how the individual is doing after the last counselling session.
- Talk about the activities recommended in the previous counselling session.

- Address any concerns or issues that may be bothering the individual and not allowing them to be present in the moment.
- Ask the individual if there's anything on their mind that they would like to discuss in this session or if they wish to continue from where it was left off in the previous session.
- Inquire if there's a need to change the counselling approach or if they want to continue with the last recommendations given.
- Finally, follow the process of terminating the counselling session.
- **Note:** A follow-up session should ideally be a minimum of 25 to 30 minutes.

8. Termination of counselling

In this section, we will discuss how to terminate counselling when, after several counselling sessions, you feel that the person is ready to manage their issues or problems in a healthy way.
Indicators that a person may be ready for termination:

- The individual demonstrates a significant improvement in their current issues, symptoms, or problems.
- It is the counsellor's experiential judgement that the person no longer requires mental health counselling.
- Other alternatives may provide better treatment for any remaining issues or problems.

How to proceed regarding termination:

1. Discuss the termination of the counselling sessions with the individual two to three sessions before the actual conclusion.
2. Take feedback from the individual regarding whether they are ready for the complete termination. If they are not ready, continue with counselling. If they are ready, proceed with the next steps.
3. Reflect on the individual's journey in the counselling sessions up to this point and assess what they have learned from counselling.
4. Prepare the individual for the termination and ask them what they would like to do at the end.
5. Create a plan for maintaining mental health after the termination.
6. Inform the individual that they can come for counselling whenever needed in the future; the door is always open.

9. Follow up

When the person no longer needs counselling or stops coming for counselling, we follow up.

In follow up we do not provide assistance to the person but ask them how they are, how they are coping with their problems with the help of new skills learned from counselling.

Ask them if there is any reason that is stopping them from coming for counselling?
Try to find out if they need any help
And if they need any kind of help and want to come for counselling then we will fix the date of the session with them.

Being mindful of gender and other marginalities

Maintain appropriate boundaries between the survivor-counsellee and the counsellor. Avoid leaning too heavily towards the survivor. Counsellors should be mindful of this and discuss with the survivor they may feel uncomfortable. Counsellors should be sensitive and aware of gender, power, and cultural biases and strive to minimise them. Having an understanding of how social structures and power shape the experiences of various marginalised groups of people (eg:- gender, sexual minorities, marginalised castes and communities) would serve useful to being a sensitive cousnellor. The priority for counsellors should be the well-being of the individual, and they should respect the individual's preferences and accommodate their needs.

Note

Consider each counselling session as the final session because we don't know if the person will return for the next session.
Provide the individual with something that can help them feel happy, comfortable, or inspired at the end of the session.
If parents are showing resistance to counselling, identify the reasons behind the resistance and address them first or engage in counselling with the parents before proceeding further.

6 Telephonic Counselling

A word from the team

Although telephonic counselling is and has been a challenging method for counselling in the context we work in the necessity and consideration for the method came into the forefront during the COVID-19 lockdown.

This topic aims at creating an understanding of the process of telephonic counselling, outlines its advantages and disadvantages, while equipping the field counsellors with ways to deal with challenges while taking ethical practices into consideration.

Discussion: Thoughts on telephonic counselling

"Nowadays counselling is being done over the telephone. What are your thoughts on telephonic counselling this?" "How was your experience (if anyone has had to deal with cases through the phone)?"

What is telephonic counselling?

Telephonic counselling is any type of psychological service that is provided over the telephone. Telephone counselling is provided in person.

How is calling someone on the phone different from having telephonic counselling?

Telephonic counselling is structured whereas phone calls are not.
There are specific boundaries that need to be kept (calls can only happen during specific times) whereas phone conversations do not require those boundaries.
The focus of telephonic counselling is on the survivor's problem/crisis i.e. the focus is completely on them whereas during a call the focus can be on anyone.
The telephone call can be for five to ten minutes or even longer but the counselling time is fixed for 40-50 minutes.

Benefits

This can be especially helpful for people who are far away, busy, or who have limited mobility due to disability or caring responsibilities.

- Working class people will not lose a day's wages due to counselling.
- Online counselling can also be given along with face to face counselling.
- When someone is out of town or can't come to the office, they can use it.
- People who are new to counselling can connect with them via telephone, making it easier for them to get their counselling.
- Counselling can also reduce the stigma associated with receiving mental health services if it is done in their home.
- Counselling can be given in a short time, the survivor does not have to stay for treatment.

Challenges

- Counselling relationships through technological devices may feel impersonal.

- Unable to see the body language of the survivor, it may be difficult to know them.
- Reduction in the number of feedback elements during counselling (e.g. non-verbal communication, visual contact, posture, gestures, dressing).
- Survivors may resist telephonic counselling.
- Network problems may create problems in counselling.
- Telephone counselling is not ideal during suicide, suicidal situations or severe mental illness
- Lack of privacy – such as single mothers who have to care for children and attend therapy.
- Lack of continuity as calls may be missed at times.
- Not seeing the counsellor can be an issue for the survivor. However, for some, not seeing the counsellor face-to-face can make them more comfortable opening up, which can lead to a deeper connection between counsellor and survivor in a short period of time.

1. Building rapport

We have to make sure that when hearing the first introduction, the survivor gets the hint that mental health help is available here. It is very important to make sure that the greeting is well articulated and conveys the counsellor's eagerness to communicate.

Survivors who are unfamiliar with the counsellor's voice need to be friendly. Hence it is essential to mention the name of the organisation during the introduction. Therefore, we should start our greeting by saying:

It is essential to make sure that they are actually speaking to the survivor and that the phone call is not being recorded and heard by anyone else.
In the absence of visual cues, it becomes more important with counselling to use understandable language to encourage the survivor to describe the issues of concern in detail (thus it is better to take cases with which the dialect is similar as it may help the survivor to get familiar and trust easily)

Creating an atmosphere of openness and trust. The counsellor should listen to the survivor attentively without interrupting and provide the survivor with the opportunity to elaborate on the information provided. The counsellor may use techniques such as open-ended questions to obtain complete information

Empathy is best seen if it is preceded by discussion and questioning during counselling. General information about the survivor for record: Name, address, date and time of call, name of the survivor, contact information. The counsellor is encouraged to maintain a steady pace with a soft tone in their voice to demonstrate empathy.

2. Identifying and defining the problem

After taking general information from the survivor, the counsellor will assess the survivor's level of knowledge and concern to ascertain the current problems and level of risk.

The first primary goal of collecting such information is to determine the client's suitability for telephone counselling, as some survivors are not suitable for counselling through this mode.

During the phase of identifying and defining the problem we will analyse the personal and environmental resources as well as the limitations of the caller. Time factor is more limited in case of telephone counselling as compared to face-to-face. This aspect can be resolved through targeted counselling and leading questions.

In telephone conversations our voice needs to be more expressive than in eye to eye contact. Telephone discussions can be easily influenced by tone, intonation, voice modulations, positive statements can be encouraged.

3. Setting goals

Discussion: Revisiting goal setting

The steps for this section would be the similar to the goal setting in an in-person counselling session. Ask the participants if they can share what those steps are. They may also share if they feel any part of this step in the process would be impacted by a telephonic mode of counselling. The facilitator and the group may discuss how these challenges if any, may be tackled in their respective contexts.

4. End of counselling session

It is difficult to predict how long the telephone discussion will last. Some beneficiaries are hesitant and have certain apprehensions and, accordingly, they need some time for their queries.

It is necessary to set a definite time limit. Arising from the fact that the maximum concentration period is 50-60 minutes, the duration of the tele-session should not exceed this.

Tele-sessions may at times be abrupt or stopped abruptly for a number of reasons, including if discomfort is experienced by the survivor, if these sessions are perceived as unhelpful/potentially harmful, due to network disruptions.
Clearly communicate other options for continued care along with the reasons for any change of decision.

With this in mind, the counsellor should end the conversation by saying: Do you have any more questions? If you do, feel free to call again.

Regardless of the length of the discussion, when such a closure occurs, it should proceed with:

- Summary of the discussion
- Feedback from the survivor
- Any questions and as often as necessary

Activity: Case-Roleplay

Case: Reena is a newly married Dalit woman. She has just come to her husband's house. She was eager to perform her daily chores in her in-laws' house when an incident happened with her due to which she has been feeling very sad for the last one month. It happened that she had gone to the well to fetch water where two women of another caste beat her up saying that she was polluting their water. She is unable to recover from this incident. The counsellor has to counsel her through telephonic counselling.

Activity: Participants will form pairs (groups of 2). They will sit next to each other, but facing away from each others backs, neither of them able to see the other. Each pair will play out a counselling session amongst themselves, with one assuming the role of the counsellor & and the other taking the role of counsellee.

After the pairs have completed the will share on how listening skills were used, how emapthy was conveyed, what kind of challenges they faced, and how skills had to be adapted to a new setting.

Challenges and ways to overcome them

1. Survivors may have difficulty accepting telephonic counselling.

- They may be resistant to talking on a call and may not take telephone counselling as seriously as they do face-to-face counselling.

- This is why the rapport building process is important.
- It is important to give structure to our counselling.
- Set their expectations and goals so that they value it.

2. Difficulty in forming a bond with the counsellor.

- The counsellor cannot see the survivor's non-auditory cues and may therefore have difficulty understanding the survivor's experiences.
- The counsellor may find it difficult to express empathy without being seen.
- The survivor may lose attention because they cannot see their counsellor.
- Just as physical appearance provides the first impression about the counsellor in face-to-face counselling, voice comes into play in telephone counselling.
- The counsellor is encouraged to maintain a steady pace with a soft tone in their voice to demonstrate empathy and understanding.
- Listen to them carefully.

3. There is no way to ensure that the survivor is following the interventions you have suggested.

- They may be encouraged to stay in close collaboration with their friends/family and seek their help in following a regular routine, doing housework, etc.
- It is very important that you ask them if they want to involve someone in their counselling process.

4. Lack of control over the surrounding environment:

- In face-to-face counselling, the counsellor has a fair amount of control over the environment.
- Such as the layout of the office, the angle of chairs and the distance between them, the ability to minimise interruptions and what others can hear during counselling.
- However, when counselling is conducted via telephone, the counsellor may lose a large amount of this control.

We should set some rules for both the counsellor and the survivor while doing the counselling over the telephone so that external interruptions are reduced.

- A time should be fixed to start the counselling.
- By talking to the survivor, those interruptions can be reduced.

5. Confidentiality may be breached.

- Make sure the person on the phone is the survivor/counsellee.

- One solution is to use a password or some other way to verify that the person on the telephone line is, in fact, the survivor.
- Do not send messages on social media discussing the counselling session.
- Ask the survivor if they are alone and comfortable talking.

6. Survivors do not take calls

- We should ask the survivor beforehand what should be done if someone else takes the call in their place?
- If we have not asked them then it depends on the situation.
- We can also explain counselling to the family members so that they can help the survivor in this process or take counselling themselves if they need it.

7. Someone is taking too long breaks and not talking

- We have to keep in mind that the person's state of mind is not good.
- Most importantly, we should give them time to talk and not disconnect the call quickly.
- If they do not want to talk, ask them if they want to meet face to face and talk.
- You can talk to them about things other than the event, like about their hobbies or their friends.
- It takes some time to warm up, so don't be in a hurry.

DO's & DON'Ts

Do's

A secure connection is ideal and ask how long the person can talk and plan the session accordingly.

Ensure confidentiality for the person. The identity of the survivor must be strictly protected under any circumstances. Also, confidentiality.

The counsellor will ensure the survivor of his impartiality in dealing with the problems and will not accept any discrimination with respect to age, gender or sexual race, culture, political or religious convictions, socio-economic status, disability, etc.

Establish ground rules for the therapy session (for example: duration of sessions, how many calls survivors can expect, procedure to contact in case of an emergency when they do not take a call, procedure to contact in case of an emergency

Maintain a generally positive attitude. The counsellor should express confidence in the survivor

Deal with the person and not just with the problem (not just address the problem but talk to the person and listen to him). We should empathise with the caller in every way.

Remain mindful of boundaries and remain in the professional role of a counsellor
Use a neutral and expressive tone.
Any record (written or taped) or data transfer should be done only with the free and explicit consent of the survivor.
Any therapeutic record (such as written exchanges between survivor and counsellor) is kept confidential
Take care of documentation

Don'ts
It is inappropriate to use an excited tone or speak in a loud voice.
The counsellor should avoid sharing his/her own stories in the limited time.
Avoid hanging up abruptly
The counsellor should also avoid mocking or shaming the caller.
Avoid premature problem solving and advice-giving
Do not record the call
There should be no online communication between survivor and counsellor outside the agreed therapy contact (for example on social networking sites)

Ethical considerations

- Counsellors will not discriminate. For example, if a survivor is from the transgender community or has a deep voice, we will ensure that we use the gender they identify with.
- Counsellors will maintain the survivor's confidentiality at all times and if they are recording the call, they will take permission from the survivor and explain to them why they are recording. Counsellors will respect the survivor's confidentiality as long as the survivor does not intend to harm themselves or others.
- Counsellors will maintain ethical boundaries at all times and will not provide services that create a conflict of interest. Keep in mind that the call is always about the caller and not the counsellor. We must remember that we are counsellors and not their friends.
- Counsellors have a clear definition of their roles.
- Counsellors are not to give any type of diagnosis such as depression.
- The counsellor should not impose their own beliefs and values on the survivor.
- The counsellor should not act outside their role as a helper. For example, the counsellor should not intervene in any legal issues.
- The counsellor should assess the risk such as violence, suicide, health conditions. If they find any, they should immediately provide an appropriate referral.

7 Case History Taking

A word from the team

Case History taking and documentation are important parts of the process when working as a counsellor in an organisational setting. In this topic we attach the case history & follow up formats we use, as well the guide to refer to on using the same. Unlike other topics, this guide may be used by field counselllors directly for reference in case of any difficulty. Do to keep a few things in mind:

- The examples provided in the guide are only for understanding; there may be various other situations or examples beyond these.
- It's not necessary to ask the questions in the order they are written; we need to fill out the case history format while conversing, so the order of the questions can be rearranged.
- It's not necessary to ask the questions exactly as they are written; you can modify the structure of the questions as needed.

Case History Format (1/7)

District:
Counselor's Name:
Case Number:
Date:

CASE HISTORY FORMAT

Name: **Age:** **Gender:**

Address: **Mobile Number:** **Place of counseling:**

Reason for referral:

Source of referral:

Education: ☐ How far have you studied? / ☐ What class are you in now?_____

☐ Never Studied ☐ Currently studying

☐ ; Left; When and why did you leave: ☐ Have taken admission but do not go; Why:

_____ _____

_____ _____

Still want to continue studying? ☐ Yes ☐ No

Other important information:

Occupation: ☐ What kind of business do you do / ☐ did you do: _____ / ☐ Never did any business

Reason for leaving business: _____

Other important information:

Case History Format (2/7)

District:
Counselor's Name:
Case Number:
Date:

Family members:

Genogram
- Family income
- Earning person
- Decision maker
- Relationship with family members
  Primary Caregiver

Interest: ☐ What do you like to do?/ ☐ What did you like before?

_____

Has there been any recent change in interest?
☐ Yes, so what has changed .....?
☐ no

When was the last time you did it?

Desire and possibility to do in future ☐ Yes ☐ No

Other important information:

Sleep: ☐Less ☐More ☐ As earlier

☐ Difficulty in sleeping
☐ Waking up frequently
☐ Waking up early without reason
☐ Having nightmares
☐ Waking up scared
☐ Feeling tired even after waking up
☐ Sleeping more at night
☐ Sleepiness throughout the day
☐ Waking up anytime

Since when is there a change in sleep?

Other important information:

Hunger: ☐Less ☐More ☐ As earlier

Desire to eat: ☐Less ☐More ☐ As earlier

Case History Format (3/7)

District:
Counselor's Name:
Case Number:
Date:

Since when is there change in appetite?

Other important information:

A routine:	Earlier	At this point
School and studies		
Homework		
Business		
Self hygiene and care		
Other		

Support:	Earlier	At this point
behavior of family members		
chat with friends		
behavior of neighbors		
Other		

Social support – (finding things in the community that can help the person – such as a school, hospital, a club or group)

Expectations from Counseling - (Which aspect of life do you need help with):
Information about mental and physical health:

How is your health? -

Case History Format (4/7)

District:
Counselor's Name:
Case Number:
Date:

Are you facing anxiety or other mental problems? ☐ Yes ☐ No

Information regarding Problem_____

What did you do to solve the problem? _____

Does anyone in the family have/had mental illness/problem?
Physical illness -
Are you on medication?
Menstruation and pregnancy: _____

Whether you are disabled : ☐ Yes_____ ☐ No

Other important information:

Emotional state:

During counselling: (How are you feeling now)

Before counselling: we can ask what are you feeling today.

Other important information:

Related to suicide and self-harm:
Thought: ☐ No ☐ Suicide ☐ Self-harm ☐ Both

Information regarding your thoughts: (what when how)

Have you tried? ☐ yes ☐ no

Information regarding Attempt:

Whether you have plans to commit suicide: ☐ Yes ☐ No

Information regarding Scheme:

Case History Format (5/7)

District:
Counselor's Name:
Case Number:
Date:

Ask the counselee to rate his/her opinion on a scale of 1 to 10.

Ask the counselor the reason for choosing the number:

Other important information:

Future:

Plans for the future: _____

Desire to try something new: _____

Seen by Counselor:

Eye contact:

Sitting style:

Self Care:

Manner of talking: (tone, relevant or not, how much talked)

Desire to talk:

Behavior and body language:

Facial expressions:

Attention:

Behavior while talking about incident/trouble:

Signs of self harm:

How were the thoughts:

Case History Format (6/7)

District:
Counselor's Name:
Case Number:
Date:

Other:

Discussion with family:

Suggestion:

Result:

Need to see someone else: ☐ No ☐ Counselor ☐ Psychologist ☐ Psychiatrist ☐ Therapist ☐ Gynecologist ☐ Others:

Comment:

After counseling: How do you feel now after talking (asked and observed by the counselor)

Primary mental health issues (identified by the counselor and counselee).

Mental health issues	Since when have you been experiencing these issues?	Comments (What are the causes, when does it occur, any other information)

Case History Format (7/7)

District:
Counselor's Name:
Case Number:
Date:

Next date of consultation:

Follow up format (1/3)

District:
Counselor's Name:
Case Number:
Date:

Follow up session form

1. How is the counselee feeling after the last counseling session (talk about it)?

2. Discuss if there is anything currently bothering the counselee and preventing them from being present in the session.

3. Ask the counselee what topic they would like to discuss.

4. If they do not want to discuss a specific topic, then briefly summarize the previous session and proceed from there.

5. (a) Discuss the activities or suggestions recommended in the previous counseling session.
   b) Did you find them helpful? ☐ Yes ☐ No
   c) Any challenges faced during them?
   d) If the counselee wants to pursue new activities, discuss those.

6. Discuss any improvements the counselor notices or observes in counselee.

7. Ask whether the counselee noticed any changes in himself.

Follow up format (1/3)

District:
Counselor's Name:
Case Number:
Date:

8. Emotional state:

Before counselling:

During counselling:

Other important information:

9. Talk about suicidal or self-harm thoughts

10. Ask the counselee to choose a number from 1 to 10 to express their thoughts.

Ask the counselee the reason for selecting that number.

Note:
If the counselee did not mention thoughts of self-harm or self-injury in the first session and does so in the second or third session, then ask all the questions in the "Regarding Thoughts of Suicide and Self-Harm:" section of the case history form.

11.Discussion with family if necessary:

12. Result

13.Counselee's plans for the future:

14. Counselor's plans for the future sessions:

Follow up format (1/3)

District:
Counselor's Name:
Case Number:
Date:

15. Need for some external help: ☐ No ☐ Counselor ☐ Psychologist ☐ Psychiatrist ☐ Therapist ☐ Gynecologist ☐ Other:

16. **Comments**:

After counseling: How do you feel now after talking (asked and observed by the counselor)

Main mental health issues (identified by the counselor and counselee).

Mental health issues	Since when have you been experiencing these issues?	Comments (What are the causes, when does it occur, any other information)

After Counseling:

Next date of consultation:

Glossary:

- **Gender:** Your gender is a label that is placed on you from birth, like a boy or a girl. It is noted on your birth certificate. Gender is the expression of an individual's inner sentiments and how they are felt on the inside. Your conduct, look, and attire may all be used to convey your gender.
- **Transgender** - Someone whose gender is different from the sex assigned to them at birth.
  - A transman is a person who identifies as masculine even if they were born with a feminine gender.
  - A transwoman is a person who identifies as feminine even if they were born with a male gender.
- **Non-binary** - Someone who is neither exclusively male nor female, or who is outside or between both genders.
- **Counsellor** - A person who has conducted counselling and is filling out the case history format, such as a field counsellor or a professional counsellor.

Guide for Case History Format

District: The counsellee's home district's name, such as Ujjain
Name of Counsellor: The name of the individual providing counselling
Case Serial Number: MH - The district's first three letters - serial number, for example, MHDEW001, MHUJJ00.
Date: The day when the counselling was conducted
Reason for referral: Rape, molestation, panic, stress, family differences, etc. (mental health issues or incident related)
Source of referral: From where the case is received e.g. name of the project, child line, dignity fellowship, etc.
Name: The counsellee's name who is receiving the counselling
Age: The counsellee's age who is receiving the counselling
Gender: The counsellee's gender who is receiving the counselling

❑ Female
❑ Male
❑ Transwoman
❑ Transman
❑ Non-binary
❑ Prefer not to state
❑ Other .....

- "What is your gender e.g. woman, man, transwoman, transman, ...?" / "What is your gender perception of yourself? / "What do you think or perceive to be your gender?"

Address: Where the counsellee receiving the counselling resides, as indicated by questions like "Where do you live?" or "What is your home address?"

Mobile Number: The mobile number of the counsellee receiving counselling (if they are comfortable providing it).

Location: The place where the counselling is taking place, such as office, home, police station, OSCC, via mobile, etc.

Education:

What is your highest education qualification?/
Which grade are you in right now?_____

- If the counsellee receiving the counselling is currently studying, which grade are they in? If they have discontinued their studies, up to which grade did they study?

Never attended - if the counsellee has never received any formal education

Ongoing - if the counsellee is still currently pursuing their education

Discontinued; when and why - if the counsellee has stopped their education, ask when and why they discontinued it. For example, due to lack of interest after an incident/ due to fear/ due to family pressure/ financial difficulties.

Enrolled but not attending; why - if the person is enrolled in school but is not attending for some reason, ask for the reason.

Do you still want to continue your education?

Yes No

- If the counsellee has discontinued their education, would they like to resume their studies if given the opportunity?

Other Relevant Information: Please include any more information about schooling that the counselling recipient offers that is not addressed in the points above.

- Would like to work
- Currently studying for another exam
- The person receiving counselling is studying while staying at home

Counsellor: You might bring up academics when inquiring about daily activities or hobbies. For example, you could inquire, "Do you like Studying?

Counsellee: "Yes, I like it."

Counsellor: "Have you ever studied before?"

Counsellee: "Yes."
Counsellor: "So, is your education currently ongoing?"

Counsellee: "No, it's not ongoing right now."

Counsellor: "So, you don't go to school?"

Counsellee: "No, I don't feel like going to school."

Counsellor: "So, have you discontinued your studies?"

Counsellee: "Yes."

Counsellor: "Okay, up to which grade did you study?"

Counsellee: "..... "

Counsellor: "Can you tell me the reason why you discontinued your studies?" (If the counsellee is unable to specify, you can provide examples such as fear, family pressure, lack of interest, financial difficulties, etc.)

Counsellee: "....."

Counsellor: If during the previous questions the counsellee mentions an incident or a type of fear, you can follow up with: "As you mentioned that you stopped going to school because of fear, when exactly did you stop going to school after that?"

Counsellee: "....."

Counsellor: "Since you mentioned that you like studying, would you like to continue your education?"

Counsellee: "....."

Occupation:

What type of business do you do / used to do: _____ / never did

Ask the counsellee if they have ever engaged in any business. If the counsellee indicates that they are currently involved in a business, tick the first option and ask them about the type of business they do, then write it in the provided blank space. If the counsellee mentions that they used to engage in business in the past, tick the second option and ask them about their past business, then write it in the provided blank space. If the counsellee says they have never been involved in any business, tick the third option.

Reason for not engaging in business: _____
If the counsellee indicates that they are not doing any type of business at present, ask them about the reason for not doing so (if they feel comfortable sharing it)

Other Important Information: Any additional details related to business that the counsellee provides, which are not covered in the above points, can be noted here.

- If the counsellee used to engage in business but is not doing so now, you can ask them about the time they stopped and the reason for discontinuing it.

Please note:

- Mark the correct option from the provided choices and write the details.
- If any of the above points are due to the lockdown, specify 'Due to lockdown.'
- Also, assess any changes resulting from the lockdown.

Family members (Genogram):

Here, you need to show the counsellee's family using a genogram, as well as include the alleged perpetrator. Preparing genogram will discussed in detail in the next topic.

Interests:

What do you like to do?/ What did you like to do before?

Counsellor: "What do you enjoy doing or what interests you? What are your hobbies?/ "What makes you happy or what do you like doing?"

Counsellee: "I don't like anything at present / I don't feel interested in anything right now."

Counsellor: "Hmm... What did you like earlier or what were you interested in? What were your hobbies earlier?/ "What brought you happiness earlier or what did you like doing back then?"

Counsellee: .....

Please note:

- You should ask the following question only if the counsellee indicates that they are not interested in anything at the moment: "What did you like earlier?"
- Tick the appropriate option from the list of options given above and write the details. If you are describing your present interests, for instance, tick the box and write the relevant details. Tick the option pertaining to former interests if you are telling about the same and write the details.

Has there been any recent change in your interests?
Yes, if so, what changes have occurred _____
No

- Has there been any recent change in your interests? If yes, what changes have occurred and since when?
- Is there something that used to bring you happiness in the past but no longer does? If yes, how long has this been the case?
  - Example: Since my father hit me, I no longer feel like doing it / I haven't done ..... for the past 15 days
- Is there something new that brings you happiness now, or do you no longer find joy in anything?
  - "What do you enjoy doing now, what interests you? / "What do you like doing now or what brings you happiness?"
- When was the last time you did it?
  - "For the activity or interest that used to bring you happiness, how long has it been since you last engaged in it?" How long has it been since you did this?"
  - Example: If the counsellee was interested in cooking, you would ask, "How long has it been since you last cooked?" or "How much time has passed since you last cooked?"

Counsellor: "As you mentioned that you like/are interested in doing ....., do you still do it now?"
Counsellee: "No, I don't do it anymore."
Counsellor: "When was the last time you did .....?"
Counsellee: "It's been about 15 days."

Please note: The purpose of asking "When was the last time you did it?" is to determine how long it has been and the reason why they stopped doing their favourite activity.

Interest and possibility of doing it in the future Yes No

- "As you mentioned, your interest was in ....., Would you like to do ..... again? It may not be possible right now, but is there a possibility of doing ..... in the future?"

Please note:

- We will only ask this question if they are not currently engaging in their favourite activity.
- Even if the interest no longer brings as much joy, we should try to incorporate it in their routine. We can suggest that the counsellee also consider it as 'homework'.
- We will consider not just those interests that could become a source of income for the counsellee in the future but also any activity that brings them happiness.

Would you like to do anything else? Yes No

If yes, what would you like to do next? _____
Ask the counsellee if there is anything else they would like to do. If they say yes, then ask them for more details about it.

Other Important Information: Any additional details related to interests that the counsellee provides, which are not covered in the above points, can be noted here. For example:

- If the counsellee finds happiness in something currently and wants to continue doing it in the future(changed interest). For example: watering plants, reading poetry, etc.

Sleep:

Please choose one of the options below: -

Less - Reduced or lack of sleep due to an incident or for some time

More- Increased sleep or excessive sleepiness due to an incident or for some time, such as feeling sleepy throughout the day or having a strong desire to sleep

Same as before - No change in sleep patterns due to an incident or for some time

- "Has there been any change in your sleep patterns recently, such as sleeping less than before or sleeping more than before?"

You may choose one or more of the following options:

Difficulty in falling asleep - Not able to fall asleep

Bad dreams - Experiencing bad dreams related to an incident or something else

Sleeping more at night - Deep sleep?

Frequently waking up - Constantly waking up during sleep for whatever cause, with the impression that you have not slept at all

Waking up in a panic - Waking up from sleep feeling panicked or anxious

Sleepiness throughout the day - Feeling more sleepy than usual

Waking up early without any reason - Waking up early in the morning without any apparent reason

Fatigue Upon Waking - Feeling tired after sleep due to poor sleep quality

Irregular Sleep Patterns - Not having a good sleep schedule

- "As you mentioned, you don't sleep as you used to before. Do you have difficulty falling asleep or do you wake up frequently during the night?"
- "How do you feel after waking up from sleep?"
- "Do you experience any type of dreams?"
- "What other issues do you face while sleeping?" / "What other sleep-related problems do you experience?"

Since when have you noticed a change in your sleep patterns?

- "As you mentioned, there has been a change in your sleep patterns compared to before. Since when has this been happening–over the past few days, months, or years, or after a particular event?"

Other important information:

Any additional information related to sleep that they provide beyond the points mentioned above can be noted here, such as:

- feel sleepy at night but cannot sleep
- Experiences event-related or other types of thoughts that make it difficult to fall asleep
- Details provided by the counsellee about the thoughts that make it difficult for them to fall asleep
- Feels sleepy throughout the day but struggles to fall asleep when going to bed at night.

Appetite :

Choose one of the options below. -

Less - Decreased or no appetite since some time or since the incident

More - Increased appetite since some time or since the incident
Same as Before - No change in appetite since some time or since the incident

- "Has there been a change in your appetite recently, such as feeling less hungry or more hungry than before?

Desire to eat:
Choose one of the options below. -
Less - Decreased or no desire to eat since some time or since the incident
More - Increased desire to eat since some time or since the incident
Same as Before - No change in desire to eat since some time or since the incident

- "As you mentioned, you don't feel as hungry as before. So, do you still have the desire to eat or not?"

Since when has there been a change in your appetite? Is it for the past few days, months, years, or after some other event

Other important information:
Besides the above points, write here any other information related to hunger or food cravings that they tell us about, such as:

- Since when has there been a change in your appetite? – can be asked
- "Has your meal timing changed? For example, you might used to eat at 12 pm before and now you eat at 3 pm. Has something like this happened?"
- "Do you experience situations where you feel hungry but have no desire to eat?"

Please note: Hunger and food cravings are two different things. A counsellee might feel hungry but might not have the desire to eat, or they might have a desire to eat but might not feel hungry since some time. We need to ask about both the situations separately.

Counsellor: "What does your daily routine look like at present, such as what time do you go to sleep, what time do you wake up, and what do you do after that?"
Counsellee: .....
Counsellor: If they mention food, we can continue on the same topic by asking, "What do you like the most in your food?"
Counsellee: "I like ..... the most."
Counsellor: To continue, we can ask, "Generally, how many rotis do you eat?"
Counsellee: .....

Counsellor: "Did you use to eat the same amount of rotis before?"
Counsellee: "No, I used to eat more before."
Counsellor: "Do you not feel like eating now, or do you not feel hungry?"
Counsellee: "Yes, I don't feel like eating now."
Counsellor: "Do you have a desire to eat?"
Counsellee: "I don't have the desire either."
Counsellor: "When did this start happening?"
Counsellee: "Since a few months / since the incident."
Counsellor: "Is there anything else that used to happen before but doesn't now, such as having more or less sleep than before, not feeling like going to school, or not feeling motivated to do household chores?"
Counsellee: "Yes, I have difficulty falling asleep and wake up in the middle of the night, and then I can't fall back asleep for 2-3 hours."
Counsellor: "Do you go to school?"
Counsellee: "No, I don't go anymore."

Routine:	Before	Now
School and studies	Did you use to go to school before?When you used to go to school before, how did you feel? Did you feel like going to school?Did you use to study at home before?When you studied at home before, how did you feel? Did you feel like studying at home?Were you able to focus on your studies at home in the past?	If you used to go before, do you still go now or not?Do you currently feel like going to school?If you still go to school, how do you feel when you go to school?If you used to study at home before, do you still study at home now or not?If you still do, how do you feel after studying? Do you want to study at home?Are you able to focus on your studies at home now?
Household work	Did you use to do household chores before, such as cooking, helping family members in chores, or going to the market for groceries or vegetables?If you did, how did you feel after doing the household chores? Did you enjoy doing them?Were you able to focus on household chores before?	If you used to do them before, do you still do them now or not? If you still do them now, how do you feel after doing household chores? Do you enjoy doing them now?Are you able to focus on household chores now?

Routine:	Before	Now
Occupation	As you mentioned that you are involved in business, did you use to do it before as well?If you did, how did you feel about doing business? Did you enjoy doing it?Did you go regularly? (If the counsellee says they did not go regularly, ask them if they would like to explain the reason for not going regularly?)Were you able to focus on your business before?	If you still run a business, how does it feel now? Do you enjoy doing business now?Do you go regularly? (If the counsellee says they do not go regularly, ask them if they would like to explain the reason for not going regularly? Are you able to focus on your business now?
Other	Did you use to do any other work before? (For example, if the counsellee mentions that they used to sing.)If you did, how did it feel? Did you enjoy doing it and were you able to focus on it?	Is there any other work that you used to do before but do not do now?If you still do it now, how does it feel? Do you enjoy doing it and are you able to focus on it?

Other:
Besides the above points, any other changes such as: -

- Do you feel like going to school? Did you use to feel like going to school before?
- Not eating even if hungry - "Since when is this happening?"

Please note: The business section is mentioned two times in the guide. Discuss this part according to the situation and the counsellee. You can address both sections together or separately, depending on the counsellee's comfort.

Support and assistance:	Before	Now
Family members' behaviour	Sending to the store alone, maintaining general supervision, and not being overly restrictive	Worry, excessive attention or caution (supervision), fear, restrictions, and blaming
Communication with friends	We used to talk, meet, and play	Stopped talking, meeting, and playing
Neighbors' behaviour	We used to talk happily and visit each other's homes	Stopped talking and visiting each other's homes, started looking with suspicion, etc.
Other		

Other:
Besides the above points, write here any other changes in a person's behaviour that they mention, such as: -

- Changes in the behaviour of teachers and relatives
- "Has your teacher's behaviour towards you changed, such as becoming more reprimanding or excessively affectionate?"
- "Has any of your relatives' behaviour towards you changed, such as not making eye contact or staring a lot while talking?"

Counsellor: "Have you noticed any changes in the behaviour of your family members recently?"
Counsellee: .....
Counsellor: "And have you noticed any changes in the behaviour of your friends?"
Counsellee: .....

Please note: If any of the above points are due to the lockdown, write 'lockdown' for that point, for eg. -
If the counsellee has stopped going to school, stopped working outside, or stopped meeting friends due to the lockdown, mention 'lockdown' for those points.

Expectations from counselling: Any specific expectations the counsellee may have from the counsellor, such as working on a particular issue or seeking improvement or change in specific areas like anger, anxiety, fear, family conflicts, etc.

Details on physical and mental well-being:

How is your health -

- How does the counsellee feel physically? (They might mention fatigue, pain, headaches, dizziness, or any other kind of discomfort.)

Is there anxiety or other mental distress present? Yes No

- If the counsellee has any mental health issues such as fear, anxiety, stress, or worry, tick the first option. We can ask -

"How is your mental health?" (If they don't understand, you can also provide examples to clarify.)

Details of the issue _____

- If the counsellee mentions any issue, discuss that issue in detail. Ask them about when the issue started, if they are on any medications related to the issue, and what emotions arise due to the issue, etc. You can also use probing questions for this. For more details on probing questions, refer to the "Counselling Questions" PPT.

What have you done to address the issue _____

- When discussing the issue mentioned by the counsellee, talk about the efforts they have made to address the issue. You can ask:
- "Then what did you do at that time?"
- "What actions did you take to deal with this situation?"
- "What helped you in this situation?"
- "How did you cope with this situation?"
- Did you consult anyone or seek help from someone, like a doctor or a healer?
- As you mentioned that you are dealing with this issue for a while, has it worsened or remained the same? Did you receive any treatment for it before?

Menstruation and pregnancy:_____

1. Menstruation/Period-Related Questions:

- "Are you having your periods or not?"
- "Do they happen regularly?"
- "As you mentioned that they are not happening, how long has it been since they stopped?"
- "Have you informed anyone about this?"

2. Pregnancy-Related Questions: (Only if menstruation is irregular or absent)

- "Have you had a pregnancy test?"
- "Was a pregnancy test conducted during any medical tests?"
- Asking about the medical report like "What did your medical report indicate?"
- "Do you wish to terminate the pregnancy?"

Is there a disability present: Yes No

- Is there any type of disability present in the counsellee? You can also find out about it from a disability certificate, and if you notice anything, you can ask the counsellee's family members about it. Some examples of disabilities are:
- **Intellectual Disability:** Significant impairment in intellectual functioning (such as reasoning, learning, and problem-solving) and in adapting behaviour to meet the demands of various situations
- **Specific Learning Disability:** An impairment that affects a person's ability to listen, think, speak, read, write, spell, or perform mathematical calculations
- **Mental Illness:** A disorder that affects thinking, mood, perception, awareness of time/place/person, or memory, significantly impacting decision-making abilities, behaviour, recognition of reality, or the ability to meet daily life demands.
- **Autism (Autistic Spectrum Disorder):** Affects communication and behaviour, with symptoms typically appearing in the early 2 years of life. It impacts the counsellee's overall cognitive, emotional, social, and physical health.
- **Cerebral Palsy:** A condition caused by brain damage that impairs muscle coordination. It occurs before or during birth and is currently an incurable, lifelong condition.
- **Leprosy Cured:** Primarily affects the skin, peripheral nerves, the mucous membranes of the upper respiratory tract, and the eyes.
- **Acid Attack Victims:** A person who has been disfigured due to a violent attack involving throwing acid or similar corrosive substances.
- **Speech and Language Disability:** A permanent disability affecting one or more aspects of speech and language due to biological or neurological causes.
- Other disabilities such as blindness and low vision, deafness and hearing impairment, locomotor disability, dwarfism, thalassemia, etc.

Please note:
If the counsellee hesitates to discuss any of the above questions or if you feel uncomfortable, you can talk to the family members about it.

Other important information:
Any other health-related information they provide about themselves, such as:
- If the counsellee is undergoing any type of treatment, you can note down the details
- If the counsellee is taking any medication, write down the name and details of the medication
- If the counsellee mentions any type of injury or wound, provide its details

Emotional state:
Since we are discussing the mental health of the counsellee, it is also important to understand their emotional state and what emotions they are bringing to the conversation. During the entire conversation, you need to carefully observe what changes are occurring or you can also understand this by asking the following questions. Sometimes, the details provided may be easy to notice, while at other times, they may require careful attention.
After the event: Before Counselling
Here, what was the mental state of the counsellee before counselling?
When you start the conversation with the counsellee for counselling, you can ask the following questions to understand their mental state: -
How are you feeling right now?
What's on your mind right now? Would you like to share?

Family
Before Counselling: The Mental State of the Counsellee's Family
1. Before consultation, you can also know about the mental state of the Counsellee's family by asking the following questions.
What are you feeling right now?
Would you like to share what is going on in your mind right now?
2. Or the family does not know what has happened to the counsellee but they are noticing a sudden change in the counsellee's behaviour, then you can ask -
How do you feel about the changes that have taken place in the counsellee?

Observation
During counselling, the counsellor should also continue their observation. For instance, note how the counsellee and their family respond to questions related to mental health. Are the counsellees or the counsellee's family members taking time to answer? If they are taking a long time, is it because they are struggling to comprehend mental

health, or are they unsure of how to respond, or are they reluctant to respond, or are they not providing comprehensive answers? The counsellor has to pay close attention to these details.

During counselling:
Counsellee during the consultation
You can decide when and how to ask the counsellee about how you were feeling during counselling in the following situations and through your own observation:

- When the counsellee pauses after speaking for a long time during the conversation, you can gently ask- How are you right now? How are you feeling right now? What are you feeling right now?
- During the conversation: You can inquire about the counsellee's emotional state if you see that he is speaking haltingly, inhaling deeply while speaking, or feeling overwhelmed throughout the talk. Additionally, the counsellee may become more aware of his own emotions as a result, and whatever difficulties he was having expressing himself may somewhat disappear.

Observation:
`During the counselling, how did the counsellee feel? During the consultation procedure, for instance, was the counsellee depressed, anxious, or sick? This is evident in the counsellee's speech patterns and his facial emotions throughout the session.

After counselling:

Counsellee after the consultation
After the counselling session, you can pause and ask the Counsellee: "How do you feel after our conversation at the moment? How are you feeling?"

Here, you must write the counsellee's emotional state before, during, and following the counselling. For instance, if the client felt depressed before and during the couselling, and whether the client reported feeling somewhat better following the conclusion of the counselling procedure.

Other important information: In addition to the information provided above, if the counsellee shares any information that you think is important, you can note it down here. For example, if the family or the counsellee mentions any habits that are not bothersome but have not stopped, such as always sensing something on their hand, feeling heavy upon waking up, or having a habit of scratching their nails or any other

thing during idle times, or if the counsellee constantly eats something. If such details come to your attention, you can ask about them or note them here if the counsellee's family mentioned them during the conversation.

Associated with self-harm and suicide:

What circumstances do we need to ask this (definitely)?
If, during the conversation with the counsellee, they repeatedly talk about harming themselves or suicide, or frequently mention that doing something to themselves would end their problems, it is crucial to address this. Additionally, if the family mentions that the counsellee has previously attempted suicide or self-harm, it is important to understand when these attempts occurred. For instance, if the attempt was made 1-2 days ago, you should inquire about it immediately. If it was 1-2 months ago or earlier, you should address it during the counselling session.

Thought:
No: If the counsellee has never felt like taking his/her own life/ has never felt like doing something that would end his/her life/ has never thought of hurting/ causing pain/ deep wound/ causing harm to himself/ herself, then you can write in this section.

Suicide: If the Counsellee has ever attempted to end their life, such as by cutting their wrist/ trying to jump from a height/ ingesting poison or chemicals, taking an excessive amount of sleeping pills/ or attempting to stop eating or not eating anything, you can tick this box. Write about any such thoughts or attempts in this section.

Self Harm: If the counsellee wants to harm themselves in any way, such as inflicting wounds with sharp objects, repeatedly scratching or picking their skin, or attempting to damage their body, then only you should tick this box. Note that this is only for self-harm and not for suicide attempts. Self-harm can be a way for the counsellee to express his/her anger or someone else's anger.

Both: If the counsellee experiences both types of thoughts mentioned above, you can tick this box.
When did these thoughts begin? Here, you can write about when the counsellee started experiencing thoughts of suicide or self-harm. Specify if these thoughts were there before the incident or if they began afterward. You can also determine this based on the following points.

Triggers (or catalysts):
When a counsellee exoereinces thoughts of self-harm or suicide, what happened before that? Or where were they or what were they doing that caused them to have these thoughts? Anything that they hear or see makes them want to commit suicide or self-harm.
Time - How many days ago did they last experience these thoughts? How many times a week or how many times a day does the counsellee have these kinds of thoughts? When did you start getting these thoughts? Are the suicidal or self-harming thoughts occuring because of anything that happened to the counsellee or someone you know?
You can write any brief or related information about the above points here.

Have you tried?
Yes - If the counsellee has ever attempted suicide or self-harm, you can write it here. You can write in one sentence that the counsellee attempted suicide so many days ago.
No - If the counsellee has never attempted suicide or self-harm, you can write here. The counsellee has not attempted suicide but has thoughts or plans regarding it. Whatever you find out about the counsellee should be written here in one sentence.

information regarding attempt:
Describe the strategy employed if the counsellee admits to having tried suicide or self-harm. You have to write about their kind of attempt here.
For instance, the counsellee may state, "I took 9-10 sleeping pills so that my problems would be solved forever and I wouldn't wake up the next day." If the counsellee has attempted, you can inquire using the following criteria:

Trigger - Would you like to share what was happening around you before the attempt? What are the circumstances around you when you feel like making such an attempt? Or under what circumstances do you get these thoughts?
By asking these questions, you will not only learn about the attempt but also gain insights into the surrounding circumstances and reasons behind it.

Have a suicide plan?:
Yes - If the counsellee has any plans for suicide or self-harm in the future, you can tick this box.
No - If the counsellee does not have any plans for suicide or self-harm in the future, you can tick this box.

Information about the plan:
On a scale of 1 to 10, ask the counsellee to rate their thoughts __
1 - No plan
10 - Plan is fully prepared and ready to be executed.
Ask the counsellee the reason for selecting the number:
Here, we can ask the counsellee to rate their plan for suicide in the future on a scale of 1 to 10. Whatever number the counsellee gives, you can then ask the following questions based on that rating. For example, if the counsellee gives you a score of 5 regarding your future possibility of suicide or self-harm, you can ask the questions given below.

- Can you explain why you chose the number 5?
- Can you describe the reason behind choosing 5?
- Why did you choose a 5 instead of a 4 or 6?

Other important information: In addition to everything mentioned above, you can record any information the counsellee provides that you feel is significant here. You can record the counsellee's plan here if they disclose that they intend to injure themself or commit suicide, along with details on how and why they want to do so. Alternatively, you must record everything the counsellee tells you concerning suicide deaths or suicide attempts in their family if any have occurred.

Observed by the Counsellor: In this section, we will write about other information regarding the counsellee that can only be obtained through the Counsellor's observations. Here we will try to understand the following points together.

Why is it important to know this?
When we talk to the counsellee, we learn many things. However, there are also some aspects that can be found out about the counsellee through observation. For example, if the counsellee is discussing an incident but cannot maintain eye contact, seems very uncomfortable, or becomes agitated while talking about the event, by observing non-verbal cues we can understand that they may not be ready to talk about it. Similarly, after observing each of the points given below, we can understand the impact of the event on the counsellee and whether they might need additional medical support. Observing non-verbal cues can help determine if there is a discrepancy between what the counsellee is saying and their non-verbal communication. Here are some examples:

- For example, if the counsellee verbally tells us that they are feeling good, and they are sitting comfortably and speaking well, then non-verbal cues will often reinforce this message and match what they are saying verbally.

- For example, if a person verbally states that they are feeling good but are rubbing their hands or looking around frequently, this contradicts the verbal message that you are trying to understand, indicating that the counsellee's verbal and non-verbal communication are not aligned.
- The counsellee's facial expressions, manner of speaking, or eye contact often convey messages more effectively than words.

Please note:

- This is the part of the case history format where your own observations will be very useful. It is possible that there are many things that people from certain communities may do due to their traditions.
- Here, you need to specifically note whether the observations about the counsellee are due to their personal beliefs, such as those related to God or religious beliefs, whether they are influenced by trust in someone or community rituals, or if they are a result of the impact of the event. Also, consider whether the counsellee is unable to purchase things for themselves or are unable to do so due to circumstances. You have to look into all these details.
- These details are important because they will help us get to the root of the counsellee's distress, and thorough observation is necessary for this purpose.

Making eye contact:
Maintaining eye contact helps build trust with the counsellee and indicates that you are an attentive listener. It also reflects how well the Counsellee is listening and concentrating. While talking with the counsellee, you can gauge their level of attention, whether your message is being effectively communicated, the impact of the event on them, and if they are blaming themselves or feeling guilty. All these aspects can be understood from the counsellee's eye contact.

Please note:
Different cultural backgrounds can influence perceptions of eye contact. For instance, in some communities, direct eye contact between men and women may be considered inappropriate, or lowering one's gaze might be a sign of respect. If you observe such cultural nuances with the counsellee, you should note them here.

Here you can observe the counsellee based on the examples provided.

No	Method of Making Eye Contact (You can write the words given in this section in Case History Format.)	Explanation of the given words
1	Making normal eye contact.	The counsellee maintained eye contact during the conversation. Just as they would with family members or friends, they made eye contact with you in a normal manner.
2	Suddenly stopping eye contact when asked something.	The counsellee was making eye contact during the conversation, but suddenly stopped making eye contact after you asked certain questions. For example, the counsellee was engaging well with you, but when you inquired about a specific topic, they avoided eye contact. Once that topic was discussed, they resumed normal eye contact. If you observe any such behaviour, note the specific topic or question that caused the Counsellee to stop making eye contact.
3	Looking around intermittently.	The counsellee started looking around during the conversation. For instance, they would occasionally look down or glance around, and then return to making eye contact and talking normally.
4	Making intermittent eye contact.	The counsellee was making intermittent eye contact. While speaking with the counsellee, the counsellee was making eye contact occasionally, but for the rest of the time, they were avoiding eye contact and looking down or around.
5	Maintaining continuous eye contact with you.	The counsellee maintained eye contact with you during the conversation. The counsellee is continuously maintaining eye contact with you during the conversation due to which you are feeling a little uncomfortable or you are feeling a little awkward while talking due to which you are not able to talk and are facing difficulty while talking.

6	Looking away the entire time, at the walls or windows.	Throughout the session, the counsellee's gaze was always directed outdoors, toward the walls or windows. Throughout your conversation with the counsellee, they did not once look up at you. The entire time, the counsellee was staring outside or at random places.
7	Staring at the same spot the entire time. Gazing into the void.	Throughout the discussion, the counsellee did not make any eye contact. They spent the entire time with their eyes downcast or fixed on something. Throughout your conversation with the counsellee, they did not once look up at you. They spent the whole time staring down or in one direction.
8	The person was speaking with wide eyes.	The counsellee was widening their eyes while talking, indicating that the information being shared was very important or that they wanted to draw your attention to it. If this behaviour occurred frequently during specific parts of the conversation, note which particular points or topics prompted the Counsellee to do this.
9	Blinking excessively.	The counsellee was blinking their eyes more frequently than usual, which was noticeable by the counsellor and was somewhat unusual during the conversation.

Sitting posture:

Our sitting posture often indicates how comfortable we feel with the person we are interacting with. For example, we might sit casually with friends, but adopt a more formal posture when interacting with an official.

Why is it important to know this ?

Similar to other indicators, this one also aids in determining the counsellee's mental state at the time of counselling. The degree to which the client feels at ease conversing with us, or whether certain counsellees experience discomfort while receiving counselling. You can have a better understanding of the changes in the counsellee's mental state throughout the future counselling session by keeping an eye out for these indicators.

Here you can observe the counsellee based on the examples provided:

No	Sitting posture (You can write the words given in this section in the Case History Format.)	Explanation of the given words
1	They were sitting in the same position the entire time.	The counsellee remained in the same sitting posture throughout the entire conversation. For example, they were consistently sitting comfortably, sitting upright, or sitting with a slouched posture.
2	They were frequently changing their sitting posture throughout the time.	The counsellee kept changing their sitting posture throughout the conversation. For example, they were alternating between sitting upright, slouching, crossing one leg over the other, and sitting with legs folded. This constant shifting in sitting posture was noticeable.
3	They were sitting straight the entire time.	The counsellee remained seated upright throughout the conversation, indicating they were either listening very attentively or were extremely nervous or anxious. Their rigid posture and lack of movement suggested they were either deeply focused or tense. (To understand the exact reason, refer to their facial expressions and other non-verbal cues.)
4	They were sitting hunched over the entire time.	The counsellee remained hunched over throughout the conversation, suggesting disinterest or a lack of motivation to engage in the discussion.
5	They were sitting comfortably on a chair or the floor.	The counsellee was sitting comfortably in the chair during the conversation, indicating that they felt somewhat relaxed.
6	They were sitting with their hands crossed.	The counsellee was sitting with their hands folded during the conversation, indicating that they were listening attentively to the counsellor.

Self-care:

The way a counsellee takes care of themselves can indicate how they feel about themselves. In daily life, when we interact with others, we often notice their appearance and grooming, including their hairstyle. Why is it important to know this?

Just as a counsellee's grooming and appearance can reflect how they feel about themselves, their self-care after an event can also provide insights into their self-perception. If a counsellee is neglecting their personal care, it may indicate underlying issues or emotional distress. Observing these changes closely can help in understanding their current state and guide future sessions effectively.

Please note:

- If you observe any tradition or practice related to the points below within the Counsellee's community, you should note it next to the relevant point.
- There may also be several practices in the community due to circumstances, and if the Counsellee follows these practices, you should document them there.
- For example, in some communities, there is a tradition where women dedicated to serving God do not wash their hair, resulting in them having uncut hair. This could be a traditional practice of the community or a personal choice made by the individual due to specific circumstances.

Why do we need to observe these things?	What to observe	How to observe?
Self Care - The way a counsellee maintains their personal hygiene can provide insights into their daily living habits and overall well-being.	1. Bathing 2. Nails 3. Hair	1. Smell: What is the counsellee's overall body odor? Has the client worn perfume excessively? Does it appear as though his or her skin hasn't been washed in a while? 2. Were bitten or enlarged, were dirty, had been eaten with teeth 3. The hair was done or tied properly, could be seen easily, the hair was unkempt and messy or the hair started forming matted hair, a lot of dirt was visible in the hair due to which it looked like a bun

Why do we need to observe these things?	What to observe	How to observe?
Clothes - An indication of how a counsellee views his or her body and portrays themselves to others may be gained from the way the person dresses.	1. According to body size 2. Dressed according to the weather 3. Comfortable 4. According to the situation 5. Clothes	1. Wore clothes that were a little bigger or a little tight. 2. Do the Counsellees have summer clothing that they wear all year round, or do they have summer clothing that they use only during the colder months? (If the Counsellee lacks the funds to purchase clothing for every season.) 3. Did the person receiving counselling wear comfortable clothing, or did he constantly modify it while we were speaking? His gaze would constantly go to his wardrobe. 4. It's easy to tell whether a counsellee has over prepared or not by looking at how he is dressed for a session, whether it's in the workplace or at home. 5. The clothes were shrunken, dirty and torn
Presentation – Grooming Grooming is another way to show how the Counsellee wants to present themselves in front of others. Grooming can be a method for the Counsellee to either hide what has gone wrong or to divert attention from it,	1. Method of Grooming 2. Kajal 3. Nail Polish 4. Hair Accessories 5. Lipstick	1. Whether the counsellee came prepared for the conversation or not. 2. Did they apply kajal or not? If yes, then how did they apply it? 3. Was it a new one or had it been forcibly removed? 4. You need to observe how many clips were used on the hair or what type of clips or hair bands were used, whether they were very shiny or plain.

or to reflect the impact of the incident. For example, the Counsellee might become more groomed than before after the incident.		5. Was lipstick applied or not? If applied, was it applied heavily or lightly (dark or light), and what color was it?

The way of speaking:

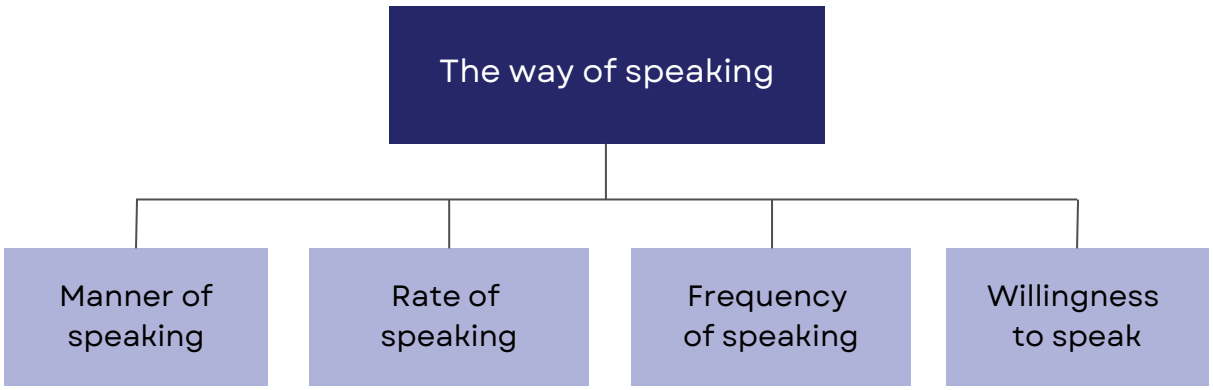
The human being is the only creature that can communicate its thoughts to other humans through words. 70% of a human's life is spent conveying their thoughts, opinions on something, their perspective on an event, or various other matters to others.

Why is it important to know this ?

The way a counsellee speaks is also a way to understand their emotions. By observing the counsellee's manner of speaking during the counselling conversation, we can gauge their emotional state. Additionally, as we continue talking with the counsellee, their emotional improvement or any other impact becomes apparent first through their manner of speaking.

Please Note:

You need to observe both the counsellee's and their family's manner of speaking. This will help us easily understand any changes in the counsellee's usual way of speaking or any deviations in their manner of speaking due to specific reasons.



Speaking	Explanation of the given words
Manner of Speaking	
They were speaking in a usual tone.	The counsellee is answering the questions asked in a normal manner. He is providing information that is relevant to what was asked.
Their voice was low while he spoke.	The counsellee was speaking so softly that the counsellor couldn't hear them. The counsellor had to repeatedly ask them to speak a little louder.
Their voice was raised as he said.	The counsellee was speaking louder than usual, which the counsellor could easily understand. The counsellor had to ask the counsellee to speak a little softer.
Rate of speech of the counsellee	
They were speaking at a regular tempo.	The counsellee was speaking at a normal conversational pace, making it easy to understand everything they were saying
They spoke quickly.	The counsellee was speaking very quickly, as if they were in a hurry to get something done or had somewhere to be. Due to the counsellee's rapid speech, the counsellor was unable to understand some of what was being said.
They were talking slowly.	The counsellee was speaking so slowly that the counsellor had to pay close attention to hear them.
Frequency of Counsellee's conversation	
They were stuttering.	The counsellee was stuttering during the conversation. The counsellee was speaking hesitantly, pausing frequently. Here, you need to observe whether the counsellee has always had this problem or if it occurs only during certain events or when discussing specific topics.

They were talking normally but haltingly.	The counsellee was speaking in a generally normal manner, but with frequent pauses. When asked anything, they responded very calmly, as if they had forgotten what they wanted to say or their attention was suddenly diverted while speaking, preventing them from completing their thoughts. Or they would repeatedly ask you what they were talking about.
They were started crying in the middle of the conversation (over something).	The counsellee broke down in tears in the middle of the discussion. (over something) The counsellee was speaking politely until you inquired about something, and the counsellee broke down in tears. You may comment on what caused him to cry here.
They were crying.	Throughout the whole conversation, the counsellee was in tears.Throughout the whole conversation, the counsellee was in tears.
The way of speaking was changing again and again.	The Counsellee was regularly altering his speech pattern while conversing. The counsellee abruptly started speaking loudly throughout the discussion. All of a sudden, his voice was low and he was speaking very softly. All of a sudden, he was speaking quickly or softly. The counsellor was finding it challenging to listen to and comprehend the counsellee since all of these shifts were occurring so regularly in their conversations.
They were panting.	The counsellee was breathing heavily while speaking. For example, the counsellee is too exhausted or unable to speak for too long. Here, you need to determine if the client is panting because of a medical condition or if they are panting when discussing a certain topic. All of this information must be written with this point.
Desire to talk:	
Answering the questions.	The Counsellee was answering your questions. The Counsellee was responding well to the counsellor's questions. They were providing additional information related to the questions.

Talking openly.	The counsellee is speaking openly. In addition to responding to the questions posed to him, the counsellee is also asking you some questions. For instance, when you inquire, "Do you go to school to study?" of the counsellee and "Yes, I go," is the counsellee's response. It appeals to me. I also want to become computer literate. Could you tell me where I can find it ?
She was avoiding answering.	The client was refusing to respond. The counsellee did not say anything at all after being questioned. Asking the same question of the counsellor or not responding to the counsellee throughout the whole of the conversation. or making any statements based solely on the counsellee's opinions. The client was responding appropriately to the inquiries or walked away after making broad remarks. As requested by the counsellor, did you have breakfast today? In response, the counsellee stated that everyone had breakfast as soon as they woke up.
They were taking time to answer.	Counsellee are taking time to respond. The counsellee is taking longer than normal to respond to questions, but he is still replying. The counsellee seemed to be responding after giving it much thought.
They are answering only a few questions.	Only a few queries were being answered by the counsellee. Only a small portion of the questions you were asking the counsellee were being answered. Even after listening to the questions, he was either ignoring them or not responding to the remaining ones.
While talking they were changing the topic.	As they speak, the counsellee switches topics. After speaking briefly on the question, the counsellee moves on to another topic. The counsellee appears to be attempting to avoid answering questions or to be reluctant to discuss anything.
Answering in one sentence.	Counsellee was answering in one sentence. Counsellee was answering the questions asked in one sentence.

Behaviour and Body language:

In our daily lives, non-verbal cues also play a significant role in effectively communicating our message to others. Here, you need to describe the counsellee's behaviour during the conversation, including their physical movements and overall conduct.

Why is it important to know ?

After the way the counsellee communicates, their non-verbal cues provide a clear understanding of their mental state. Therefore, it is essential to observe the counsellee's non-verbal signals.

Behaviour and Body language (You can write the words provided in this section in the Case History Format)	Explanation of the given words
They were making a stir.	1. Kept rubbing their hands throughout the time. 2. Frequently touching their face or hair. 3. Repeatedly scratching their hands or legs. 4. Moving one leg and one hand, or both, together. 5. Frequently turning to one side while sitting. 6. Sat with their hands or feet, or both, bound throughout the conversation.
Facial expressions.	1. Consistent expression throughout the time. 2. No expression throughout the time. 3. Facial expressions changed according to the questions. 4. The counsellee's behaviour and mannerisms appeared more like those of a younger person. For example, if the counsellee is stating their age as 15, their behaviour, way of speaking, or use of hands while talking is childlike, such as repeatedly putting their thumb in their mouth while talking.
Others	1. Were trembling while talking. It is important to understand the reason behind the counsellee's trembling. Determine whether the counsellee always trembles while speaking. 2. Were panting while talking. 3. If you observe anything different from the points mentioned above, you can note it here.

Facial Expressions:

Picture of facial expressions	Explanation of the given words
Surprise	
	Eyebrows were raised.
	Eyebrows are furrowed. The skin below the eyebrows is tense.
	The eyelids are lifted.
	The jaws open.
	Wrinkles appear on the forehead.

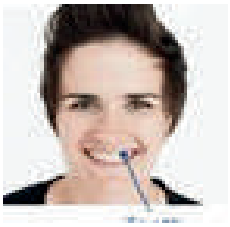
Resources: https://www.scienceofpeople.com/microexpressions/

Picture of facial expressions	Explanation of the given words
Fear	
	The mouth is open, and the lips are slightly tense or stretched back.
	The upper whites of the eyes are visible, but the lower whites are not.
	The upper eyelid is raised, but the lower one is tense and pulled.
	The eyebrows are raised and drawn together.
	Forehead wrinkles occur in the center between the eyebrows.

Resources: https://www.scienceofpeople.com/microexpressions/

Picture of facial expressions	Explanation of the given words
Disgust	
	The upper lip is raised.
	The upper teeth may be exposed.
	Wrinkles appear around the nose.
	The cheeks are protruded.

Resources: https://www.scienceofpeople.com/microexpressions/

Picture of facial expressions	Explanation of the given words
Happiness	
	The corners of the lips are pulled back and upward.
	The cheeks are protruded.
	The outer edges of the eyes are narrow.
	The lower eyelid may show wrinkles or appear tense.
	The teeth are visible.
	A line extends from the outer nose to the outer lips.

Resources: https://www.scienceofpeople.com/microexpressions/

Attention:

Attention. (You can write the words given in this section in Case History Format.)	Explanation of the given words
Full attention.	The counsellee was fully focused on the conversation during the discussion. Counsellee was answering questions and speaking in a normal manner, similar to how one would in everyday life.
Partial attention.	The counsellee was responding before the conversation was complete. There was noticeable physical restlessness, such as frequently rubbing their hands and changing their sitting position, indicating that the counsellee's attention was also focused on other things beyond the conversation.
Lost in thought.	The counsellee shifted to another topic while talking and forgot what they were discussing, talking to themselves. The counsellor had to repeatedly ask what topic they were talking about.
Attending two places at once.	The counsellee was also engaged in other activities while talking, such as checking their bag, searching for something, inspecting the surroundings of the conversation, or frequently touching parts of their body like hands, feet, and mouth, or repeatedly adjusting their hair.
Very restless throughout.	When asked something, the counsellee appeared startled or seemed lost in their own thoughts, and responded nervously when questioned.

When discussing (traumatic) event-related matters (e.g., when asking a specific question):

Sudden changes that appear only after asking about the event, such as becoming very quiet, avoiding eye contact, showing signs of panic, changing their sitting posture, increased anxiety, hesitation in speaking, or shouting. Do they avoid discussing the event?

Signal of self harm:
The counsellee has some injuries on their body that may have been inflicted with the intention of self-harm, such as blade marks on the wrist, scars on the hands or legs, or marks on the neck or other body parts that the counsellee is trying to hide. The counsellee may not be able to provide a reliable explanation for these marks or injuries. It is essential to observe the counsellee's behaviour and interactions throughout the conversation carefully.

Others :
If the counsellee provides any additional information that seems important, you should note it here. For example, if the counsellee mentions that they harm themselves to make their family members listen to them or to get what they want, such information should be recorded.

If there have been any changes in the counsellee's behaviour from the family's perspective, when did these changes begin? What does the family think might be the reasons for these changes? How has the family been affected by the counsellee incident? Do any of the family members have mental stress? How are the counsellee's family members doing toward him or her? Regarding whatever has transpired with the counsellee, what are their thoughts? Have the counsellee's diet, hobbies, appetite, or sleep changed at all, according to the family members? After these modifications, how does the family interact with the counsellee, or how do the family members perceive these modifications? What are their thoughts on this? You can briefly write any information that family members provide you about any of these topics below.

Suggestions:
If the counsellor has any recommendations for helping the counsellee feel better or for lowering stress throughout the talk, those recommendations should be recorded here. For instance, you can write down any advice you have given the counsellee if he is having trouble falling asleep or is not eating.

You must record any recommendations you have made for the counsellee here if you have discussed any of your activities with them, such as breathing exercises, or if you have offered advice on how to deal with stress or any other kind of recommendation, like how to lessen stress in daily life or at work, or if you find yourself getting anxious or stressed out while working.

Results:

You must record below any changes you have seen in the counsellee both before and after the session with the counsellor. For instance, the counsellee appeared extremely anxious, perplexed, or despairing prior to the chat, but by the conclusion, he appeared to be feeling little better, a little hopeful, or a little optimistic. The counsellee felt a little more self-assured after the discussion. You might ask the counsellee how he is feeling following the conversation once it has concluded.

Need to consult someone else:

No - There is no problem or discomfort that requires anyone to be seen.

Counsellor (Professional Counsellor) - It seems necessary to consult a professional counsellor for mental health issues. You should check this box if it is necessary to see a professional counsellor.

Psychologist - If the counsellee is experiencing a mental illness that requires further treatment, such as a thorough mental health assessment, you can check this box if you believe it is necessary.

Therapist - If it seems necessary for the counsellee to receive additional treatment beyond counselling, such as for issues like frequent anger, persistent sadness, severe fear affecting daily activities, or repetitive behaviours e.g., washing hands or excessive cleaning leading to restlessness, then you can check this box.

Clinical Psychologist - If the counsellee needs psychological services that include the assessment of mental, emotional, and behavioural disorders, and if there is a need for treatment and fostering change through the science of psychology, you can check this box. Clinical psychologists also promote resilience and help individuals find their strengths.

Psychiatrist - If the counsellee requires more comprehensive treatment for mental illness, including medication along with psychological assessment, or if there is an immediate need for hospitalisation or admission, you can check this box. Hospitalisation in case of emergencies and also medications.

Physician - If the counsellee has any physical ailments or injuries beyond mental health issues, such as deep wounds or persistent pain complaints, and the counsellor believes a physician's evaluation is needed, you can check this box.

Obstetrician/Gynecologist - If the counsellee, particularly women, is experiencing any menstrual issues or infections related to private body parts that require examination, you can check this box.

Other: - If the counsellee has any other issues not covered above and you believe it is necessary to see a different type of doctor, please check this box. Additionally, specify the type of doctor needed in one or two words. For example, if the counsellee needs treatment for vision issues (optometrist), hearing aids, or any disability, you can note that here.

Next date of counselling:

1. You will decide the next date of consultation with the counselee.
2. You can schedule the consultation date for one to one and a half weeks later.
3. After deciding the date, it is important to inform the counsellee that if they are unable to come on that date, they can visit one or two days before or after.
4. For the next consultation session, you should arrange a time that is convenient for the counsellee.

8 Genogram Guide

A word from the team

A genogram is a graphic representation of a family tree that displays detailed data on relationships among individuals, and is a useful visual representation of the family history.

This topic aims to provide field counsellors with a basic understanding of what genograms are, as well as guide to refer and prepare genograms.

What is a genogram?

- A genogram is a graphic representation of a family tree that displays detailed data on relationships among individuals.
- It goes beyond a traditional family tree by allowing the user to analyze hereditary patterns and psychological factors that punctuate relationships.
- Genogram is a useful tool to gather information about the family and guide the clinical practitioner for intervention.
- This visual representation helps you to understand about the relationships and networks associated with the family.
- It is used to display the three or more generational information to track the source of stressors and available resources.
- The purpose of drawing a genogram is to map out the complex interpersonal relation present in the family and their biopsychosocial environment.
- It is a standard tool to assess the composition and structure of one's family background, roles, pattern of communication, social interactions, and interrelationship with the environment.
- This tool helps the mental health professional to recognise visual representation of the individual, family, and disorders running in the family through specified coding or symbols in a snapshot observation.
- These symbols are graphical, circle, rectangular, dotted lines, straight lines, vertical lines, etc.
- Genograms allow a therapist and his patient to quickly identify and understand various patterns in the patient's family history which may have had an influence on the patient's current state of mind.
- Genograms were first developed and popularised in clinical settings by Monica McGoldrick and Randy Gerson through the publication of a book in 1985.
- Genograms are now used by various groups of people in a variety of fields such as medicine, psychology, social work, genealogy, genetic research, and education.

How does it help?

- A genogram helps educate the clients and families about present family patterns in order for intervention to take place for better mental health of the client.
- It helps in working with the individual client or subsystem of family through mapping out the problem such as delineating family relations, relationship dynamic, and family structure.

- Genogram provides insight on emotional bonds between family members and alliances present in the social unit, in order to reinforce positive relationships and work on negative relationships for overall cohesiveness within the family.
- Family patterns can be transmitted from one generation to the next. Such repetitive patterns occur in functioning, relationships, and family structure. Recognizing such patterns often helps families avoid repeating unfortunate patterns or transmitting them into the future.
- Tracking critical events and changes in family functioning allows us to make systemic connections between seeing coincidences, assess the impact of traumatic changes on family functioning, identify the family's resources and vulnerability to future stresses, and finally to put all of this into a larger social, economic, and political context. This tracking enables the clinician to promote resilience based on past sources of strength, helping family members modify past adaptive strategies that have become dysfunctional.

Genogram format includes:

1. Symbols: to describe basic family membership and structure
2. Family interactions/Dynamics: least precise information on the genogram but key indicator of relationship patterns
3. Medical history: only major or chronic illness and problems.
4. Other family information

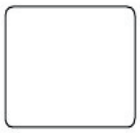
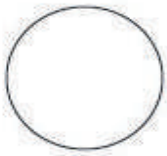
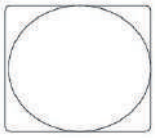
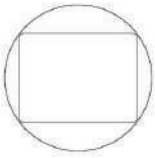
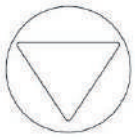
Family structure and subsystems can be further explored through -

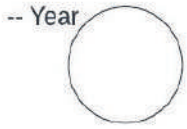
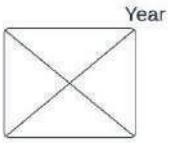
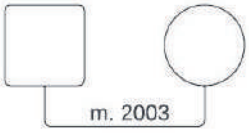
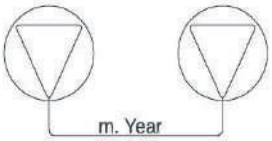
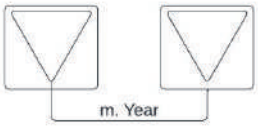
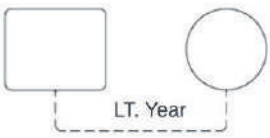
1. Themes and patterns in three generations - who is close to whom, who is similar to whom, interests, hobbies, professions, decision making.
2. Physical and mental health issues across three generations.
3. Family values, beliefs and goals
4. Parenting style, communication styles and parent child or sibling relationships
5. Roles, rules, and rituals in the family- who is the provider/safe space, secret keeping rules, family specific rituals.
6. Exploring how affection is shown, and punishment decided.
7. Family strengths, events in the timeline of the family that are like family legends or history - migration, natural disaster, war, famine etc.
8. Exploring what the support system for the family is.

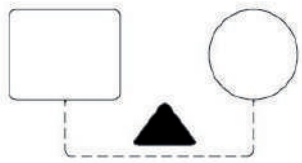
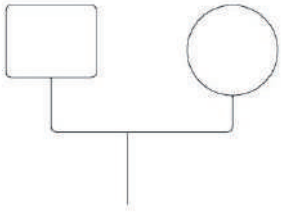
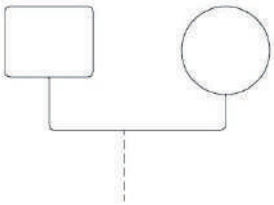
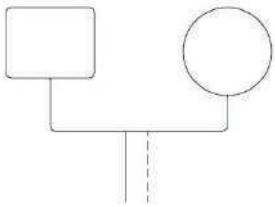
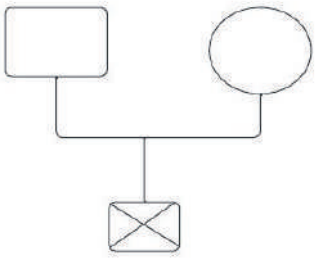
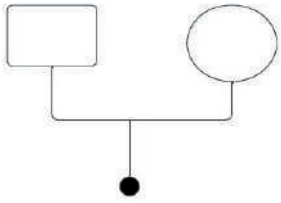
Basic rules to build a Genogram:

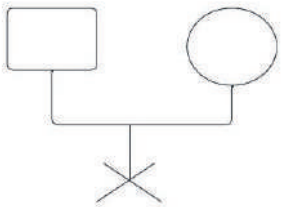
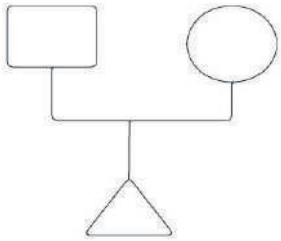
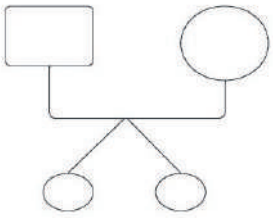
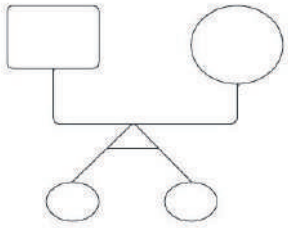
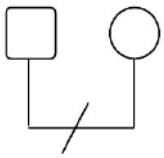
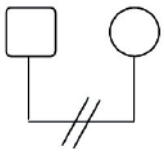
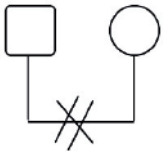
- The male should always be drawn at the left side whereas the female is at the right side.
- Assume a male-female relationship to avoid the ambiguity rather male-male or female-female in drawing the family.
- A spouse must be drawn in close to his/her partner and maintain chronological order thereon for further onward partner.
- According to birth order, children should be drawn from left to right in a horizontal line.

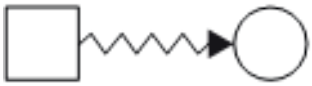
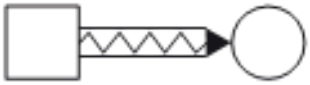
Symbols:

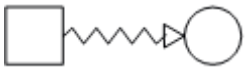
Name	Symbols	Note
Male		A male person is represented by a square
Female		A female person is represented by a circle
Transman		A transman is represented by a circle inside a square Transition from woman to man
Transwoman		A transwoman is represented by a square inside a circle Transition from man to woman
Lesbian		A lesbian person is represented by an inverted triangle inside a circle
Gay		A gay person is represented by an inverted triangle inside a square

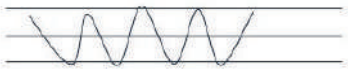
Birth date		The date of birth shows up to the left of the symbol. When representing we use the year of birth.
Age		Age is written inside the symbol In some cases, you can use either the birth date or age. Sometimes you need to use more than one symbol in a genogram, so you can choose either age or date of birth
Death		The cross inside a square/circle represents the person's death and the year of death is written on the right side of the symbol.
Marriage		This family relationship represents a married couple. - We write the year of marriage as shown in the image
Lesbian Couple		The same symbol of marriage applies for lesbian and
Gay Couple		gay marriages.
Living Together (Without Marriage/ Live-in-Relationship)		The same applies for lesbian and gay couples living together

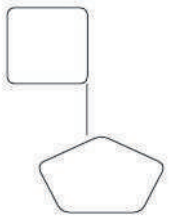
Secret affair		For a secret affair, a solid triangle symbol has to be added to the living together symbol.
Biological Child		A biological child is indicated by a straight line below the marriage symbol
Foster Child		A dotted straight line is used to indicate a foster child.
Adopted Child		A straight line and a straight dotted line together is used to indicate an adopted child.
Still Birth		A cross is used inside male and female symbols to indicate stillbirth. A stillbirth is the death or loss of a baby before or during delivery.
Miscarriage		The small solid circle is used to indicate miscarriage. Miscarriage refers to the death of a baby before 28 weeks of pregnancy - WHO

Abortion		The cross is used to indicate abortion Abortion refers to the termination of a pregnancy before 20 weeks
Pregnancy		The triangle is used to indicate pregnancy.
Non-identical Twins		Two lines divulging from a single point are used to represent non-identical twins
Identical Twins		A horizontal line is added to two lines divulging from a single point to represent identical twins
Marital Separation		The one diagonal line across the marriage line is used to indicate Marital Separation
Divorce		Two diagonal lines across the marriage line are used to indicate divorce.
Re-marriage		To indicate Re-marriage one cross is used on the two diagonal lines across the marriage line.

Counselee		The diagonal lines inside a symbol and an arrow outside are used to indicate Counselee.
Accused		To indicate accused multiple dots are used inside the symbol of male, female or transgender.
Psychiatric Illness		Any solid colour must be added to the required symbol to indicate psychiatric illness.
Physical abuse		- A bumpy solid arrow is used to indicate physical abuse. - Defines a relationship in which one individual physically abuses another. It includes any non-accidental injury to an individual, typically to a child or a woman. This includes hitting, kicking, slapping, shaking, burning, pinching, hair pulling, biting, choking, throwing, shoving, whipping, and paddling
Sexual abuse		A bumpy solid arrow with two horizontal lines on both sides of the arrow is used to indicate sexual abuse. Defines a relationship in which one individual sexually abuses another. It includes any sexual act between an adult and child, or a forced sexual action between two adults. This includes fondling, penetration, intercourse, exploitation, pornography, exhibitionism, -

		child prostitution, group sex, oral sex, or forced observation of sexual acts.
Emotional abuse		A bumpy arrow is used to indicate emotional abuse. Defines a relationship in which one individual emotionally abuses another. It includes any attitude or behaviour which interferes with mental health or social development. This includes yelling, screaming, name-calling, shaming, negative comparisons to others, telling them they are "bad, no good, worthless" or "a mistake".
Symbols denoting Interactional patterns between people		
Close		Two straight lines are used to represent close relationship Defines a close relationship (friendship) between two individuals in which they share affection or esteem and engage in mutually helping behaviours.
Distant	.....	A dotted line is used to indicate a distant relationship Defines a distant relationship between two individuals. Communication is very limited, usually due to differences in lifestyles.

Close- Hostile		A wavy line with two straight lines on each side of the wavy line is used to represent a close-hostile relationship Defines a close-hostile relationship between two individuals. These people often come into contact, but they argue and keep secrets from one another.
Focused on		An arrow is used to represent one who is focused on another Defines a relationship in which one individual has an unhealthy focus (obsession) on another individual. This may include favoritism and stalking.
Fused		Three straight lines are used to represent a fused relationship Defines a fused relationship between two individuals. Individuals become dependent on one another, and also become inseparable, with little room for their own identities.
Hostile		Defines a hostile relationship between two individuals where the individuals argue on major issues and feel heightened stress and aggression when they are together.
Fused - Hostile		Defines a fused-hostile relationship between two individuals. These individuals are always together and depend on each other, yet they are unable to live without arguing.

Cut-off		Defines a cutoff relationship where two individuals have no contact at all, characterised by extreme disengagement and emotional intensity where there had formerly been love, affection, or friendliness.
Person relationship to professional and institution		
Institution		The straight line ending in a hexagon is used to represent the person's relationship with an institution
Professional		The straight line ending in a triangle is used to indicate Professional relationship of individual with his/her profession (Professional os the work which they do for their own livelihood.

Drawing genograms for cases

Example Case 1: Draw the genogram for Rani's case

Rani, who is 17 years old, lives with her parents and grandfather in a small village in Dewas. Apart from her parents, her family includes her maternal uncle, paternal uncle, paternal uncle, who live separately. . His grandmother died a few years ago. One day when the rest of the family members had gone out, Rani was sexually assaulted by her grandfather.

Discuss and construct more cases that connect to the experinces from your field realities. Discuss and draw the genograms of these cases with the participants.

9 Case Study Guide

A word from the team

As counsellors, case studies can serve as rich qualitative data as a helpful method in better understanding and improving our work and help the people that we work with better, as well as as a record of our journey as professionals. Case studies thus serve as very commonplace practice in mental health work.

This topic serves as a guide to writing case studies. While some particulars of the format are specific to our work and organisational context, the format we use in this chapter can serve as a reference point for writing case studies.

Discussion

- Why is it important to write case studies? Share your thoughts.

Need for case study writing:

- Providing information about the case
- To understand the outcome of counselling in a case and the experience of the case
- To understand the type of cases we are getting
- To understand your achievements, challenges, experiences that influence the session
- This improves the quality of your counselling and ensures monitoring
- To further facilitate skill training on specific topics

Which cases to choose for writing a case study?

- Cases that have had 2-3 sessions as this can better reflect the details of the case
- Cases where we can observe and measure change
- Specific challenges, accomplishments, particular personal thoughts that influenced the session, thoughts that influenced you, anything that reflects your work as a counsellor

The format we use for case studies is given here:
The discussions and guide in this chapter will be based on this format.

Case Study Format

1. Case details
(Basic socio-demographic details including age, gender, caste, SES, family details, while ensuring anonymity by omitting identifying information. Use a pseudonym or initials, and only use the unique ID or case ID if necessary)

Case ID:
Program ID:
Name (imaginary):
Age:
Gender:
Class / Education:
Religion:
Caste:
Address (imaginary):
Case Type:
Total Sessions:

Social and economic status of the family-
Total Family Members:
Genogram:

Occupation, Income:
Relationship with family members:

2. Brief synopsis

(General description of the case, precipitating factors if any, and reason for referral, while ensuring anonymity by omitting identifying information)

Description of the case (Name, age, address etc.):

Reason for referral:

Situation:

Present Status of the Counsellee:

Other factors (Internal, External) which are causing the problem in the case:

3 Session Summary

(Brief summary of each session, while ensuring principles of confidentiality and anonymity)

Assessment: Describe their mental health, emotional state, important disclosures necessary to ensure safety and wellbeing (behavior, emotional and status, disclosure of distress, etc)

Interventions and Support Provided: Describe the strategies used based on the evaluation and observations made during the counseling session and the strategies collaboratively (between the two) decided to use in the session. Mention the goals, plans, and consensus reached during the session.

4. Challenges

(Challenges and barriers faced during counselling sessions, both personal and contextual)

5 Factors Facilitating Counselling

(Brief description of all intrinsic and extrinsic factors that aided the process of counselling. Do not write factors that are of help to the counsellee)

6 Positive outcomes from Counselling

(Changes observed in or stated by the counsellee or their family members, what worked for them. Do not write changes that were not a result of counseling such as ration support)

7. Further Plan of Action

(Plan with respect to changing or adding interventions, what they need, need for referral, need for supervision)

8. Reflections

(Thoughts, emotions, experiences and reflections through the counseling process)

How to write a case study?

1. Case Details

Provide basic details about the counselee including age, gender, caste, socio-economic status, family details.

Ensure anonymity while providing counselee details. Provide counselee's Case Unique ID, Case ID, initials or fictitious name as required.

This is mandatory

Case ID- MH_MP_CHH_2023_F/P001
Program ID:
Name – A / Savita (Fictitious Name)
Age –
Gender – Female / Male / Transwoman / Transmen / Non Binary / Boy / Girl
Class : 5th std / 10th
Religion & Class – Hindu / Muslim / Sikh/ Christian/ Jain/ Buddhist; SC / ST / OBC / General Address :
Case Type :
Total Sessions :

Social and economic status of the family
Total family members- 1 younger sister, 1 younger brother and 1 elder sister, mother, father, grandmother

(Genogram)

Occupation, income

Relationship with family members

How not to write

Name - Sushila (real name)
Caste/Class - Ahirwar

(Under this, the caste of the person is not to be mentioned but they are to be written as General, OBC, SC, ST etc.)

Do not display any such information which may reveal any confidential information about the counselee through the case study.

2. Brief Summary

In this part, a brief summary of the case has to be written, in which all the main issues related to the case have to be described briefly.

What to write -
Give a description of the case in general terms. (Name, age, address, etc.)

Write the reason for referral.

Incident or event, personal situation of the counselee)

Write other factors (internal, external) which are causing problems in the case.

What not to write -
Remember that here we have to write only the summary of the case, so do not write it like a story.

Do not write the name of the counsel or any person related to him. Keep it confidential. Do not disclose confidential information

"We talked to the girl in our counselling session, a boy from her own village used to abuse her when she used to go to school, he used to behave badly with her, because of this the girl was very stressed. The family also filed a complaint in the police station but nothing happened. So the girl is very scared. During counselling we told her not to be scared and to be courageous"

Example
15 year old Rohini (name changed), resident of Devnagar (name changed) is a class 9 student. She is very stressed for the last 3 months. The reason is that a boy from her own village teases her and uses abusive language when she goes to school. When she complained about this to her parents, they tried to file a police report but the police did not take any action. This case has been received from the xyz program of Jan Sahas. The girl is very stressed right now. She is afraid that the boy will keep harassing her. Her education is getting affected due to this and she is feeling very frustrated. No action is being taken by the police either.

3. Summary of the session

Session (Clearly describe only the main issues discussed in the session to maintain confidentiality)

Assessment: (behaviour, emotional and mental state, family relationships, other)

Interventions and support provided: Write about the support provided based on the assessment and observations made during the counselling session and mention the goals, plans, and agreements made by the counsellor and counselee during the session.

How to write (example)

Clearly describe the efforts made by the counsellor in the counselling process and what interventions helped and what did not.

Do not be vague, be specific especially in terms of duration and intensity

As soon as the session started, the counselee (15 years old girl) was talked to and the counsellor tried to establish a connection. In this, the counselee was asked about her likes and dislikes, activities and friends. While answering, the counselee was not talking openly. She was hesitating and was not making eye contact. After this, she was asked about her education and school. She started talking openly about this. It appeared that she likes going to school and listening to songs. The counselee was talked about her daily routine. She said that she has less appetite and sleeps most of the time. The counsellor talked about improving her daily routine. She was suggested to spend some time doing activities of her choice.

What not to write -

While writing the assessment, write things as they are and do not write your personal opinion or comments.

While giving the summary of the case, do not write what the counselee said and what you replied. Do not write like a story.

4. Challenges

In this part, write about the personal challenges you faced during the counselling session.
Write about the challenges you faced in the case.
You can also write about how those challenges are affecting the counselling process and how supervision or discussion of the case is required in that case.

What to write -
Challenges felt by the counsellor which hindered the counselling process.
You can also describe the emotional challenges felt by the counsellor himself.
Examples:
You did not know what to do when the counsellor was crying a lot.
Despite good rapport and intervention with the counsellor, you felt frustrated.
You felt angry, annoyed at who called you or the counsellor during the counselling session.

What not to write-
Do not describe the personal concerns and challenges felt by the counselee in this part.
Example - The counselee could not come to the office due to which the session had to be held at his home
The counselee's house was not available

5. Factors that help in counselling

In this part, briefly describe all the internal and external factors that help in the counseling process.
What to write-
The girl's parents cooperated in the counseling, only then could we talk to the girl in private and the girl was told about the confidentiality of counseling, due to which the girl agreed to participate in the counseling process.
Due to the encouragement of the family members, the counselees agreed to go for counseling.
The counselee was also eager to take counseling, she wanted to solve her problems.

What not to write-
Here we are talking about the factors that help the counsellor in the counselling process, not the factors that help the counselee. Hence, the factors that help the counselee should not be written here.

6. Positive outcomes of counselling

In this section, describe the positive changes noticed by the counsellor, counselee or his/her family during the counselling process.

How to write:
After two to three sessions, a bond has been formed with the counselee.
The counselee has experienced less stress and better sleep than before.
The counselee's relationship with his/her parents has become normal.
The counselee has now started going to school and interacting with people.

How not to write:
The girl's maternal uncle is sensible so he gave permission to talk.
When I talked to the counsellor in the counselling session, I got support from the parents and the counsellor herself was ready to talk and the girl is able to take care of herself and I got a chance to talk to the counsellor in private.
While writing the achievements, write only those achievements which you got due to counselling and not from other things like ration support, girl's admission in school

7. Plan for the next sessions

Describe the new plan, mentioning the needs of the counselee and continuing with the plan from previous sessions or discussed with the supervisor.

Goals should be set in collaboration with the counselee.

Mention if there is a need to refer the case to another professional (PC"S, CP, Psy) or if the case needs supervision by another professional.

While writing about the plans, describe a clear plan.

It must include how and why you are deciding on it

How to write -
First work will be done on the counselee's daily routine in which the counselee will be asked about the problems in her daily routine,
What is the counselee feeling and what kind of problems are she facing, which will be discussed.

How not to write -
Further counselling follow-up sessions are being taken. (Do not write like this)
Do not write what is to be said and discussed in the next session.
While writing the future plan, write clearly, do not write that we will talk to the parents, write what, why and how we will talk

8. Reflections
In this, write your experience of counselling with the counsellor. Like sometimes it feels very difficult while doing counselling. Sometimes it is very difficult to make a connection, sometimes the counsellor also does not want to talk much or it may also happen that the counselling session went well where it was easy for you to make a connection with the counsellor and the counsellor also understood what counselling is. At such a time, if you are in the counsellor's place, then how would you feel.

Why is it important to write about counselling related experiences?
Because it tells us what we have learnt, what went well in the counselling session, what did not go well and what I need to do better in future.

How to write -
The counsellor was not talking in the first session, so it was a little difficult to continue the session.
In the second session, when the counsellor was taking time to talk, I felt a little pressured that the counsellor was having difficulty in talking or the counsellor did not want to talk.
Personal Biases

How not to write -
The physical and mental condition of the girl is fine now but it will take time to become like before. Follow-up will be done from time to time. Help from a professional counsellor was taken from time to time.

Do not just write that I felt good, I got angry, explain it

Following ethics when writing a case study

While writing a case study, do not write too private things of the counselee (which the counselee does not want to be disclosed). Therefore, maintain confidentiality.

While writing a case study, write only those things which happened in the counseling process and do not write about those things which did not happen.

Do not give any information in the case study that identifies the counselee, such as name, village name, etc.

Activity: Writing a Case study

Discuss a case outline that fits your field context and ask the participants to write a case study for it. Present the same to the larger group.

10 Referral Guide

A word from the team

Referral is the process by which we identify something worrying in an individual or family, develop an action plan to deal with the problem, and then communicate the problem to a skilled service provider so that a plan of action can be made.

This guide was divided into three parts and outlines a flow from referring to the mental health team to referring out of the organisation. The guide outlined the process not just for the field counsellors of the organisation, it was designed to provide information relevant to those involved in different roles so that it may refer relevant cases to the mental health team.

The team composition and processes of organisations may vary from context to context, and it is worth keeping in mind that this guide is just one example that may need to undergo adaptations to best suit different contexts.

Conditions for referral

Grief/bereavement
Loss/death of a loved one, being affected by natural calamity, financial loss, shifting to a new place.

Interpersonal issues
Marital problems: conflict between partners, family-related issues (property conflicts, adjustment problems), relationship issues, problems with co-workers

Domestic violence
Violence by spouse, emotional (name calling, character assassination, insults), financial, sexual (marital rape), physical (beating, kicking), property disputes, dowry

Sexual violence
Rape/molestation/sexual abuse, child sexual abuse, non-contact sexual abuse (exposure to pornographic literature, deliberate flashing of genitals, inappropriate undressing)

Learning difficulties or educational problems
Bullying/peer pressure: often dropping out of school or college/fearful of going to school, living alone or having few friends, change in sleeping/eating patterns

Maternal health
Stress due to pregnancy (due to complications, young age of mother, etc.),
stress/abuse due to giving birth to a woman, postpartum depression, fewer cases/cases of abortion pregnancy at age

Caste-based atrocities
Exploitation (physical, sexual, emotional, financial), manual scavenging, discrimination

Forced labour/bonded labour/migrant labour
Unemployment after rescue, abduction for human trafficking, migration, violence faced by individuals and family

Mental health issues due to gender and sexuality-related concerns
Coming out to parents/friends, lack of social acceptance, discrimination/exploitation, stress about life if they decide to live on their own

Sexual disorders
Lack of interest in sex, performance anxiety, erectile dysfunction, premature ejaculation, difficulty in achieving orgasm

Mental health issues arising due to concerns related to gender and sexuality
Coming out to parents/friends, lack of social acceptance, discrimination/exploitation, stress about the world
If they decide to live on their own

Workplace stress
Excessive workload, dissatisfaction with job profile, low pay, gender or caste based discrimination, sexual harassment at workplace.

Referral to professional counsellor

In the context of the work in Jan Sahas, Professional Counsellors are the counsellors that supervise and train field counsellors.

Using the following indicators, field counsellors can decide when to refer a case to a professional counsellor.

If you feel the counselee needs more help, or the field counsellor feels the counselee has not improved much or at all after several sessions, you may want to refer the case to a professional counsellor.

Thoughts

- Suicidal thoughts
- Lack of attention and concentration
- Staring into space for long periods of time and not being aware of what is happening in the present
- Demise: not being able to remember past events, forgetting to make tea, not being able to retain new information, forgetting important events and dates like date of birth, age etc.

Behaviour

- Substance use
- Frequent self-harm
- Suicidal attempts
- Extreme antisocial behaviour – aggression, hitting, kicking, anger outbursts
- Repetitive urges: The person is doing repetitive behaviours, repetitive behaviours are taking a lot of time

- The counsellee is not responding to anything/refusing to interact/too young to understand the meaning and importance of counselling
- Children – bed-wetting, stealing, running away, hitting, lack of speech, spending too much time alone, not going out to play with friends, not reaching out for help etc.
- After the sessions, the child is still showing clinical symptoms such as engaging in violent behaviour, night terrors, bed wetting, etc. and there is no improvement (which may be a sign of PTSD)

Emotion

- No improvement in mood
- The survivor experiences extreme anxiety, shortness of breath and fear
- The symptoms are interfering with their daily routine (not able to step out of the house/interact with people)
- Even after a few sessions, there is no reduction in irritation/anger in the individual
- The survivor finds it difficult to trust the counsellor (mostly seen in cases where the survivor is a victim of sexual abuse and the counsellor may be a male)

Other reasons

- The counsellor and counsellor are different, in terms of attitudes or how they understand or approach different issues, or different in terms of gender or community, and the difference it strong enough that it makes the counsellor or counsellor feel uncomfortable or hinders the counselling process. Eg:- a cousnellor may have difficulty working with abusive husbands, or a female counsellee may find a male cousnellor uncomfortable to share with, or a counselee might find that the counsellor has a very different lens of understanding.

Discussion: What do referrals mean to us?

- Why is it important for a counsellor to refer to some cases?
- Does referring cases to someone else mean that one is a 'worse' counsellor?
- Have you ever encountered cases that are probably better served by kinds of intervention outside your role or skill set?
- Do you think there are counsellors who might not be best suited to work with a particular counsellee? Do you think some cases are a better fit for you than others? Are there cases were a counsellor can be a bad-fit for a counsellee (be it due to some social reason like gender, or due to approaches)

Referrals to other professionals, outside Jan Sahas

Clinical psychologist

A clinical psychologist is a professional who provides counselling for most mental disorders and is also qualified to train different types of psychologists.

We will refer any counselee to a clinical psychologist in the following circumstances:-

(1) Psychological evaluation

- If the counselee is showing any weakness in his intelligence
- If the child coming for counselling is having difficulty in reading and writing

(2) Need for long term therapy

- The person needs long term therapy

Psychiatrist

This is a doctor who has done his specialisation in mental diseases.

We will refer any patient to a psychiatrist in the following circumstances:-

(1) Need for medicines – Sometimes we may come across cases where counselling alone is not enough to provide relief to the person and they also need medicines. Example – Feeling extremely depressed due to which the person's inner consciousness has become very weak, the person is seeing, hearing or feeling things which do not have any reality, the person is suddenly feeling a lot of energy due to which he is not able to sleep or is doing many things at the same time, fainting repeatedly or feeling pain in the body that has no biological cause

(2) Need for hospitalisation

- Repeated suicide attempts or self-harm
- Epilepsy
- Excessive substance use
- Person is extremely violent or at risk of harming others

Child psychologist/ psychiatrist

- Their work is similar to that of a clinical psychologist/psychiatrist, except that they work specifically with children and adolescents.
- They work on a variety of problems related to children, such as, working on low IQ, the impact of parental divorce or fighting, behavioural problems in school, etc.
- If any problem requires medication or hospitalisation, refer to a child psychiatrist

Psychiatric social worker

- Mental health workers work on the mental health of the person, as well as their social and economic problems.
- Along with working with the person coming for counselling, they also work on other factors that can hinder the mental health of the person such as poverty, social structure, etc.
- We will refer any advice to a mental social worker in the following situations: - If the person has social problems Need to know about needs or resources.
- If the person needs to enroll in a government scheme or needs to ask about a scheme.

Occupational therapist

- These professionals treat injured, ill or disabled patients through the therapeutic use of everyday activities. Also, they help patients develop, recover, improve as well as maintain skills needed for daily living and work.
- We will refer someone to an occupational therapist in the following situations: - Need for basic skills training - Helping in vocational rehabilitation of those who have severe mental illness.

Special Educator

A special educator is a professional who provides services using educational programs and equipment designed for students with low intelligence or giftedness. Students who require special educational approaches, equipment, or care for their mental abilities, physical abilities, emotional functioning, etc. - Example - Children who have difficulty in reading or writing or who have difficulty in studying in normal schools due to low intelligence, children who have difficulty in seeing, hearing or speaking and due to this reason they cannot study in normal schools.

Speech therapists

Speech therapists are professionals who are trained in the study of human communication, its development, and its disorders. They work on speech, language, cognitive-communication, and oral/playing/swallowing skills.
We will refer a person to a speech therapist in the following situations:
- Difficulty speaking
- Stuttering
- Mutism
- Changes in eating or swallowing
- Changes in cognition - The person is unable to recall previously learned words or is unable to understand someone else's words

Rehabilitation Centre/De-addiction Centre

A place where people live and need treatment for serious mental illnesses or substance abuse.

Usually people who are admitted here who are very violent, find it difficult to go about their daily routine or whose family cannot treat them at home for long.

Sometimes people have been using drugs in large quantities and for a long time, due to which they are unable to quit the drug on their own and hence they need outside help.

III

Understanding Mental Health

11 Sleep & Appetite

A word from the team

Patterns in sleep and appetite are often the most commonly observed physiological symptoms and behavioral signs that tie to mental health distress and common mental illnesses.

This topic is aimed at training barefoot counsellors to navigate these conversations. While there are strategies listed in this module, it is also worth mentioning that many common strategies can be difficult to make work in low resource settings. One way of navigating this challenge would be to explore the principles behind these listed strategies and find creative adaptations for them.

Sleep and mental health

Discussion: On Sleep

Why do you think sleep is necessary?
How do you think sleep affects your mental health, your emotions, thoughts and behaviours?

Sleep disturbances are found with mental health issues.
Sometimes the initial symptom of a serious mental health problem is unhealthy sleep.
Mental health problems become more serious due to unhealthy sleep.
Sleep problems can especially increase the risk of developing mental illnesses.
Sleep is essential for the physical development of the body, and it also helps in maintaining cognitive skills such as attention, learning, memory and emotional regulation.
Sleeping less also has a direct impact on our mental state. Our brain also gathers new energy during the time we sleep. But if the sleep is not complete, the brain is not refreshed, due to which many mental problems occur and sometimes memory related problems also occur.
Sleeping more than required is also not good for our mental health, it makes a person feel less energetic and tired, and also makes it difficult for the person to remember things.

Healthy sleep
Sleeping for 6-9 hours
Waking up feeling refreshed
Staying asleep once you fall asleep
Having a fixed time to sleep
Deep sleep and fewer dreams

Unhealthy sleep
Sleeping less than 6-9 hours or too much
Not feeling refreshed even after sleeping, feeling tired
Waking up from sleep frequently
Difficulty breathing during sleep
Waking up from sleep frequently in panic

Types and symptoms of poor sleep
Less sleep **(Quantity of Sleep)**
Difficulty falling asleep **(Quality of Sleep)**
Difficulty staying asleep
Waking up early

Not feeling rested upon waking up,
Feeling tired
Irritability
Lack of concentration on anything.
Sleeping too much
Sleeping more at night
Sleeping throughout the day
Sleeping at any time
Not feeling rested while napping
Talking, walking, making movements in sleep
Twitching of legs at night
Feeling tired during the day

Serious problems with sleep
Excessive difficulty in breathing during sleep - sudden breathing stoppage
Excessive sleepiness during the day, falling asleep suddenly
Waking up but not being able to move hands, legs, body for some time (this happens repeatedly)

How to ask about sleep disturbances
How many hours of sleep are you able to get?
How do you feel when you wake up in the morning? Do you feel fresh when you wake up in the morning?
Are you facing any problem or trouble while sleeping?
-----(If the answers to these questions indicate that the survivor has some sleep disorder, ask the following questions)
Do you get deep sleep or shallow sleep?
Do dreams disturb you?
Do you feel more sleepy during the day? Or do you sleep more during the day?
What is the environment around you while sleeping? (Quiet, dark, right temperature)
Do you snore a lot while sleeping? And do you wake up repeatedly at night due to breathing stopping?
Do you consume alcohol to sleep?

Sleep Hygiene

Some suggestions that can be given
Avoid taking long naps
Exercise regularly but avoid strenuous exercise close to bedtime
Maintain a regular routine

Do something relaxing at bedtime
Try to use the bed only for sleeping
Avoid looking at the clock repeatedly
Try to sleep only when you feel sleepy
Avoid using mobile phone or laptop
Avoid thrilling and suspenseful stories
Change your diet
Make your room comfortable
Listen to soothing music or sounds
Don't worry about not getting enough sleep

Ways to relax for better sleep

Write down whatever comes to mind and put it off until the next day
In a comfortable position, focus on breathing in and out, either deeply through the nose so that the stomach expands and exhale through the mouth so that the stomach moves in
Inhale through the nose for a count of 4; hold your breath for a count of 7; exhale through the mouth for a count of 8
Visualise a safe and comfortable place, image, or story using all senses and as many details as possible, or recall whatever calms you down
If your thoughts wander, gently bring your attention back to your breathing

Strategies for better sleep

Do:
At least 10 minutes of walking, cycling, exercise, yoga or any other form of physical activity
Follow a fixed routine for sleeping and waking up
Make sure the sleep environment is pleasant like a quiet atmosphere, darkness, comfortable pillows, etc.
Go to sleep when you are really tired.
If you find it difficult to sleep, get up and do something relaxing, like reading or listening to music until you are tired enough to sleep.
Drink moderate amounts of fluids at night.
Get some sunlight exposure in the morning.
Limit daytime sleep to 20-30 minutes and try to get up before 5 pm.
Have dinner several hours before bedtime and avoid heavy foods that can cause indigestion before bedtime.
Visualisation and counting techniques.

Don'ts:
Avoid coffee, tea, chocolate, cola, tobacco and alcohol a few hours before bedtime.

Avoid emotionally upsetting or stressful conversations and activities before trying to sleep.
Don't check the time repeatedly while trying to sleep or when you wake up in the middle of the night.
Try to minimise the use of mobile, TV or laptop before bedtime

Discussion: Adapting to context

Do you think these strategies are feasible/sensitive to your field context? The group may also discuss other solutions that are more relevant to their respective context.

Appetite and mental health

Appetite disturbances are a symptom of many mental health problems
Appetite disturbances are often the first signs of a problem

Loss of appetite or no desire to eat
Very little appetite, eating less food
No desire to eat despite being hungry
Lack of interest in eating favourite food, no enjoyment
Sudden excess loss of body weight
Excessive hunger
Sudden increase in appetite, eating too much
Desire to eat despite not feeling hungry
Sudden excess increase in body weight

Serious problems with appetite

Extreme concern about food intake and body weight and shape
Vomiting after eating
Having multiple episodes of eating large amounts of food in a short period of time

How to ask about appetite disturbances

How is your appetite?
Do you feel like eating?
Is there any change in your appetite and eating pattern compared to before?
Do you feel interested in eating your favourite food? Do you enjoy it?

Some tips if there is reduced appetite

Have a set meal schedule
Eat easy-to-eat, nutrient-rich foods
Make meals fun, such as eating with family or friends, going out to eat, or watching TV while eating

Eat small meals often and increase portion sizes over time
Eat favourite foods

Some tips if there is increased appetite

Identify when and why you are eating
Ask yourself if you are really hungry.
Notice feelings before and after eating, such as feeling empty, guilty
Replace unhealthy snacks with healthy ones
When you know you are not hungry but are feeling something else (such as anxiety, depression, etc.) talk to someone to lighten your mood, or acknowledge their hunger and negotiate some behaviours to be put in place, with a ("I understand that you might not be hungry, but isn't it important to also make sure that your body and health are somewhat taken care of? Can we figure out and agree on how long you might skip meals before you eat something, even if you're hungry?)

Working with family to help with sleep and appetite

In the contexts that we work in, when it comes to issues with sleep and appetite, families, friends, caretakers are resourceful with whom solutions may be explored together.

Activity: Roleplay and Discussion

Shalini is a 43 year old woman who used to work as a domestic help in her village. A few months ago, her husband met with an accident and died. Shalini's daughter had approached you to seek help, letting you know that her mother was having trouble sleeping. She also let you know that her mother hasn't been eating regularly, and hasn't been going to work for some time.

The facilitator may ask 3 volunteers to come forth, and play out a session of when the counsellor meets with Shalini.

The facilitator may also particularly take note of the context characterised by the role-play, and the interventions suggested by the counsellor. After the role-play, the characters may be asked of their experience playing the characters, and the challenges and reflections they want to share. Following this, the whole group of participants alongside the facilitator and the volunteers, will discuss their reflections and notes.

It is also important here that the interventions that may be suggested

and their relevance be examined with the context presented by the case (or by the contexts from the field realities). This discussion may also serve as a point to discuss with all the participants on the kind of interventions they would suggest and discuss their thought processes.

The objective behind the roleplay is to also highlight that, while the interventions suggested in the topic's content may have varying degree of relevance and that counsellors have to recognise their capability and necessity to be flexible in creatively adapting the essence of these interventions into the reality of the context.

12 Trauma

A word from the team

Trauma is often a pervasive factor in the lives in the context of working with women and marginalized communities who often face violence and discrimination as they navigate through their daily life. Recognizing and working with survivors of violence and those living through trauma requires sensitivity, presence and a thorough understanding of trauma.

This topic first aims to introduce the concept of trauma, what it is, some of its common causes, and how people's responses are shaped by trauma and later goes into what some principles of trauma informed practice are like.

Understanding the concept of Trauma

What is trauma?

- Trauma is the response to a deeply distressing or disturbing event.
- It overwhelms an individual's ability to cope.
- It causes feelings of helplessness, diminishes their sense of self and their ability to feel the full range of emotions and experiences.

Difference between distress and trauma

- Trauma is a sudden event that changes the way one perceives the world. A traumatic event is often life-threatening.

Stress, on the other hand, is a reaction to less dramatic and often daily events that are perceived as threatening such as a job interview, deadlines, finances, or worries related to an ongoing security situation.

- Traumatic experiences are always stressful, but stressors are not always traumatic.
- What might seem like mild ordinary stressors of everyday life, may bring about an avalanche of emotions and functional impairment because their coping resources are already maxed out.
- The difference between stress and trauma is similar to the difference between feelings of sadness and deep depression.

Causes of trauma

- War
- Natural disaster
- Personal assault
- Severe illness or injury
- Sudden death of a loved one.
- Witnessing the act of violence.

Note:

- Trauma varies quite dramatically from person to person. It is very subjective and is defined more by its response than its trigger. It is caused not just by the event but by one's reaction to it.
- Trauma can be caused to workers who work with individuals going through trauma. The organisation that we work in can make us vulnerable to suffer from it because we listen to the counselees with empathy that can generate feeling, and seeing oneself in their trauma may put us at the risk for developing trauma so if one of us feels that they are experiencing any symptoms then seeking help is very important.

Trauma caused due to natural disasters:

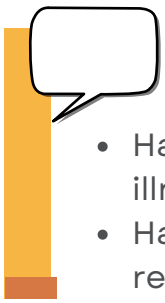
Uttarakhand Floods

- In 2013, floods swept through the state of Uttarakhand destroying anything and everything in its wake, around 5,000 people died in the floods.
- What do you think were some behaviour and emotional changes that people who saw deaths around them and lost relatives and homes experienced?

Emotional problems that can be displayed by people-

- The most immediate and typical reaction to a calamity is shock, which leads to numbness or denial. Then, shock can cause an overly emotional state that often includes high levels of anxiety, guilt or depression.
- They may feel helpless, they may have to live in camps or shelters without support from relatives or friends for extended time periods.
- Natural disasters in particular can bring victims a feeling of being betrayed by "their god," which can result in a loss of faith.
- These types of experiences are dangerous because they tend to traumatise large populations of people at once.

Trauma caused due to severe illness or injury:



Discussion

- Have you ever been in an accident or got news of a life changing illness? How did it affect you?
- Have you ever experienced getting news of severe illness in a close relative or sudden passing of a close person? Share experience.

Examples:

- Individuals receiving painful or invasive medical procedures.
- Long-term treatment as a result of chronic illness, accidents, or injuries.
- Sudden accident causing loss of bodily functions.
- Watching a close one going through a life threatening disease.

Emotional problems that can be displayed by people-

- For many people living with chronic illness, during interactions with doctors and hospitals they re-experience the pain even if they get well. For them, driving by the hospital may cause panic; the prospect of both testing and treatment procedures creates tremendous anxiety.

- The financial toll of paying for treatment can also cause panic.
- People also face job loss and they might feel helpless during these situations.
- Navigating relationships when others don't understand what the person is going through, can have a big impact too.

Vicarious Trauma

Primary trauma is an event or situation that is experienced as threatening to one's life and overwhelms the ability to cope with the intense negative feelings experienced at the time.

Complex childhood trauma can occur when children suffer from repeated relational trauma such as physical, emotional or sexual abuse; neglect; and family or interpersonal violence. Complex trauma refers to the cumulative effects of repeated traumas during a child's development.

Secondary traumatic stress is the emotional duress that results when an individual hears about the first hand trauma experiences of another.

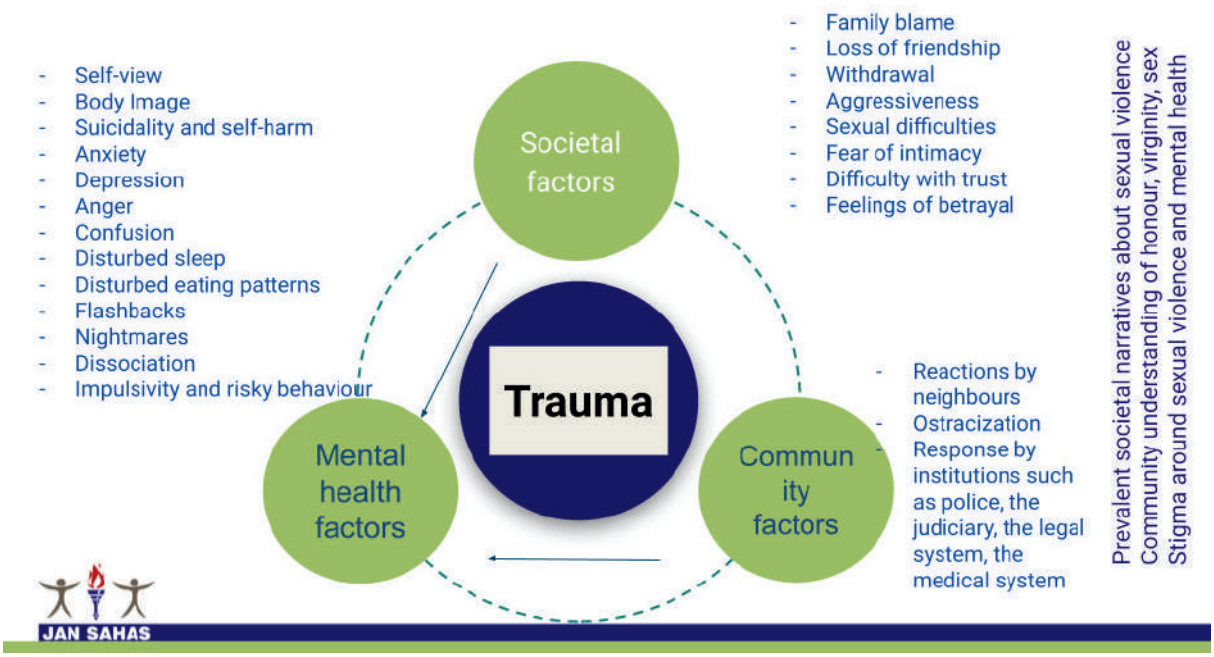
- It is caused when people/ counsellors hear trauma stories and become witnesses to the pain, fear, and terror that survivors have endured.
- This can lead to self-sacrificing behaviours. There is a line between helping survivors who seek counselling and becoming over involved with them. The opposite can also occur.
- Sometimes practitioners begin to disengage from those they see due to the level of trauma and this is a defence mechanism. This can occur for a period of time which can lead to vicarious trauma.

Trauma in survivors of sexual violence

- Abuse can impact every area of life- social abilities, self-beliefs, career potential and relationships too.

- Each person's reaction to trauma experienced will be unique and it will also depend on many factors including the type of trauma experienced.

- Some things that must be considered while looking at Trauma-
  - How often the counselee was abused.
  - For what duration.
  - Counselee's relationship to the abuser



How do survivors protect themselves?

- Survivors of sexual abuse go through physical and psychological reactions and even if responses to the trauma are unpleasant or hurtful, they are designed to protect them.
- For example- the function of the immune system is designed to fight any viruses or bacteria and to keep the body healthy. So, the emotional immune system works the same, it is designed to protect the individual from emotional turmoil.
- How do you think do they cope up with the trauma?

Freeze Response

- When someone has overpowered the survivor, it heightens their sense of vulnerability.
- Freezing can protect them from experiencing the full physical pain. Survivors mention feeling a sense of calmness washing over them, even numbing the body.
- Freeze response protects the person from an even worse threat of brutality. However, in the individual's mind, they may feel that they gave in, and that by doing so, they were passive and perhaps, even to blame.
- When an adult faces an impossible abusive situation, submitting to the situation (freezing) may be the only option for them.

Avoidance

- Avoiding thoughts, feelings or distressing memories, avoidance of external reminders i.e. conversations, activities, places, people or objects and avoidance of any feelings interconnected with the traumatic event.
- It prevents them from going to certain places, or to indulge in certain activities, they may even feel the need to avoid certain people. They can easily become very isolated.
- If a counselee tells you they watch a lot of television, or they work hard and for long hours, or, they say they suffer from compulsive behaviours, they may be practising avoidance which is a method of escape.
- They may turn to alcohol or drugs, some indulge with food or self-harming.

Dissociation

- Dissociation can be a mental flight which occurs because physical flight is just not possible.
- This is an adaptive response when trauma is deemed inescapable. It provides a barrier of the mind and this enables the individual to detach from anybody's sensations, feelings or, indeed, reality.

Memory Problems

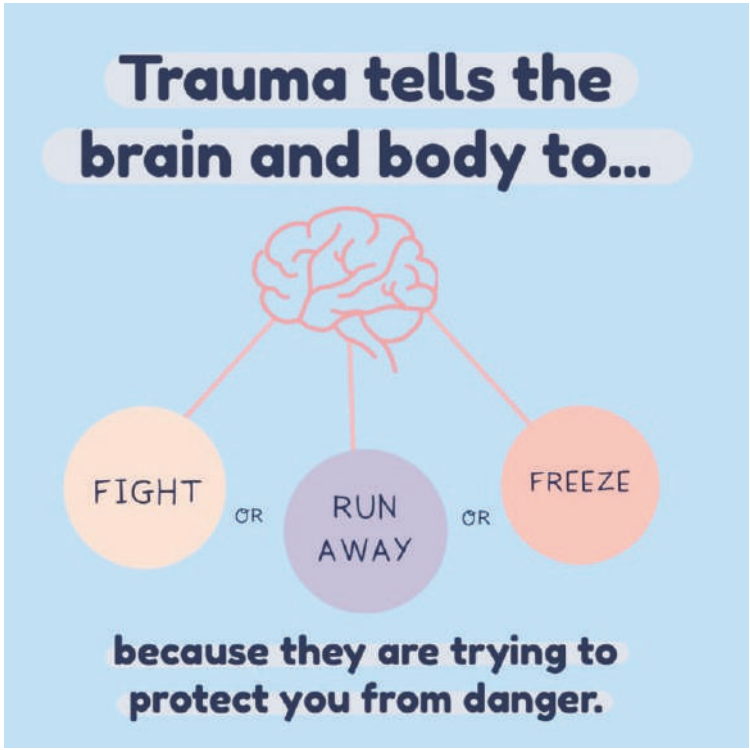
- Memories can be so distressing that survivors will instinctively want to avoid them, but this only makes them even more frightening to deal with.
- Sometimes these memories are suppressed by the survivors but sooner or later they will still rise to the surface.
- People go into an almost trancelike state. Due to this sense of detachment and feeling of numbness, it can be very difficult for the individual to reflect upon those experiences, to process them, or even to feel a sense of compassion for others, let alone themselves.

How do survivors protect themselves:

- These responses cannot prevent emotional pain, trauma or stressors from occurring, but it can soften the blow and enable the individual to deal with the outcome.
- Emotional immune system occurs outside of conscious awareness. It is not under the person's control. So, counsellors should help the survivors understand that their reactions would have been caused

out of conscious control. So, they are not to blame in any way for how they responded.

Common Symptoms of Trauma



Physical Symptoms:

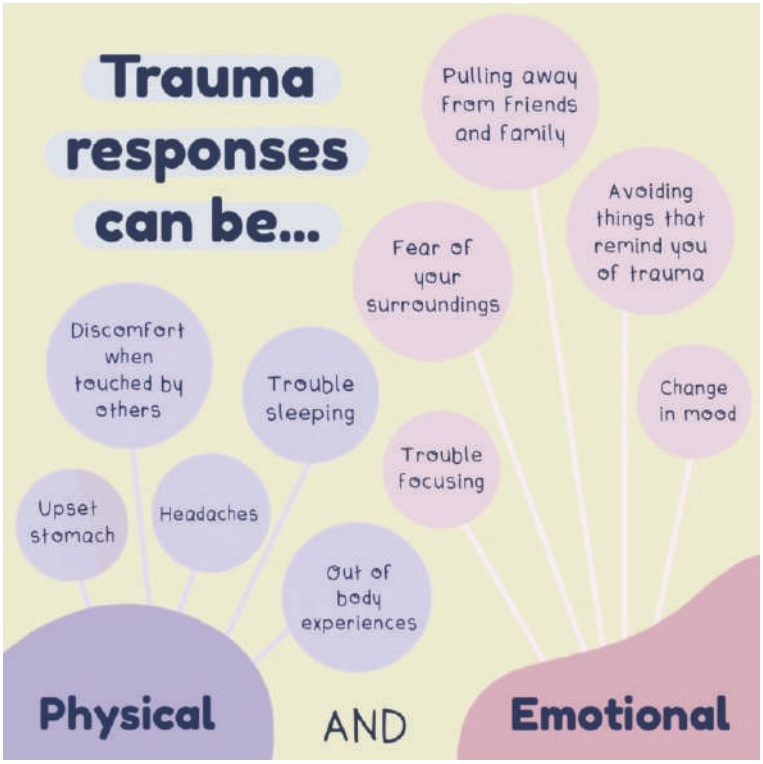
- Physical exhaustion, sleep impairment and respiratory issues and digestion. Hypertension can also be experienced.
- The stress response can even reduce the person's immunity.
- People after trauma may feel psychosomatic symptoms like stomach ache, or a burning sensation.
- They may also not feel like eating and sleeping or even have breathing problems.

Hyperarousal:

- These occur because the experience has not been processed fully.
- The individual finds themselves sweating, or, experiencing muscular tension and their heart will start to pound and breathing, becomes rapid.
- Traumatised person may adopt the same posture and mechanisms used during the traumatic experience.
- Sensory stimuli including images, touch, taste, smell, sight and sound can trigger flashbacks.

Nightmare

- During the dream stage, scenarios unfold so to sort through the trauma, and in many ways, this can be worse for the person. During sleep, the coping strategies that exist go offline and this makes it harder to manage the traumas that occur within the nightmares.
- If the traumas remain unprocessed, these are going to simply keep recurring leading to that individual being unable to sleep.
- It can be useful for those who are suffering from nightmares relating to the traumas, to keep a dream diary and this helps the processing of the trauma while improving overall sleep patterns.



How does Trauma affect relationships?

Traumatic events deeply challenge:

- Sense of safety and security in the world- anxious or frightened in relation to others, experience them as having power or control, or easily feel abandoned or rejected.
- Confidence in the future- isolate from others, withdrawing, feeling distant, disconnected, or detached.
- The way they understand the meaning of life.
- The way they think and feel about themselves- feel intense shame, unlovable or bad in some way, or guilty
- Expectations of danger, betrayal, or potential harm.
- Survivors may feel vulnerable and confused about what is safe, and therefore it may be difficult to trust others, even those whom they trusted in the past.
- People may feel angry at their helplessness and the loss of control in their lives, and become aggressive or try to control others.
- Anger and aggression may also arise because, after traumatic experiences, a person may feel threatened very easily.
- may worry that it is a burden to discuss these experiences.
- may become overprotective or dependent. May feel emotionally numb and have trouble feeling or expressing positive emotions in a relationship.

Trauma Informed Care

Discussion

- When we talk about trauma, what is the image we get in mind about the person?
- What are your thoughts and feelings about Trauma-survivors?

Trauma doesn't look like one thing always, sometimes even within the different stories of the person

Discussion: Trauma - Psychological illness OR a response to what is wrong around me?

- How would it feel to live in a constant state of "danger"?
- What happens to your decision making ?
- Were you surprised to learn that trauma can change a person's underlying neurological makeup (normal response of the brain)?
- When we talk of trauma, are we saying that 'the person needs to recover from it?'

- We build a comprehensive understanding of the life situations and life stories (that includes stories of healing, strength) that the person and family has experienced. Do we also include aspects of social injustice in our understanding of trauma?
- Therefore, when we say trauma, where do we locate the problem?
- In the person or collective responsibility of the community/society?

Principles of Trauma-Informed Care

1. Trustworthiness - Introducing yourself (name) and the kind of work you do in the organisation for more clarity and power sharing with those requiring the organisation's service. Taking regular follow ups. If a date is given to a survivor then reach out to them at a decided time from your end.
2. Transparency - of the kind of services provided by you or the organisation, not giving false hopes. Taking informed consent.

3. Safety - Physical and emotional safety, experienced boundary violations and abuse of power, and may be in unsafe relationships (vulnerable to see danger)
Asking if they are feeling safe, if they want to share, confidentiality.
Feeling of safety is closely associated to trustworthiness and transparency
4. Collaboration & mutuality - (Who has the power in the session)- Trauma-informed services create safe environments that foster a client's sense of efficacy, curiosity, self-determination, dignity and personal control. Service providers try to communicate openly, equalise power imbalances in relationships, allow the expression of feelings without fear of judgement, provide choices as to treatment preferences, and work collaboratively.
5. Empowerment & choice - Strength focused, building their capacities, looking into peer support
6. Cultural, historical & gender issues - but move beyond stereotypes.

Qualities and characteristics essential to working with people affected by trauma

- Empathy and not sympathy (Samaanubhuti vs sahanubhuti) - (To break the invisible barrier between you and the survivor that arises from a number of reasons like different life experiences, education, employment, family support etc., empathy is important. Feeling of pity gives rise to power imbalance, lets one get away with not understanding the survivor, and creates an 'us vs them' feeling. On the other hand, empathy helps in staying grounded, understanding not just other's experiences but also understanding how that impacts our lives. Empathy also provides one with the humility to accept that we do not understand everything every time) - Give example: how when a tree grows, we see leaves, grown branches, fruits etc. We are unable to see the everyday progress of a tree growing. Empathy works in a similar fashion. It is everyday work and not a switch on/off mode.

- Compassion (karuna) "Feeling the suffering of others with a felt desire to help." In other words, the helper feels a sense of equality and common humanity with the suffering of another.

- Able to Talk Openly Ability to engage a survivor in a conversation regarding their experiences can initiate healing. If you show discomfort through actions or words, survivors would think you don't want to hear their story.

- Self-Aware (emotional intelligence) (What are my beliefs, values? Do I have a history of traumatic experiences? Have I been experiencing or experienced desensitisation that makes it difficult for me to empathise and connect to my own feelings etc)- here, emphasise the importance of supervision by a professional counsellor.

- Self-Care and Wellness (It is important to remember that our health is in our own hands and under our control. In our work when we deal with mostly cases that are not within our control, it is important to take care of our physical and mental health. This helps in avoiding burnout and attending to survivors with more authenticity)

- Flexible (While working with survivors, it is important to show flexibility sometimes for their comfort. That may include scheduling intake sessions and follow-ups as per their time suitability.)

- Comfortable with the Unknown (It is not possible to completely relate to a survivor's experience every time. Therefore, it is important to remain open to possibilities of new learnings overtime)

- Willingness to Learn from survivors (we are not the expert of survivor's life and experiences)

Repositioning the person who experienced trauma

Discuss the following scenarios and think of appropriate and inappropriate responses based on what we have learnt so far:

Scenario 1

A young woman discloses that she was sexually assaulted a few months ago. She goes on at length about the situation, asks for your advice, and says that she feels she needs to work on the impacts she is only now acknowledging. She says she feels comfortable talking with you.

Appropriate response:

Acknowledging the feelings and courage it takes to disclose trauma is important, but it is not necessary for you to counsel people if it falls outside the realm of your role. A more appropriate response is to refer them to the service that is right for them and their situation, and that they are willing to use. For example, you could say, "This is a hard time for you, and I thank you for sharing this with me. Sounds like you have a lot to talk about and I'm wondering if counselling is an option for you right now?" It would be important to highlight the trust the client has shown in sharing this information with you, and to encourage them to "trust" you further in making a recommendation for a referral to another counsellor.

Inappropriate response:
Shutting a person down by cutting off the contact: "I'm not a counsellor, so I can't help you, but here's the number for some services." Or conversely, trying to provide counselling that is outside your role: "I'm not a counsellor, but I can try and give you the best advice I can."

Scenario 2
You are speaking with a man in his mid-40s who says his childhood was really hard, and that he lived in fear of his father for most of it. You ask him if his father abused (durvyavhar) him, and his reply is, "Yeah, he was really mean and he'd let you know with his fists when he was angry. He also knew how to take it to the next level of humiliation in my room at night." You feel he is referring to sexual abuse.

Appropriate response:
Acknowledge his reference to sexual abuse and validate the experience. For example, "You described physical abuse by your dad, and I know abuse can often be sexual, too. Is that what you mean by the humiliation in your room?" The man says, "Yeah, he did stuff to me and I hated it, and I never told anyone about it because I was afraid they'd think it was my fault and I was gay." Responding to this appropriately would allow you to invite the man to acknowledge the harsh judgments as a societal myth. For example, "Abuse is never the fault of the child; you were in a situation where you had no choices. Sexual abuse cannot make you gay because it is used as a weapon, but society sure seems to send us that message. It's not easy to talk about this stuff. I appreciate your sharing it with me."

Scenario 3
You are speaking with a woman whose emotions of panic, anxiety and hopelessness are very strong. She seems overwhelmed, distracted, and in need of immediate help. She states that she's been bombarded with memories and flashbacks recently, has missed work, is crying a lot, and isn't really feeling she's in reality. She needs help now.

Appropriate response:
Acknowledge her feelings and fears and assess her current situation as someone who is in crisis and having difficulty containing her emotions and dealing with daily functioning. This individual is not physically or mentally able to function properly, so asking about the trauma may exacerbate the situation by adding to her inability to cope. Instead, you could ask, "How can I help you now? What needs to happen to help you feel more under control now?" Also, "Let's take some deep breaths together." Panic and anxiety can often be reduced by intentional deep breathing.

Important aspects of trauma recovery

- Safety and stabilisation
- Remembrance and mourning
- Reconnection

Themes of trauma exposure response

- Feeling hopeless and helpless
- A sense that one can never do enough
- Hypervigilance
- Diminished creativity
- Inability to embrace complexity (black and white, right and wrong, "us" and "them" thinking)
- Minimising
- Chronic exhaustion/physical ailments
- Inability to listen/deliberate avoidance
- Dissociative moments
- Sense of persecution
- Guilt
- Fear
- Anger and cynicism (negative thinking)
- Inability to empathise
- Addictions
- Grandiosity

Emergency Self Care Worksheet

1. Make a list of what you can do when you are upset that will be good for you. a. What will help me relax?
2. Make a list of people you can contact if you need support or distraction.
3.Next, make a list of positive things to say to yourself when you are giving yourself a hard time.
4. Next, make a list of who and what to avoid when you are having a hard time.

Subordinate storyline development

- Responses to trauma are founded upon what people give value to.
- People are not passive recipients of trauma.
- Responses to trauma are rarely recognised or acknowledged.
- Focus on how we could decrease the sense of vulnerability and increase the sense of agency in survivors?

13 Depression

A word from the team

This topic aims to help field counsellors identify signs and symptoms of depression as well as provide them with some strategies to help counsellors manage symptoms.

While this remains the aim of the topic, it must also come with the acknowledgement that there are different situations and different lenses that view and work with depression in a variety of ways, that might not focus on episodic symptom management [like a trauma informed lens]. Choosing what works best requires thoughtful sensitivity to the context one is working in.

Discussion

- What is the first thought that comes to your mind when you hear the name of depression?
- What is depression called in your local language?
- What is talked about around you regarding depression?

Introduction

It is a mental health disorder that causes persistent sadness, loss of interest in work and significant impairment in daily life.
Depression is a common condition.
One in ten people are affected by depression.
Depression is more common in women than in men.
This condition can affect anyone.

Activity

Rajni is a 24-year-old student who is currently completing her college studies. She spends the whole day in classes and tries to get all her work done on time. She also goes out with her friends in the evening after work, but for the last few months she comes home every night and cries a lot. She is unable to understand what is the reason for this. In her childhood, Rajni has often seen her mother crying and sitting dejected like this. Rajni tries to keep herself busy with work and other things even on difficult days, but sometimes it overwhelms her.

Discussion

What is happening here?
What are the problems she seems to be facing?
What are the symptoms that are causing him problems?

Symptoms of depression

Thoughts

- Low self-esteem
- Hopelessness
- Worthlessness
- Helplessness
- Suicidal thoughts and attempts

Emotions

- Persistent depressed mood.
- Significantly decreased interest in, or pleasure of activities
- Feelings of guilt
- Irritability

Behavioural signs

- Reduced social contact or being alone
- Inability to concentrate on work
- Difficulty in making decisions
- Feeling like crying frequently
- Physical symptoms
- Pain throughout the body that has no apparent cause
- Weakness, fatigue
- Sleep problems (too much or too little)
- Significant change in appetite or weight (weight gain or loss)

The main symptoms of depression

Persistent depressed mood.
Significantly decreased interest in, or pleasure of, activities.
Symptoms must last for at least two weeks.

Physical illnesses and depression

It has been observed that some physical diseases can also cause symptoms like depression
Anemia
Vitamin B-12 deficiency
Vitamin D deficiency
Thyroid
Serious diseases - Cancer, HIV

Discussion

Can you tell me what the causes of depression could be?

Causes of depression

A sad or distressing event in our lives, such as the death of a loved one, divorce, or loss of a job, can trigger depression.
Physical illness can also cause depression.
Regular and excessive consumption of alcohol.
Biological factors may contribute to a person developing depression, such as a person with a family history of depression.

Certain social factors such as caste, economic status, gender, being uneducated, etc. increase the risk of depression in excluded and disadvantaged communities.

Diasthesis stress model

How to help someone with depression manage symptoms

- *Reach out to people and stay connected*
- *Do things that make you feel good*
- *Keep your body moving*
- *Eat a healthy diet*
- *Challenge negative thinking*
- *Seek professional help for depression*

Reach out to people and stay connected

- Try to spend time with people who make you feel safe and care about you.
- Try to keep yourself busy with social activities.
- Try to spend face-to-face time instead of on the phone.
- Try to help others, which may make you feel good.

Do things that make you feel good

- Spend some time in nature
- Make a list of what you like about yourself
- Read a good book
- Watch a funny movie or TV show
- Try to keep yourself busy with small activities
- Play with a pet
- Connect with friends or family
- Listen to music

Keep your body moving

- Do housework
- Clean your room
- Take a walk
- Exercise (start with 5 minutes a day)

- Join an exercise partner
- Play with kids
- Practice yoga/meditation

Eat a healthy diet

Eat regular and timely meals.
Boost your diet with B vitamins - Deficiency of B vitamins like folic acid and B-12 can trigger depression.
Limit substance abuse.
Eat nutritious food that is rich in carbohydrates as well as proteins and minerals, such as cereals, eggs, milk, yogurt, cottage cheese, green vegetables (beans, spinach, peas, fenugreek etc.) and seasonal fruits.

Challenge negative thinking

"What would indicate that my thought is true? Not true?"
"What would I say to my friend if she were thinking this way?"
"Is there another way to look at this situation?"
"How would I look at this situation if I didn't have depression?"
In the process, you will develop a more balanced perspective and help relieve negative thinking.

Seek professional help for depression

If you've taken self-help steps and made positive lifestyle changes and still find your depression worsening, seek professional help.

14 Psychoeducation

A word from the team

This topic introduces psychoeducation, establishes its importance in the counselling process, specifically one that is trauma-informed and client-centric, and lists some ways to practise it with clients and families.

Families play a significant role in the mental health and process of care in the context of India. Navigating families as well as unhelpful and myths and stigma surrounding mental health

The importance of psychoeducation

This education helps a person understand and deal with life's challenges. This education helps a person recognize his or her strengths and internal and external resources, which makes a person feel in control and can take better care of his or her mental health.

When a person has the right information and awareness about his or her mental condition or mental illness, instead of feeling crazy or ashamed of it, they understand that they can get better with the right treatment and effort and that it is completely normal to feel this way.

When family members of the counselee participate in psychoeducation, the counselee is more likely to receive better support from the family during treatment, which helps the counselee to get better.

Through psychoeducation, we are able to eliminate the false myths about mental health in society or the stigma attached to it, such education increases the acceptance of people struggling with these problems in society.

Psychoeducation can help in social progress of an individual, which gives the individual opportunities for better employment and building better relationships in society in life.

Psychoeducation can be helpful in reducing stress. For example, several studies have shown that providing a person with the right knowledge or information about depression and its treatments increases their chances of recovering from depression and also reduces the psychosocial burden on their family.

The importance of psycho-education for trauma survivors

Psychoeducation in this context has come to be understood as providing accurate information about the nature of the trauma and its effects, and assisting in integrating both the new information and any effects it produces into the survivor's perspective.
The rationale in this application is that many survivors of interpersonal violence are traumatized in a context of extreme emotions, forced dissociation of attention, and – sometimes – early cognitive development at the time of the trauma.

All of these factors, as well as the traumatic presence of a powerful

figure distorting objective reality – serve to undermine the accuracy and coherence of the survivor's understanding of the traumatic event.

Trauma symptoms
Shock or disbelief.
Anger, irritability, mood swings.
Guilt, shame, self-blame.
Feeling sad or helpless.
Numbness
Confusion, trouble concentrating.
Agitation and fear.
Isolation from people.
Apathy
Denial
Digestive symptoms

Types of psychoeducation

Individual psychoeducation:
In individual psychoeducation, we provide information and knowledge directly to the individual about their mental health problems/illnesses, this information is given based on the individual's condition.
To understand the person's condition, we can provide psychoeducation keeping in mind factors such as their conceptual and emotional capacity, their illness, disability, treatment and their prognosis.
This psychoeducation ensures confidentiality and safety as sometimes the person may feel uncomfortable in front of the group and family members.
Sometimes this psychoeducation can also be given during the counselling process when the person asks questions about his/her condition.

Psychoeducation for parents: Psychoeducation is not only helpful for the individual or the counselee but also for their family, it can reduce the ongoing tensions in the family, and can help in establishing better relationships among them.
It can help in reducing feelings like unfair expectations, criticism, hostility, stress among family members.
It can bring cooperation among family members, in coping with challenges, social competence, day-to-day household chores, and in the family to follow the treatment properly.
Psychoeducation can bring better results at the family level because in it, through deep dialogue and discussion with all the family members, they can increase awareness and sensitivity towards their own and other family members' mental health and emotions.

Psychoeducation for a group:

Group psychoeducation is given to a specific group. It is given to a group of people who share a common experience, identity or are facing common mental health problems.

Such as women suffering from the trauma of sexual violence, children from marginalized communities, youth or women, groups of people suffering from common mental illnesses, young bonded laborers, etc.

Group psychoeducation helps to deal with social misconceptions, shame and stigma associated with mental illness.

In such groups, individuals feel that they are not alone, and can share their experiences, problems, thoughts, and feelings without worrying about how others will react.

All members of such groups receive mutual support, encouragement, and guidance under the supervision of mental health professionals.

Studies on this subject show that group psychoeducation promotes positive emotions, a sense of acceptance, and better mental health among its members.

What topics can psychoeducation be provided in the context of our work?

Information to the family and counsellee about counselling and its importance.

Information to the family and counsellee about what stress is, its effects and ways to handle it.

Information to the family and counsellee about problems in sleep and appetite.

Information for family and counsellee about the effects of trauma.

About mental health

About depression and anxiety

About suicide risk

About the mental health effects of bonded labour and migration.

About how to deal sensitively with mental health problems of family counselees.

About mental illnesses and their treatment.

About the mental health effects and symptoms of sexual/domestic violence.

Psychoeducation about a serious mental health problem:

Make people aware of the causes, effects and possible treatments for mental illness.

Remember that when the mental illness is long-standing and severe, priority should be given to the person for medication and treatment by a psychiatrist.

Encourage them to get treatment for the illness along with medicine and prayers.
Encourage them to take the medication on time (the medication may have to be taken for a long time) and to get regular follow-up from a psychiatrist.

Psychoeducation about everyday mental health problems:
About the importance of mental health
About daily routine and exercise
About feelings like fear, worry, anxiety, sleep, stress, depression etc.
About self-care and setting healthy boundaries.
Some things to keep in mind in the context of psychoeducation
Psychoeducation is a continuous process. (It should not be done just once)
Psychoeducation can be given more than once if needed.
Psychoeducation is not always verbal, sometimes we also use fact sheets, brochures, pamphlets, books or videos.
If you feel that your education is lacking in any subject, then avoid giving information about such a topic to the counselee, refer to reading if needed.
The psychoeducation provider (mental health professional) should always keep improving his knowledge and skills about the subject of mental health to provide proper psychoeducation.

Activity: Role play

3 Participants may be chosen to come forward - one of whom is a counsellee, Meera a 20 year old woman, accompanied by her mother. They report that the counselee seems to be exhausted and extremely sad and hasn't been able to work for over the past month. She says she wishes that she wasn't so sad and weak. Her mother also wishes that her child recovers quickly.

The third participant will play the role of the counsellor. The role-play will play out how the counsellor may use psychoeducation with Meera and her mother to help Meera.

15 Suicide & Self harm

A word from the team

Conversations on suicide and, suciidality and self harm can feel heavy and difficult for cousellors. It is important to also recognize this discomfort as well as how this discomfort may shape a counselling sessions and how we choose to respond to suicidality.

This topic aims to equip field counsellors with the ability to manage cases where suicidal ideation or self harm are reported, and assess the risk of suicide, so that safety plans maybe developed.

What is self harm and suicide?

Suicide is the act of intentionally killing oneself
Self-harm is a broad term that means intentionally poisoning or injuring oneself, which may or may not have a dangerous intent or consequence.

Why do people attempt suicide?

- Hopelessness, helplessness and worthlessness- due to any event in life such as a breakup, academic pressure, violence, critical environment at home/ upbringing
- Trauma
- Mental illness
- Substance use and impulsivity
- Loss or fear of loss

When should we talk about self harm and suicide?

- Severe depression and sadness
- Current or past thoughts or plans for suicide/self-harm
- Self-harm by poison or excessive intoxication
- Bleeding from a self-inflicted wound
- Loss of consciousness/unconsciousness (hosh na hona/ behosh)
- Extreme drowsiness (bohot zyada susthi)

What needs to be done- Assessment-Management-Follow up

First checkpoint: Has the person attempted to harm themselves seriously enough to require treatment?

Find out if there are signs/symptoms of self-harm or other symptoms that need immediate treatment:

- Self-harm due to poisoning or intoxication
- Bleeding from self-inflicted wounds
- Unconsciousness
- Extreme drowsiness

If yes, how to manage?
1. Keep the person in a safe and supportive environment in a hospital.
2. Do not leave the person alone.
3. If the person has consumed pesticides or poison, take him to the doctor immediately.
4. If admitted to the hospital, always keep the person under observation to prevent suicide.
5. Provide care to the person who is self-harming.
6. Provide psychosocial intervention.
7. Support caregivers.
8. Consult a mental health specialist, if available.
9. Maintain regular contact and follow-up.

5. Provide care to the person who is self-harming.
1. Place the person in a safe and supportive environment in a hospital setting and do not leave the person alone. If the person must wait for treatment, provide a stress-free environment; if possible, place a staff or family member in a separate, quiet room to monitor the person to ensure safety at all times.
2. Remove any items from the person's vicinity that could pose a risk of self-harm.
3. Consult a mental health professional, if available.
4. Gather family, friends or other community members who know the person to support them when they are most at risk of self-harm.
5. Give the person the same respect, care and privacy that everyone deserves. Be sensitive to the person's reasons for self-harm.
6. Involve carers in treatment if the person wishes.
7. Provide emotional support to carers/family members when needed.
8. Ensure that care is always available.

6. Psychosocial intervention
- Provide support to the person
  - Find and talk about reasons and ways to keep going.
  - Focus on the person's strengths by encouraging them to talk about how they have dealt with problems in the past.
  - Focus on the current situation and hope for the future.
- Provide psychosocial support
  - Mobilize family, friends, relatives and other available resources to ensure close monitoring of the individual as long as the risk of self-harm/suicide persists.
  - Advise the individual and caregivers to restrict access to means of self-harm/suicide (e.g., pesticides/poisons, prescription drugs, firearms, etc.) as long as the individual has thoughts or plans of self-harm/suicide.

- Utilize available community resources. These include informal resources, such as relatives, friends, acquaintances, co-workers and religious leaders, or formal community resources, if available, such as suicide helplines and local mental health centers.

7. Support to Caregivers

- Tell caregivers and family members that asking about suicide can help the person feel relieved, less anxious, and better understood.
- Often the person's caregivers and family members experience severe stress at such times. Offer emotional support if needed.
- Tell caregivers that even though they may feel frustrated with the person, they should avoid criticizing or being mean to the person.

Second Checkpoint: Is there a risk of self-harm/suicide?

Ask the person and caregiver if they have any of the following:
Have you currently thought about self-harm or suicide?
Have you had thoughts about or planned self-harm in the past month or attempted self-harm in the past year?

If yes, how to manage?

1. Remove items that could pose a risk of suicide or self-harm
2. Place the person in a safe and supportive environment – if possible, place them in a quiet place
3. Do not leave the person alone
4. Have dedicated staff or family monitoring to ensure the person's safety at all times
5. Take care of the mental and emotional state
6. Provide psychoeducation to the person and their family on these issues
7. Provide psychosocial support and ask people to do the same
8. Support the people who take care of the person
9. Consult a mental health specialist if available
10. Always stay in contact and keep following up

6. Psychoeducation to the individual and their family on these issues

- Important messages for individuals and carers:
- If someone is thinking of self-harm/suicide, seek help immediately from a trusted family member, friend or health worker.
- It is okay to talk about suicide, talking about suicide does not make someone think about suicide.
- Suicides are preventable.

- Having suicidal thoughts or attempting suicide indicates that the person is experiencing extreme emotional stress. The person does not see any other way out. Therefore, it is important that the person gets immediate help for emotional problems and stress.
- Remove any means of self-harm (such as pesticides, firearms, drugs) from the home.
- Use social support, including social networks, family and related others.
-

Third checkpoint: Does the person have MNS (mental, neurological, substance use disorders)?

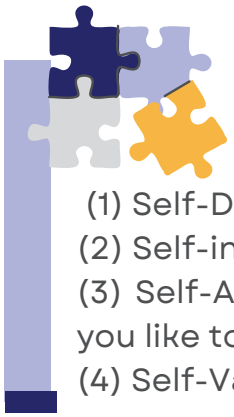
- Depression
- Problems caused by alcohol and drug abuse
- Psychosis
- Epilepsy

If yes, then manage it.
Risk of self-harm/suicide
1. Provide psychosocial support.
2. Seek advice from a mental health specialist, if available.
3. Maintain regular contact and follow-up.

Follow - Up

1. Regular follow up (once a week or once in 2 weeks) (home visit or telephone follow up)
2. At each follow up look for -
   A. Self harm by poisoning or excessive intoxication
   B. Bleeding from self inflicted wound
   C. Loss of consciousness/unconsciousness
   D. Extreme drowsiness

Risk Assessment



Activity

Draw your "self" consisting
(1) Self-Definition: Who are you?
(2) Self-in-Relation: What are your intimate and distant relationships?
(3) Self-Achievement: What are your accomplishments and what would you like to accomplish?
(4) Self-Value: What gives your life meaning and purpose?

Activity: Role play

Self harm (non-suicidal)- Person A is 17 years old and she has a very neglected childhood. She studies in class 10th. She came with the concerns of self-harm. She has cuts on arms and she also expressed that self harm makes her calm and she enjoys doing that. Her parents are not aware of the entire situation.

Suicidal ideation- Person B is 18 years old and is single child in the family. Recently, he had a fight with his friends and has been bullied at school. His parents are working and he didn't tell them about him as they are hardly at home and he started having feelings of burden on parents. He has no one to share his feelings. Students are insisting him to die when they bully him. He has been thinking of suicide lately and has been planning to cut his arm on Saturday as his parents will not be around and he has a holiday on Sunday.

Discussion

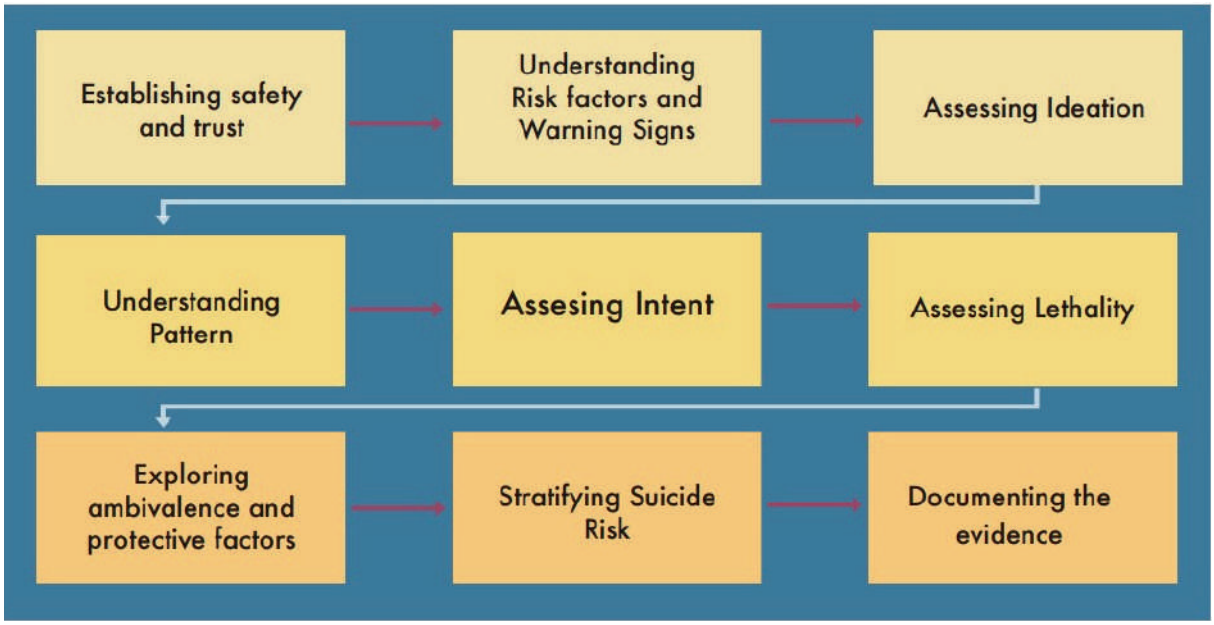
- As a counsellor (Achievements and challenges)
- As a counsellee and they were being helped or not being helped
- How did they feel
- Counsellee has to reflect on the skills of the counsellor and what different they will do in the situation
- Their beliefs about the suicide (comfortable with the topic)
- What else information is required

Key terms

- Suicide is an intentional, self-inflicted act that results in death. It is a complex and multifactorial phenomenon which has biological, psychological and social underpinnings.
- Suicide: Death which is because of injurious behavior undertaken by the person themselves with intention to die as a result of the behavior (Centre for Disease Control and Prevention, 2017).
- Risk factors: Factors which operate at the biological, psychological, family, community, or cultural level that precede and are associated with more probability of occurrence of negative outcomes (Substance Abuse and Mental Health Services Administration [SAMHSA], 2019).
- Warning signs: Symptoms or stressors observed during the last few day(s) before the advent of an event.

- Suicide attempt: An act possessing the following characteristics (a) self-initiated, potentially injurious behavior; (b) presence of intent to die; and (c) nonfatal outcome (Apter, 2010)
- Suicidal Ideation: Thinking about, considering, or planning suicide. It exists on a continuum ranging from having fleeting thoughts to detailed plans for suicide. Having a death wish is thinking about not wanting to live or imagining being dead whereas active suicidal ideation is thinking about different ways to die or forming a plan to die.

Risk Assessment process



Pathway to risk assessment

1. Establishing trust and safety

Talking to the client about painful emotional states without immediately trying to 'fix' the problem and without giving too many reassurances at first. Thus, we will have to convey our stance of unconditional acceptance and empathy throughout the session. We will have to genuinely try to understand why suicide feels like the only way out for them and empathise with this distress.

2. Understanding risk factors and warning signs

- Diagnosis of disorder
- Hopelessness (asking about future)
- Inadequate social support
- Recent crisis and Loss
- History of family member dying by suicide
- History of Trauma

- Feeling like a burden (Feelings and thoughts about themselves or How do you think others in your life see you?)

3. Assessing intent:

- Some questions that may help us in assessing intent are given below.
- Have you made a decision already?
- Have you been exploring ideas for how to carry out the act?
- Have you made a plan as to how you will kill yourself ?

4. Assessing lethality:

Lethality refers to the likelihood of the chosen method resulting in death. Some of the methods high on lethality include:

- Shooting
- Hanging
- Self-immolation
- Jumping from a height
- Ingestion of pesticide/poison
- Specific kinds of drug overdose

5. Exploring ambivalence and protective factors

Ambivalence refers to the balance between the wish to die and the will to live. We can try to understand if the client feels there is anything to remain alive for.

- Presence of children, pets or close and strong relationships
- Fulfilling sense of purpose
- Access to treatment
- Therapeutic relationship
- Survival and coping beliefs
- Problem solving abilities

6. Stratifying suicide risk

Very low risk- Thinking casually about death (No intervention required)

Mild risk- Thoughts about death and dying are present but the intention is not strong. Good self control and protective factors. Emotional state- Crying, irritability, sad and hurt

Interventions- Requires intervention such as psychoeducation, increasing the coping skills, suggesting a referral to a therapist or a helpline in their community and planning a follow-up call.

Moderate risk- Suicidal Ideation is frequent. Intensity might not be strong and they has a plan but don't know when and where to execute it. They also acknowledge the urge to live also.

Interventions- Safety planning and immediate action is required.

High risk- Ideas of hopelessness and a bleak future. They has strong intention with the plan ready to execute. They have the lethal means with multiple risk factors and they are weak to control the urge to commit suicide. Extreme emotionally numb or anxious.
Interventions- Requires referral and immediate safety planning collaborating with their family and friends.

7. Interventions
Regulating distress-

- Listening attentively and not rushing to suggestions
- Show empathy
- Reframe suicide as a way of coping with unbearable pain.
- Convey the nature of suicidal thought as 'waves'.
- Understanding how the client views suicide (purpose)
- Seeking exceptions to hopelessness
- Miracle questioning
- Find reasons to live

8. Activating social support

We can offer strategies such as sharing the responsibility of caring with others, activities which they can engage in which they find soothing, and seeking help for themselves.
Helping them recognise signs of low mood,
Providing education about suicide risk, and providing helpline numbers.

9. Removing the access to means of harm

This would involve ensuring that the clients do not have access to implements

- Knives
- Razors
- Scissors
- medications or any other way in which they can be harmed.

10. Safety planning

- Identify high risk moments and triggers
- Develop a coping plan - Activities that help (either for calming down self) or Accessing a coping tool box (photos, lyrics, poetry, messages that help) or List of reasons for living or Distraction techniques to ride the wave until the suicidal urge passes
- Keep the contacts of friends and family members accessible.
- Maintain a resource book of health care professionals who can be contacted and Referral

Other modalities

- Narrative practices- especially using alternative stories and finding exceptions, externalization
- Providing alternatives to them
- CBT if required
- Art modalities

Some stats-

More than 700 000 people die by suicide every year.
It was the fourth leading cause of death among 15–29-year-olds globally in 2019.
77% of global suicides happen in low- and middle-income countries.
164,033 Indians completed suicide in 2021
Suicides are preventable.
Much can be done to prevent suicide at individual, community and national levels.
World Suicide Prevention Day- September 10

Think about-

1. What is suicide?
2. Why do you think one would think about or want to kill themselves?
3. What could be the reasons our suicide rates are so much higher?
4. What are the factors that might contribute to this?
5. Do we believe that those who want to kill themselves are weak?
6. Do we want to place the onus of the individual completely on the individual?

Myths -

1. *Talking about suicide or asking someone if they feel suicidal will encourage suicide attempts.*
2. *Suicide attempts or deaths happen without warning.*
3. *Once a person is intent on suicide, there is no way of stopping them.*
4. *People who threaten suicide are just seeking attention.*
5. *People who take their own lives are selfish, cowards or weak.*
6. *Marked and sudden improvement in the mental state of an attempter following a suicidal crisis signifies the suicide risk is over.*
7. *People thinking about suicide are insane or mentally ill.*
8. *Every death is preventable.*

Risk factors -

People of all genders, ages, and ethnicities can be at risk. Suicidal behavior is complex, and there is no single cause. The main risk factors for suicide are:

- Depression, other mental disorders, or substance use disorder
- Chronic pain
- Personal history of suicide attempts
- Family history of a mental disorder or substance use
- Family history of suicide
- Exposure to family violence, including physical or sexual abuse
- Presence of guns or other firearms in the home
- Stressful life events (such as the loss of a loved one, legal troubles, or financial difficulties) and interpersonal stressors (such as shame, harassment, bullying, discrimination, or relationship troubles) may contribute to suicide risk, especially when they occur along with suicide risk factors.

Warning signs -

Warning signs that someone may be at immediate risk for attempting suicide include:

- Talking about wanting to die or wanting to kill themselves
- Talking about feeling empty or hopeless or having no reason to live
- Talking about feeling trapped or feeling that there are no solutions
- Feeling unbearable emotional or physical pain
- Talking about being a burden to others
- Withdrawing from family and friends
- Giving away important possessions
- Saying goodbye to friends and family
- Putting affairs in order, such as making a will
- Taking great risks that could lead to death, such as driving extremely fast
- Talking or thinking about death often

Other serious warning signs that someone may be at risk for attempting suicide include:

- Displaying extreme mood swings, suddenly changing from very sad to very calm or happy
- Making a plan or looking for ways to kill themselves, such as searching for lethal methods online, stockpiling pills, or buying a gun
- Talking about feeling great guilt or shame
- Using alcohol or drugs more often
- Acting anxious or agitated
- Changing eating or sleeping habits
- Showing rage or talking about seeking revenge

16 Self care & Boundaries

A word from the team

This topic aims to introduce the concepts of self care, and boundaries, and while mainstreamed conceptions of them are challenging to implement in low resource settings, these principles are nonetheless radically transofrmative, and connect particularly well in the lives of women.

Introduction

Self care is anything you do to promote your own physical, mental and emotional health. It is about being aware of your own health, identifying your needs and taking appropriate steps to meet them. It is a personal process and can vary from person to person, so it is important to figure out what is the best way to take care of yourself for yourself. Self care doesn't mean you are selfish. Self care is different from self improvement because it is about helping yourself feel happy and at peace today as opposed to working harder for the future. Self care can be physical, emotional, spiritual and social. Every individual has their ways of self-care- In the beginning, we can ask them how they do self-care, they can note down those activities, then discussion and then continue with the content.

What are boundaries?

An imaginary line that separates us from others. It keeps our thoughts, feelings, responsibilities and needs separate from others. Every person has different boundaries. Boundaries tell people how other people can treat you, meaning what behaviour you accept or reject.

A healthy boundary is one where you can ask someone to change their behaviour because you don't like it (e.g., please don't yell at me or please don't lie to me) or a boundary is one where you can do something to protect yourself (e.g., leave the room or block a phone number). Healthy boundaries are where boundaries are set collaboratively with people. With the support of others, we can create new boundaries for ourselves as well as strengthen old ones.

Unhealthy boundaries are where other people's wishes are not respected, their privacy is invaded, and actions are taken that make the other person feel uncomfortable (e.g., touching inappropriately, going against your own morals and values to make the other person happy). Unhealthy boundaries are also when the person is forcing boundaries or forcing you to adhere to them (e.g., not helping someone in an emergency because they missed a deadline)

Why is self care and maintaining boundaries important?

Discussion

Why might it be important to maintain boundaries?

Maintaining healthy boundaries help with:

1. Handling stress
2. Development of freedom/independence
3. Building healthy relationships
4. Good emotional health
5. Avoiding excessive empathy fatigue
6. Developing your own identity, values, and needs without guilt
7. Creating a Work-Life Balance
8. Relief from burnout
9. Help in dealing with self-trauma by seeing counselee's situation

Self care

Self care can look like:

- Eating healthy foods
- Drinking enough water
- Exercise or being physically active in any way
- Getting enough sleep
- Practising favourite activities
- Setting boundaries and saying 'no'
- Take frequent breaks
- Practising relaxation and grounding techniques
- Following a routine

Self care can also look like:

- Listening to my favourite music or dance.
- Rereading your favourite books, or reading a new one.
- Taking a shower in between, either hot or cold (whichever you prefer)
- Painting, drawing, colouring, writing poetry, or journaling.
- Watching a funny movie.
- Cleaning or organising your surroundings.
- Wearing comfortable clothes or clothes that make you happy.
- Eating or cooking something you enjoy.
- Take a nap or rest.
- Go for a walk or light jog.
- Try deep breathing or meditating for five minutes.
- Have a good laugh at least once a day.
- Seeking help

Discussion: Challenges to self-care

What are some big challenges you face in practising self care? Can you think of any ways you can overcome them?

Some of the main challenges in self-care:

- Having a busy schedule (I can't do this because I have so many other things to do.)
- Lack of energy (I don't have the strength to do this.)
- Lack of desire (I don't want to do this.)
- Excessive helping mentality (Helping others is more important even if I'm hurting.)
- Superhero mentality (I should be able to handle every situation.)
- Prioritization (I am too busy.. or I need to do ..... first)
- Misuse of self-care time (Self-care is a waste of time as it has no benefit)
- Not being part of a routine (I am really motivated but...it is hard to change habits and/or start things I have never done before)
- Workplace environment or work style (No one is doing self-care, so why should I)
- Lack of support from others (Lack of support/encouragement from others in any attempt to make a change)

When Facing challenges:

- Start by scheduling "me time" in the week
- Use holidays
- Try to take out at least five minutes for yourself every day initially (homework)
- Prepare yourself
- Don't expect too much from yourself
- Keep reminding yourself
- Be patient
- Try constantly
- Any other way?

Discussion: for counsellors...

Why is self care important for counsellors?

Practising self-care and boundaries can help the counsellor prevent the following problems.

- Anxiety
- Lack of enthusiasm or interest
- Feelings of alienation from counsellors and seeing them as a case rather than a person

- Feelings of depression and isolation
- Mental and physical exhaustion
- Difficulty concentrating
- During the counselling process, sometimes the counsellor can also get traumatised by listening to the difficult experiences, stories, and trauma of the counselee, due to which he may feel anger, rage, sadness, or have other mental health related problems thinking about the harassment of the counselee.

Self-care in the context of a counsellor:

- Practice relaxation and grounding techniques (before and after the session/during panic attacks)
- Do not think about the session once it is over (unless you need to prepare for the session). Focus on something else.
- When entering or giving data for the sessions, prepare yourself mentally.
- Maintain boundaries with the counselee
- Do not have back-to-back or continuous sessions – take adequate breaks

- If it is not in that frame of mind, schedule the session at another time or refer to someone else in case of emergency.
- If you ever feel the need, don't be shy to seek counseling or mental health services for yourself (being a counselor doesn't mean you can't seek help or counseling on your own).
- Any other techniques/methods that have been helpful for you?

Activity: Discuss scope of self care in the case

Rani is 30 years old. She works in a biscuit factory. Her job starts at 7 am and ends at 7 pm. She has a 10-year-old child who goes to school and her husband goes to work as a labourer. Rani wakes up at 5 am. As soon as she wakes up, she prays to God for 10 minutes. She likes doing this and it gives her a feeling of peace. Then she makes tea for herself and drinks it while sitting in the courtyard. Then she does all the household work, from cleaning the house to cooking. Rani gets a lunch break of 1 hour in the factory, in which she eats food after chatting with her two friends and if she has time left, she also goes out for a walk with them. When Rani returns from the factory at night, she takes a bath with cold water which removes her tiredness of the whole day. Then she cooks food for everyone, and after finishing the work, she goes to sleep.

17 Working with Children

A word from the team

Children can be a uniquely challenging group to work with, particularly when working children facing violence and trauma. This topic explores into understanding who a child is, how their immediate and broader surroundings play a role in their development, before delving into some techniques and principles that may be useful while working with children.

Child and adoloscent counselling

Group discussion (10 mins): Who is a child?

Rationale- Focusing on how a child is different in terms of size, age, behaviour, intelligence, language, learning abilities; along with definitions in different cultures and time; how different laws refer to a child as; is the definition of a child similar across all these areas, if no, then what is the need to have different definitions or should we just define a child universally.

- Close your eyes and think of a child? What image do you have in mind?
- Why is there a need to define a child? What are the differences between a child and an adult?
- What are the cultural differences in defining a child?

Definition of a child as per international and national laws.

According to United Nations Convention on Rights of the Child (UNCRC), "a child means every human being below the age of 18 years unless, under the law applicable to the child, majority is attained earlier."**This gives the various countries freedom to fix the age limit in determining that who is a child.**

In India after passing The Juvenile Justice (Care and Protection of Children) Act 2000, any person below the age of 18 is considered as a child as the mental state of adults and children are different; therefore there is a need to treat them separately under the different purview of law.

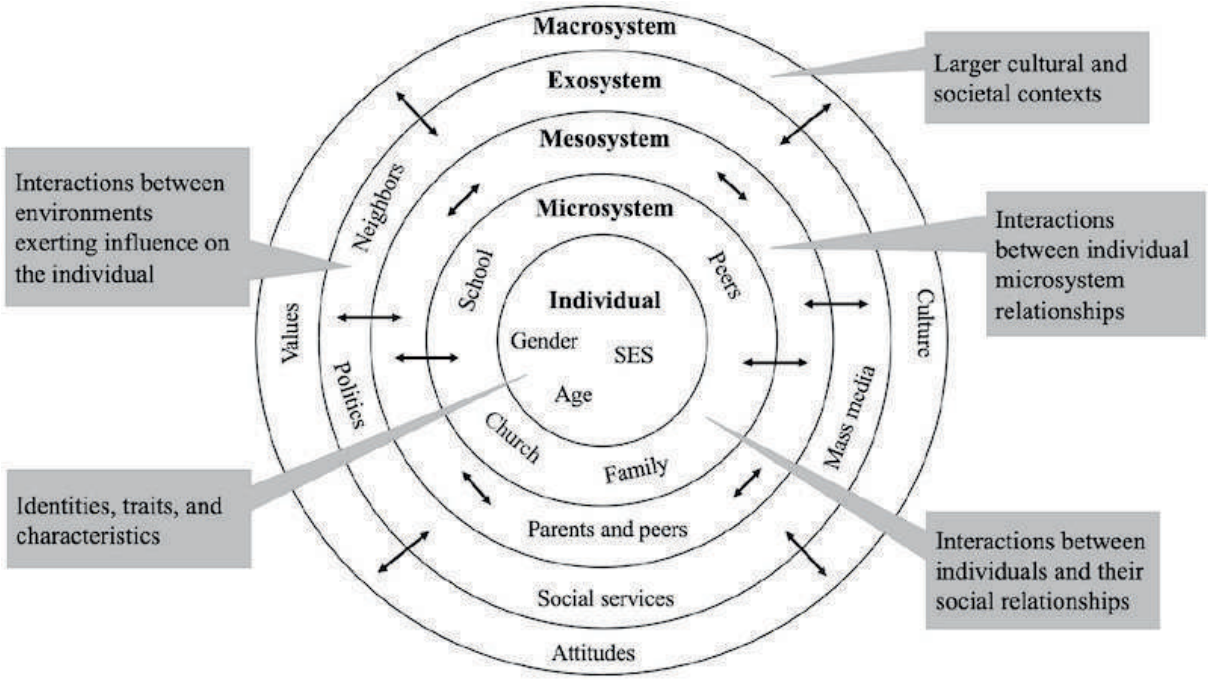
Activity: Handouts - What is the developmental need of a child?

Answer the following questions in the handout (10 minutes) and discuss:

- When or how does a child (who still cannot speak) learn that they can impact the world around them? - when a primary caregiver responds back actively to a child's babbles
- What will happen when a child is not given an appropriate response?
- How does a child look for safety? - primary caregiver's presence, their protective and warm touch (like a hug, holding hands etc.)
- How does culture and context impact a child's development?
- What qualities can be inculcated in children through play?

Bronfenbrenner Ecological Theory

Let's locate a child in their context

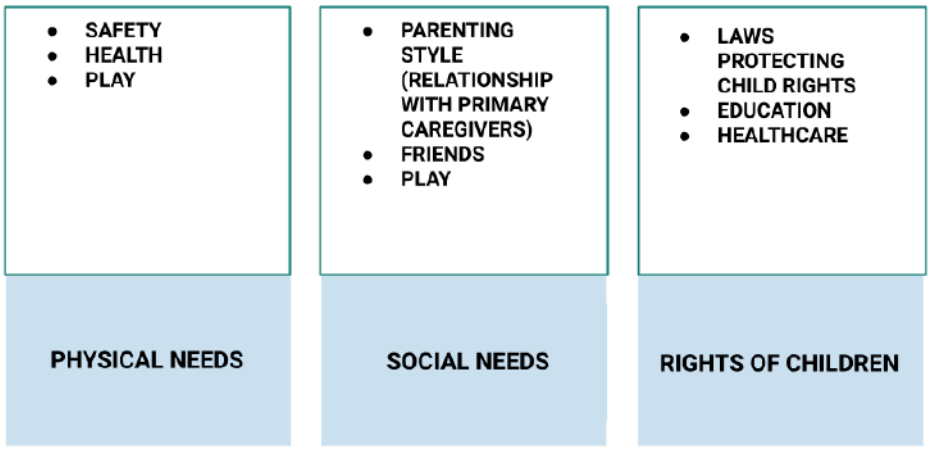


Discussion

- How does gender, age, health etc. impact an individual?
- How does family/home environment, parenting, etc impact an individual?
- How does school, friends, neighbours/neighbourhood, interaction between family and school, interaction between family and neighbours etc., impact an individual?
- How does mass media, healthcare system, local government, societal values etc., impact an individual?
- How does culture impact an individual?

Facilitators may expand on these questions and relate them to the developmental needs.

Developemental Needs of a Childs



Stakeholders in child counselling

To understand a child's world, we need to understand the people who surround them:
Parents/ guardians
Other family members
Teachers/ tutors
Neighbours/ Community

With all these groups of different kinds of people and relationships that surroudn a child, it might be worth exploring with these people:

- Concerns/worries
- Relationship with the child
- Understanding of child's concerns

Discussion

Can we as MH professionals solely work with children; why is it important to involve the parents and teachers in the case of children; whose opinions, needs, experiences do we prioritise-parents', teachers' or child's?

Interactive techniques with children

Trauma and play therapy
Reptilian brain is always asking, "Am I safe?"
Limbic brain is always asking, "Am I loved?"
Thinking brain is asking, "What can I learn from this?"

-Becky Bailey (Developmental Psychologist)

Discussion

- What will a child who has suffered trauma, look for first?
- Why do children play?
- What is the significance of play in a child's development?

"Play is the talk and toys/tools are the words"
Play becomes a digestive enzyme that metabolises trauma. Play can tell difficult/complicated stories, but the story has to be heard and held by the other (professional, parents etc.).

Trauma principles

- Safety.
- Trustworthiness & transparency.
- Peer support.
- Collaboration & mutuality.
- Empowerment & choice.
- Cultural, historical & gender issues.

Play

- Regulates emotions
- Reduces stress
- Promotes creative problem solving
- Builds trust and mastery
- Encourages open and voluntary communication
- Fosters learning
- Promotes creative problem solving

In play:

- Let the child choose (power transfer)
- Whether they want to play or not.
- Which game they want to play.
- How they want to set the rules of the game (ensure their safety)
- Let the child express
- Interact with the child in simple language. Let them know that they have been seen and heard. Eg., "I see this is an important part of your story. Thank you for sharing with me."

Externalising (problems, emotions, thoughts)

- Giving physical characteristics to the problem (colour, shape etc.)
- Using drawing, painting, toys to facilitate externalising
-

Hearing and holding stories

- Collaborative efforts in building a cohesive and comprehensive insight.
- Shared lived experiences
- Building an empathetic understanding of issues faced by people in their day to day life.

Intervention techniques

Painting or Art Therapy: (5-18 years)

Give the children art supplies so they can use drawings or other artistic expressions to convey their emotions. Ask them to explain what they created and talk about the emotions that went into it.

Storytelling: (5-12 years)

Encourage the children to make up or narrate stories. This allows children to explore and creatively convey their experiences.

Games: (5-12 years)

Play therapy can be supported by using toys, dolls and puppets. Games are a common way for children to comfortably communicate their thoughts, which can be helpful for the counsellor to understand what the children are feeling and experiencing.

Emotion Chart: (5-12 years)

Create a chart that shows various emotions. Ask the child to identify the emotion they are experiencing at that moment. This can assist them in recognizing and expressing their emotions.

Self-care techniques

Journaling: (10-18 years)

Give the children a journal so that they can express their ideas and

emotions through writing or drawing. A child can use journaling as a therapeutic means of exit and a method to think back on their experiences in between counselling sessions.

Emotion Card: (5-12 years)

Create several cards that represent various emotions. Let the child choose the emotions that most accurately represent their current state of mind. Talking about emotions and their wellbeing can be aided by this.

Cognitive and physical techniques

Creating an Approach:

To create an approach, provide drawings, directions and glue. Ask the child to select the pictures or words that symbolize their goals, anxieties, or passions.

Therapeutic games:

Play therapeutic games intended for counselling sessions. These games frequently concentrate on certain emotional or social abilities and they can be an enjoyable and engaging method to explore and learn a number of topics.

Role-playing: (7-18 years)

Engage the child in role-playing practices to assist them in practicing strategies for developing courage and provide them with assistance. For the development of social skills, conflict resolution, or efficiency under challenging circumstances, this may be very suitable.

Mindfulness Activities: (11-18 years)

Provide guided imagery, mindful breathing or gentle yoga poses, as appropriate mindfulness activities. Children can learn emotional control through these activities.

Emotional Temperature: (7-12 years)

Establish an "emotional temperature" on a scale of 1 to 10, allowing the child to indicate how emotionally they are feeling at the moment. This can be used to monitor emotional outbursts and talk about coping mechanisms.

Role play- 5 Different scenarios (1 to 1.5 hour)

5 groups are to be made with 1 PC in each for facilitation. FCs are supposed to contextualise the situation through their own understanding and build on a 5 minutes conversation focusing on how various counselling skills could be applied in various situations for better response to different situations. After presenting the group and the audience can collaboratively note down the techniques which can be used in counselling sessions and critically reflect on the presentation.

- *A child has to take an exam the next day in the morning. Just the previous night they begin to develop fever and shivers, they talk to their mother about this.*
- *Teacher notices a very active child all of a sudden has stopped talking in class and tries to run for home as soon as the bell rings, who otherwise used to hang out with his classmates and calls him after the class to talk about her observations.*
- *Mother of a child approaches a counsellor for sessions for her child with aggressive behaviour(mention your understanding of aggressive behaviour). Enact the conversation between the counsellor and the child after the above mentioned brief from their mother.*
- *A child who has faced an attempt of sexual harassment recently is unable to concentrate on their studies and has increased anxiousness due to approaching examinations.*
- *A young child doesn't seem to talk much. Earlier this was taken as shyness but it has been consistent in all the environments except his home only if his parents are present. This is reported by his teachers when they observed that he scores considerably worse in oral examinations than written examinations with the same questions.*

Ethics

- Consent- Of the child and primary caregiver
- Physical boundaries- Do not initiate touch
- Avoid giving suggestions/imposing personal beliefs on the survivors

18 Anger

A word from the team

The communities we work in, we see the anger survivors of sexual and gender based violence often carry. Discrimination, trauma and social marginalisation have a cumulative effect on feelings of helplessness, powerlessness, frustration and anger. However, expression, understanding and conceptualization of anger as an emotion often fails to take into consideration the multifaceted relationship it shares with social position and prescribed norms around it.

Is anger necessarily always supposed to be "managed" rather than expressed? Are there ways to express anger that are socially acceptable and sustainable? How can we equip families with a history of trauma to deal with built up resentment leading to anger? These are some of the broad questions this topic has tried to explore.

Understanding Emotions

Activity 1: Bhaavana Sena

The facilitators direct the participants' attention to the a large circle made of slices. Each slice has an emotion listed.

The facilitators ask the participants to voluntarily fill themselves into teams for emotions and stand behind the respective slice. The team of their choice would be an emotion that they think is important, and speak on behalf of the emotion when we ask questions.

If there are emotions that no one has chosen, the facilitators may either leave it empty to discuss this point as the session progresses or have one of the facilitators volunteer in an empty team. Once everyone has chosen their team, the facilitators will ask a few questions.

"When does your team's emotion show up?"
"Do you think we should feel ---- all the time?"
"Do you think we should feel ---- once every while?"
"How do other people respond when women express this emotion"
"Do you think there is a difference in how men and women express this emotion"
"How do other people respond when men express this emotion"
"What does this emotion try to say?"

The facilitators may take a few responses from each team and move on to the next team.

All emotions seem to do different things in our lives, playing different roles. We often expect them to come up as a response to particular situations/events. Our attitudes towards each emotions may be shaped by our social upbringing, personal experiences and identities. Therefore, how we express these emotions are also different. Men and women are afforded/enforced with different ways to express their emotions by society.

Since we all seem to have different understandings, attitudes and expressions of our emotions - Perhaps it is possible to look at, understand and express these emotions differently from how we have always known them?

What does anger do?

Activity 2: Darts

In front of the group is a canvas/large paper/thermocol with the silhouette of a body.

A few people may be given the opportunity to throw darts at the canvas. They may be chosen through a game, such as passing the ball until the music stops. Once the dart is thrown, the person/group has to describe what anger does to the parts where the darts land. Their response is stuck as a sticky note on where the dart landed.

Note: If the activity with darts is are hard to arrange or are felt as risky, another way to facilitate the activity is to have blindfolded participants stick a note on the silhouette.

If a dart lands outside the silhouette, the participants are prompted to discuss some effects anger has on the surroundings of a person expressing anger. This can be about immediately visible behaviour, the responses it induces, and even how it may shape relationships and others.

- What do you do when you are angry?
- What could be the impact of those actions on others, or things outside your body?

Anger may cause

- Certain changes/experiences in our bodies.
- It can affect the way we think in the moment.
- It also affects someone's behaviour, and their environment.

From our descriptions, we might see that we often find the anger unpleasant to experience, It is unpleasant to ourselves, and unpleasant to others.

Often we are told to stop being angry.
But today, let us try to understand this complex emotion.

Why do we get angry?

Activity 3: Anger Iceberg

The image of an iceberg will be in the midst of a session.
The facilitators will divide the participants into groups of six-seven people and provide each group with a case study.

The facilitators will then explain the activity:
"What do you see here? Do you see the iceberg? What do we know about icebergs?"
"When we see icebergs we only see a small portion above the surface."
"We believe anger is similar, in many cases - when we see anger above the surface, there are many other emotions underneath."
"So now that you all have your cases, all teams will take 10-15 mins to read and discuss the case amongst themselves, to try to figure if there are other emotions underneath and what they might be?"

"If everyone is done with discussing amongst themselves, let us discuss what you think these emotions are, and why. We can finally take a look at what's underneath the iceberg"

Each team with a unique case study discusses their thoughts.(Some groups will receive the same case studies. For instance if there are 7 groups in total, 5 groups will have their unique case studies although the remaining two will have the same case studies as any other two groups)

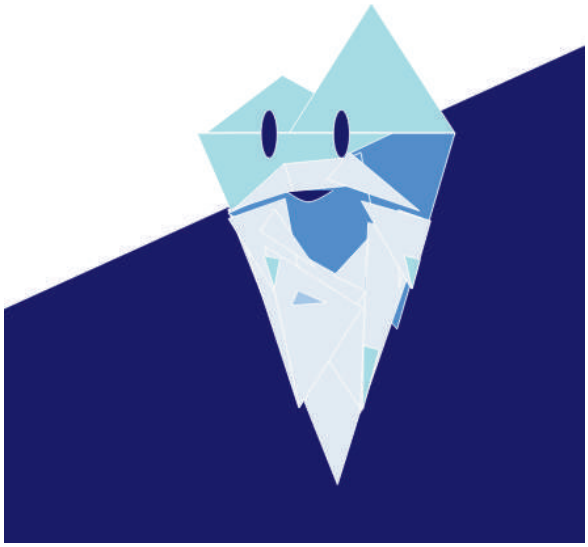
After each/every team is done, another team with the same case study may be consulted, and a brief discussion on what the similarities in differences in their answers are, could be highlighted.

Note:

- Writing down all the identified emotions from all cases onto an image of an iceberg, might help with giving a visual idea of the scope of emotions that can be associated and be worked on when dealing with anger. Having such a tangible work born out of discussion can also serve as an object to call back to this discussion at any later point where it is relevant.

- Make a note of the commonly noted emotions
- Ask if they've made similar observations from the field.

So what does Baba Iceberg teach us?



- "Anger and its expression has a diverse set of underlying emotions."
- "As a counsellor, It is important to be able to identify the emotions underlying anger through contextual understanding of the counselee's situation."
- "Hence when we try to work with anger as counsellors we also work with emotions underlying the anger"

Anger and Trauma

Note: Remind the participants to be mindful of their own emotional safety and inform the participants that if anyone finds themselves feeling intense emotions, they may take a break from the session, walk around and rejoin the session when they feel a little more comfortable.

- **Recap: What is trauma?**
  - Trauma is the response to a deeply distressing and disturbing, often life threatening event, which overwhelms an individual's ability to cope.
  - Events could be abuse/acts of violence, deaths, severe illness, wars, natural disasters etc.
  - What does our physical immune system do? - The function of the immune system is designed to fight any viruses or bacteria and to keep the body healthy. A fever might be difficult, but it happens when the body tries to fight to keep your body safe. So, the emotional immune system works the same, it is designed to protect the individual from emotional turmoil.
  - What would an emotional system do to these events?

- **Do you think aggression and anger could be a response to traumatic events? Why?**
  - How might people respond when their sense of safety is threatened?
  - How might people respond to helplessness, or when they can no longer have control over their lives?

Anger and Power

Anger as a tool to resist and challenge structures of power

- We see that anger has layers of emotions underneath. Be it fear, grief, shame - we see that anger can be triggered by a sense of wrongdoing, a sense of justice or breach of our personal boundaries. And because anger can energise our bodies, it has the potential to pull us out of an environment that hurts us, or even give us the motivation to change/stop the causes of the pain.
- Eg: A recent study from Norway found that anger was the most powerful emotion to drive climate action, Nirbhaya protests that changed rape laws.

Discussion

Ask the participants for examples of when anger plays/played into bringing positive changes.

Anger as tool to maintain the power structures

- But does that mean anger cannot be felt by or used by those with privileges, against women or marginalised groups?
- Can anger and aggression be used to maintain power in society, when it comes to caste, class, gender, etc. (Can anger be used to break resistance?)
- Can we think of examples we see where anger has been used to maintain power. Does this dismiss the anger or other related emotions felt by them?

Check: The facilitator can pause and check up on the participants:

- How are you all feeling right now?
- How are our bodies reacting to our emotions?
- Where are we feeling these emotions in our bodies?
- If the participants seem distressed or overwhelmed may pause for a few minutes.

Looking into our own anger

Activity 4: Anger Memories Worksheet

Note: The objective of this activity and section is to reflect on how our attitudes and expression of anger is learnt through our experiences with anger, through our personal histories and our environment.

The facilitators will pass a worksheet to each participant. The worksheet which contains the questions listed below. The facilitators ask the participants to fill the sheet by themselves. Once they are done, the facilitators may ask the group of participants to volunteer to share some answers they have written (list specific question numbers if any) and any insights they have gathered through the activity.

Let the participants know that they can clarify doubts regarding any questions, at which point the purpose of the activity could also be made more clear.

The worksheet ----------

1. Think about your childhood: What did you learn about anger when you were a child?
2. What were you told about expressing anger?
3. How did you mostly express your anger directly?
4. How did you express your anger indirectly?
5. How did your mother (or mother figure) express her anger? *If you did not have a mother figure in your life how may have that impacted your anger?
6. How did your father (or father figure) express his anger? *If you did not have a mother figure in your life how may have that impacted your anger?
7. How did your siblings express anger? *If you were an only child how may have that affected the way you experienced anger?
8. How were you expected to express anger when at home?
9. How did you express anger outside of the home?
10. How did your friends express anger?
11. As you got older, did the way you expressed anger change? If so, how?
12. How did your family respond to the way you expressed anger?
13. How did your teachers/peers respond to the way you expressed anger?

14. As a result of your experiences with anger growing up, what were some of the beliefs you held about anger?
15. In summary, considering everything discussed up until now, how do you think all of your past experiences with anger growing up affect you today?

After the participants are done with the worksheets, start with asking reflections on the activity and have a general discussion about a few questions that stood out -

- "Which questions stood out to you?"
- If the discussion doesn't highlight it, Facilitators could reflect on the gendered nature of how people respond to one's anger. Prompt: How did different groups/people respond to your anger?
- Close the activity with a discussion of the summary question.

Activity 5: Cool-off activity

Sit upright, but in a position that feels comfortable. Close your eyes, if you are comfortable with this. If not, you may focus on any particular blank space or object.

Take easy, deep, slow breaths.

Slowly turn your attention towards your breathing. The way it travels through your nose and mouth and fills your lungs. The way you slowly let it go, and the air going back from your lungs through your nose. Keep focusing on your breathing, as you inhale and exhale.

As your mind might wander elsewhere - wherever that is - home, a garden, a place of peace, or something that happened - you might notice muscles that feel tense in your body - acknowledge them - then try to bring it back to the breathing - focusing on the flow of the air, in and out.

Expressions of anger

Discussion: Various expressions of anger

"What kinds of anger have you seen? (in sessions with counselees, families, etc)"
The facilitators could start the discussion with some of these prompts:

A few kinds of expressions of anger:

- Expression of anger, outward as well as inward
- Ways of external expressions of anger - examples from the previous activity
- Ways of repressing anger or internal expression of anger - touching up on self harm, suicide, self isolation, negative self talk
- Passive aggression - what are some examples - could it also be harmful? Why?
- We could also talk about repressing anger/ expressing it internally and how that can be harmful too.

"Do all kinds of anger have the same effects?"

Four types of anger

Short Anger
As the name suggested, this state of anger does not stay for a longer duration. It basically protects us from danger. For example- somebody disrespects us and we respond to protect our dignity and to maintain boundaries. It might be momentary.

Long Anger-
It sustains for long periods of time until the injustice prevails or the grief prevails.

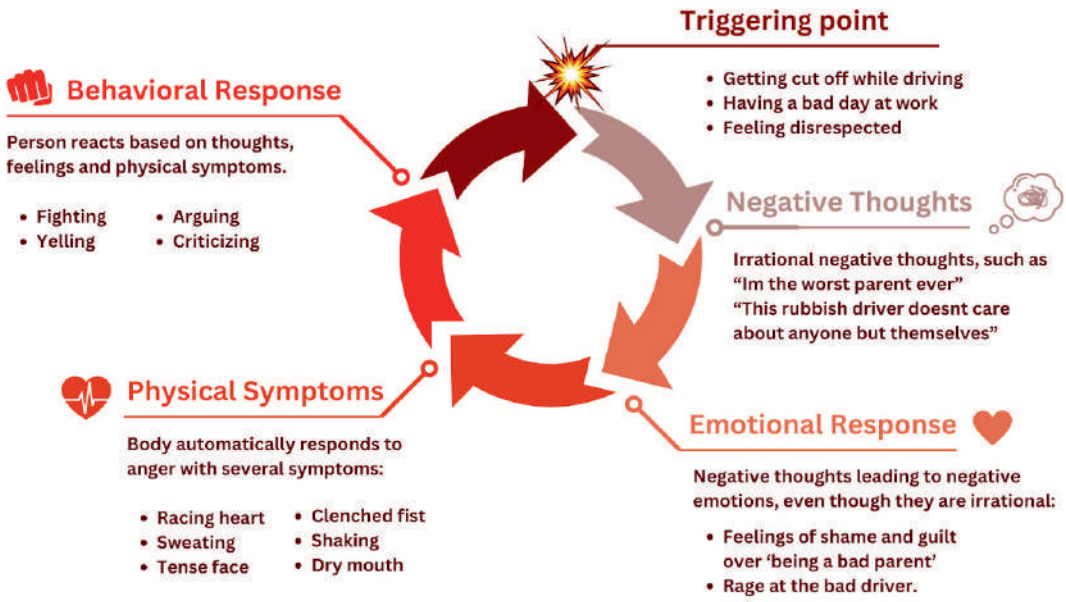
Hot Anger
It is an explosive against an unfair incident or something. If it gets sustained, the person would face the repercussions.

Cold Anger
Productive and Channelized Anger. Putting one's anger into the creative work.

How do we deal with anger -Stages of anger

From this section forward, focus on working with clients on anger.

Understanding the stages of anger



Present the cycle of anger and discuss all of its components, and how anger can be managed by understanding each of the components- triggering event, negative thoughts, emotional response, physical symptoms, behavioural response.

Remember! Each of these points on the cycle of anger serve as points that can be identified, planned for and managed/intervened at.

Warning signs/ Knowing your triggers

Activity 6: Warning Signs & Anger Thermometer

In smaller groups, discuss and list out warning signs that are 1. Physical signs 2. Actions or 3. Thoughts

This can include:

- Mind goes blank
- Body or hands shake
- Heavy or fast breathing
- Scream, raise voice, or yell

- Punch walls
- Become argumentative
- Pace around the room
- Insult the other person
- Start sweating
- Stare at the other person aggressively
- Clench fists
- Feel hot
- Go quiet and shut down
- Headaches
- Face turns red
- Throw things
- Scowl or make an angry face
- Feel sick to the stomach
- Become aggressive
- Crying
- Can't stop thinking about the problem)

Then, distribute the anger thermometer worksheets, and follow the instructions on the same to complete the activity. Mention that this worksheet can be used to help clients understand their triggers and their symptoms.

Anger Thermometer

The anger thermometer is a technique that will help your clients learn about their anger symptoms and warning signs, and how these progress as anger escalates. An anger thermometer is a 10-point scale where a "10" represents a person's maximum anger, and a "1" represents no anger at all. Symptoms of anger–such as balled-up fists, argumentativeness, or frustration–are recorded on the anger thermometer at the point where they begin. You may choose to use the anger thermometer to discuss anger triggers, as well. On the thermometer, record triggers based upon their intensity. This is a helpful way to associate specific symptoms and reactions with triggers.

Exploration Questions

- "Tell me about a time you were at a 10 on the anger thermometer."
- "When you're at a 6 on the anger thermometer, what sort of things are you thinking about?"
- "How do you feel differently when you are at a 1 on the anger thermometer compared to a 5?"
- "If a stranger saw you when you were at an 8 on the anger thermometer, how would they describe you?"

- "Try thinking about your symptoms in reverse: What do you lose as you go up the anger thermometer? For example, maybe you are friendly and talkative at a 1, but not at a 5."

Coping by anger level

Use the completed anger thermometer to plan coping strategies according to anger intensity. At what point should someone use a relaxation skill, and at what point should someone simply walk away? What coping skills should be used in the case of extreme anger, when a situation has grown out of control?

For example, if a person's "3" on the anger thermometer is "becoming argumentative", a good coping strategy may be to practice deep breathing. It is likely safe to practice a relaxation skill at this low level of anger, and deep breathing is an incompatible behavior with arguing (you cannot argue while 'practicing deep breathing).

However, if the situation escalates to a "5" and is at risk of escalating further, it may be best for the person to walk away. At an "8", it is probably more appropriate to make a plan to call a friend, or resort to a safety plan.

Keep in mind that the best coping strategies vary from person to person, but using an anger thermometer provides an excellent framework for discussion.

Strategies to deal with anger

The objectives of this section will be:

1. To be equipped with a plethora of strategies and tips on how one may deal with anger, in personal and counselling contexts.
2. To discuss and practise effective utilisation of the previous learnings throughout the session in counselling contexts.

These contexts may be:
Personally managing anger from personal life.
Anger in interpersonal relationships.
Helping counselee with the anger they feel.
Dealing with/understanding the anger that counselees receive.
Dealing with anger you FEEL WITH and AT the counselee through the session as a counsellor.

Helping a couselee's anger

- Problem solving
- Can we make plan to solve/reduce impacts of problem that is causing anger

- Can we help them move/spend time in environments that are safer/make them less angry?

- **Note:** Anger is a form of communication that tells a lot about the surroundings and oneself. Reflecting and getting aware of the anger is a powerful strategy for accepting our emotions. Second task is to manage those emotions which are harming oneself. When discussing the questions above, facilitators may provide common examples from the field that can be worked on in this manner.

- Can we work on other emotions?
  - Callback to the iceberg. Working on other emotions associated with it - (write a few examples here on what that looks like?)

Anger in Interpersonal relationships

- Finding healthier ways to communicate (discussion and sharing)

- Assertiveness training

Sometimes anger stems from boundaries being breached, and it is made worse by not having done/being able to do enough about it. During the counselling session, help them practise being assertive in the required situation, in their personal lives with you, so as to build confidence.

- How to respond when you sense anger in a conversation?

If a conversation is getting heated, and if one is in touch with their body, sensing the anger can also serve as a reminder to not immediately be defensive if not necessary, to listen carefully, slow down the pace of the conversation, or to not to engage with it at all if that would be better for the relationship. Developing these understandings and habits within both parties in the relationship could also be useful.

Anger and Trauma - Parts Work and Reauthoring

Story Time!

The pedals went round and round before Ashish's cycle came to a stop again.

The cycle's chain had slacked off again. Frustrated, Ashish got off, once again and mounted the chains properly again.

"Stupid chain, why do you have to be so difficult?" he thought as he rubbed his dusty hands.

"Yeah. You always keep slacking off" said the right handle.

The bell rung in agreement.

"Keeps giving the boy a hard time!" the brake pads were annoyed.

The chain looked over to the misaligned frame. "It hurts" it thought as it rubbed its back.

"I wish I had another way of letting him know" it thought.

Discussion: On the story

Let's sit with some questions.

1. What did you find interesting about this story?
2. Have you ever tried imagining your anger as a part? What would your angry parts look like?
3. Have you ever had parts that are in conflict with each other?
4. What would a part of one's self, that has gone through trauma, say to them?
5. How would they behave?
6. What kind of emotions would this part feel?
7. Through what ways will it try to communicate, achieve its needs?
8. Do you think it's important to acknowledge that part?

Problems as parts

We all carry within ourselves different parts, each with their own contexts, with different needs, developed under different circumstances, that function differently.

So it is important to recognise that a behaviour or a response doesn't define the full extent of a person. A person may be a survivor, another may suffer from alcoholism, another may show angry outbursts, another may suffer from severe mental illnesses. But it may be important to remember that a person is more than just a problem or a life event they've suffered from. The problem is the problem, and may be a part and passenger alongside the person's life. (This process of separating the problem from the person is called externalising.)

Reauthoring

Creating alternative stories of how the person understands themselves - How?

- **Externalising** internalising problems
- **Engaging with all parts**, see what each part is communicating
- I**mportant in the context of trauma:** Looking at **behaviours as resistance** within each part's capacity, within the power and resources the person has under their life circumstances.

Eg: - A child that refuses to go to an abusive environment, suddenly showing discomfort and hesitation to go to school - rebelling within their capacity to keep themselves safe, amidst the fear.

(some example of resistance within our mental capacity)

- **Build and Co-author a new story -** one that empowers the counselee, that accounts for the parts that they want to hold on to, the parts that are still communicating to them, and one that helps the counselee reconcile/escape/acknowledge/move beyond etc with their different parts to create a newer understanding of the self.

Anger felt by counsellors

Feeling anger WITH (alongside) the counselee
(Emotional safety of the counsellor)

Sometimes we as counsellors may feel similar anger as the counselee as they share their story. We might remember similar life circumstances from our lives, we might feel that our ideals/sense of justice has been violated. How do we sit with this anger, how do we deal with it?

- If not many others in the counselee's life acknowledge the validity of the anger, or have tried to understand the reasons and emotions behind it, acknowledging the anger you feel through their sharings could be powerful.

- Something to be mindful of when you identify with their anger - Recognise your emotion, be mindful that the session is for the counselee's aid, and its focus must stay with the counselee's case. But it is also important to process our emotions after the session, be it about ideals or about your life, history and circumstances.

- **How might we take back control** - Acknowledging the power we have as counsellors and the role we play in preventing injustices and restoring lives.
- What do we do in contexts where they too feel powerless - Recognise the sphere you have control over, connect with the team, share.

Feeling anger AT the counselee (Also about managing the session)

- If there is anger at the counselee because **we may feel that they are not collaborative** in the counselling process, it might not be a bad idea to talk to them and **explore if you and the counselee have the same understanding of 'why they need counselling'**. Providing the counselee with the space, voice and power to be honest, and set their own goals with what they want out of the counselling process is fundamental to client-centred counselling.
-
- **Boundary setting (SET THEM!)**
  - In cases of heavy dependency, lacking other support systems - Setting boundaries, reassuring, being open about your challenges alongside the reassurance. [Your emotional health is important, set timings for your work and personal time.
  -
- **Anger due to ideas/actions of the counselee that we disagree with** - Can we challenge certain notions that we may disagree with in counselling, through exploration, and curiosity? Should we introspect about why we feel the need to challenge the disagreement? Who can we afford to challenge (issues of safety)?

Discussion: Challenges

- What could be some challenges you face in implementing the above?
- What other circumstances make you feel angry in/after a counselling session?

Tips and Things to remember

Some tips -

- Channel the anger into creative pursuits - writing, painting, exercising. Could also be scribbling, random shapes, randomly colouring.
- Using senses in your environment - sitting with nature (could sit in a field, pay attention to everything that is happening around). Removing yourself from annoying noise.
- Stretch or massage areas of tension -
- Deep/Belly breathing. Focus on the physical sensations of your body as you breathe.
- Slowly count to ten - When there are consequences for your actions.
- Exercise, Sunlight - General life changes to regulate mood. Exercise and body/dance movement could also help in managing emotions.

A reality check:

- How important is it in the grand scheme of things?
- What's worth in here to get angry?
- How will this anger affect the rest of my day? How has it usually been?
- What's an appropriate response to this situation?
- The thing I'm angry at - Is this within my locus of control? Can I do something about it? What all could I do about it?
- Is taking action worth my time?

These questions are directed towards managing anger by oneself. Counsellors could exercise more caution when engaging with the cousnellee through such questions and must take care to be aware of the context and not be dismissive of a counsellee's experiences.

Activity 7: Role Play

Each team was provided with a case study in the 'Anger iceberg' activity. With the same case study, teams are asked to briefly briefly discuss amongst themselves on how they envision this case being handled. After the discussion the teams have to do the role play activity within their

groups. One team member has to be a counsellor, one has to be the counselee and one/two can be a relative/family member. Remaining group members have to observe the role play and take notes. One of the team members will have to observe. The discussion may be based on the following questions -

- "What were the interventions used and what was the thought process behind the same?
- "What do you think stood out in the session?"
- "What do you think could have been done better?"
- "What were some challenges faced during the session?"
- "What could have been some of the alternative ways or strategies for counselling?

The teams are informed that they will be provided **10-15 minutes for preparation** and **5-7 mins for the roleplay**.

After a team is done with their group activity, members of all teams will present the points they observed during the activity.

Discussion: Sumary

- So what did you learn about anger?

Cases for Activity 3 & 7

Case 1:

S is a 15 yo girl. Lives with her family (Mother + Elder sister + younger brother + father). S's father is an alcoholic and her sister is a survivor. The family dealt with a lot of social exclusion and hostility for the same. S's mother approached us for help and told us that S has gotten very aggressive and irritable over the years. Family members find it difficult to talk to her as she gets angry very often and sometimes even raises hand on her younger brother.

Case 2:

P is a 12 year old boy. He lives with his mother, father and younger brother. P's parents want him to score well in his studies and they keep talking to him about the same. They often tell P that to earn a good job, he has to do well in his school. Although ever since P's younger brother was born, his parents have been busy with him. P's mother contacted us after an incident in the school when P got into a fight with a few children in his school. P's mother also mentioned that P has become very quiet and restless over the past few months. She also said that he is very irritable and easily becomes aggressive. There has also been an incident where P broke some toys of his brother.

Case 3:

J is a 27-year-old woman who works at a bank. She lives with an elderly mother who requires constant care and is unable to work or help around the house. She has an elder brother who lives with his family in a town that is hours away from her home. J earns and takes care of her mother all by herself. After being cheated in a relationship with someone from her village, J has made attempts to take some time away from the village, which has been objected to by her mother, as she requires care. In the past few months, J has been quite irritable, often yelling in the house. Recently, her mood and behaviour have also affected her work.

Case 4:

P is a 26-year-old female and she is a survivor of sexual violence. She lives with her mother, father, one younger sister and one younger brother. After the incidence of sexual assault, P has felt that her family does not treat her the same. P's family holds her responsible for their inability to find a groom for her younger sister and the taunts and comments they

... Cases for Activity 3 & 7

have had to hear from the society. Over the months P has started getting increasingly angry towards herself. She hates that she let a sexual assault happen to her, just like what her relatives say to her. A few weeks ago P felt extreme anger towards herself and engaged in self harm behaviour to punish herself. P has also stopped eating and sleeping well. P's sister is someone who cares a lot for P and she has approached her for counselling.

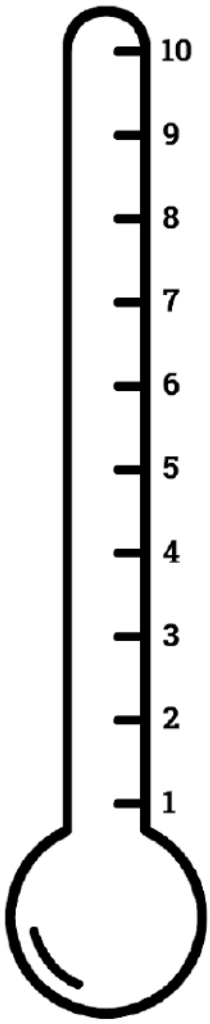
Case 5:

R is a 27 year old male. His case has been referred to us from MRC after he was rescued from a thekedaar's custody. Ever since he has been back, he has become extremely angry and has also started to drink alcohol in a dangerous amount. He often beats up his wife and children. R also gets easily startled when spoken to him and reacts aggressively in such situations. He often talks about the money he has lost to the thekedar and doesn't go for work. His wife has told us that this behaviour of R is something that has started ever since he has been back and she is worried about the wellbeing of their family.

Worksheet for Activity 6: Anger thermometer

Anger Thermometer

Record your anger symptoms on this 10-point scale, where a "10" represents your maximum anger level (the angriest you have ever been, or can imagine being), and a "1" represents no anger at all. Give *specific* examples of symptoms you have at each point on the scale, as your anger escalates. Symptoms can include thoughts, feelings, and behaviors.



19 MHCA 2017

A word from the team

This topic aims at familiarising the field counsellors to the key concepts, rights, duties and provisions as given in the Mental Health Care Act of 2017. The aim is they are able to help in awareness and advocacy efforts for the same with their clients and in their communities.

MHCA 2017 has been a legislation that has significantly expanded and advanced the conversation on the rights of persons with mental illness. Although much of its provisions are yet to be reflected on ground, the rights guaranteed under for any mental health professional working towards building informed and empowered communities. Additionally, apart from the specific rights, the perspective that this legislation is rooted in, and how it views people that seek mental healthcare, can be a helpful lens in having a humane understanding of people with mental illness.

Discussion: Context for MHCA 2017

Prior to discussing the act, it may be important for the facilitators to set the context for the relevance of this act. It may be helpful to start the discussion off by asking the participants of what they know of persons with mental illness and mental healthcare institutions and hospitals through their depictions in popular media.

- Have you seen movies depicting people in mental healthcare institutions/mental hospitals/asylums? What do these depictions look like?
- What does treatment look like in these depictions?
- What kind of rights do you think persons with mental illness have had in their treatment spaces ?
- Do you think it's important for persons in need of mental healthcare to have adequate rights and a say in their treatment? Why?

The facilitators may talk about incidents of violence faced by persons with mental illness, due to the lack of rights and protection they received during their healthcare. Incidents like the 'Erwadi fire tragedy' serve as horrifying examples.

Erwadi Fire tragedy: In 2001, a fire broke out in a mental asylum in Erwadi, Tamil Nadu. 28 people with mental illness died in the fire, because they were inside the asylum and tied to chains.

Optional Discussion: History leading up to MHCA, 2017

Prior to the MHCA, 2017, India has had different laws that set out rules on dealing with persons with mental illness.

The Lunacy act of 1912, detained persons with mental illness and moved them away from society into asylums. This act was concerned with protecting the public from persons with mental illness as it saw them as dangerous or a threat to regular public life and conduct.

The mental health act of 1987, amended the laws regarding their treatment, providing provisions for guardianship and management of property for persons with mental illness. However, they were largely devoid of protections or rights within mental healthcare institutions, and they were often stuck in these institutions with clear plans or conversations on their rehabilitation or discharge.

In 2007, India ratified the United Nations Convention for Rights of Persons with Disabilities (UNCRPD). The UNCRPD was drafted by building on the social model of disability which highlights the responsibility of society to remove barriers that inhibit persons with disability (eg: building ramps and architecture, making wheelchairs accessible, so that persons with locomotor disability may not have these barriers in participating in society). Since India had ratified the UNCRPD, the drafting of MHCA 2017 also had to keep in mind to align the act with the UNCRPD.

Mental Health Care Act, 2017

The purpose of this Act is to provide mental health care and services to people suffering from mental illness, and to protect their rights.

The Mental Health Care Act 2017 (MHCA 2017) has been made keeping in mind the rights based approach.

This Act came into force on 7 April 2017

Important Definitions

"Mental illness" means a major disorder of thinking, mood, perception, orientation or memory affecting judgement, behaviour, ability to recognise reality or to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation

"Local authority" means a Municipal Corporation or Municipal Council, or Zilla Parishad, or Nagar Panchayat, or Panchayat, and such other authority or Board as is empowered by any law for the time being in force to exercise administrative control over a mental health establishment or to function as a local authority in any city or town or village.
"Mental Health Professional" means– (i) a psychiatrist, or; (ii) any professional registered with the concerned State Authority under section 55; or (iii) any professional who possesses Master's degree in Psychology and Mental Illness (Ayurveda) or Master's degree in Psychiatry (Homeopathy) or Bachelor's degree in Mullahs (Nafsiyat) (Greek) or Master's degree in Sirapu Mathuvam (Siddha);

"Clinical Psychologist" means a person who possesses–
Recognition as a Clinical Psychologist from an institution recognized by the Rehabilitation Council of India constituted under section 3 of the Rehabilitation Council of India Act, 1992 (34 of 1992); or

(ii) PG degree in psychology, applied psychology or clinical psychology and also M.Phil in clinical psychology or medical and social psychology from an institution recognized by UGC and RCI
Psychiatric Social Worker"- Those who have PG degree in Social Work and also M.Phil degree in Psychiatric Social Work from a UGC recognized university

Psychiatrist" is a doctor who has done PG or Diploma in Psychiatry from a UGC recognized university

“Informed consent” means consent to a specific intervention given without force, undue influence, fraud, threat, mistake or misrepresentation, and disclosure of all information regarding the benefits, harms and alternatives of the specific intervention, in a language and manner that the individual can understand.

Prescribing mental illness

(1) Mental illness shall be determined in accordance with such nationally or internationally accepted medical standards.

A person shall not be diagnosed with mental illness on the basis of:

political, economic or social status or membership of a cultural, racial or religious group, or any other reason not directly related to the mental health condition of the person.
non-conformity with the moral, social, cultural, work or political values or religious beliefs prevailing in the person's community.
Previous treatment or hospitalisation in a mental health establishment, though relevant, shall not in itself justify any present or future determination of mental illness of the person.
In the context of legal process: The determination of mental illness of a person shall not alone be taken to mean or imply that the person is of unsound mind, unless he has been so declared by a competent court.
Capacity to make decisions for mental illness treatment
Every person, including a person with a mental illness, has the capacity to make decisions about his or her mental health care or treatment if such person:
has the capacity to understand information about treatment, such as the consequences of taking or not taking treatment, and to communicate that decision through speech, gestures or other means.

Advance Directive

An advance directive is a written document that lets you explain what kind of mental health treatment you would or would not want if you develop a mental health problem in the future that makes it difficult for you to make and communicate decisions about your care and treatment. Advance directives ensure that your wishes and choices are respected in these cases. Mental health practitioners, nominated representatives and carers have a duty to follow your advance directives.
The advance directive can be written on a plain paper in the format issued by the Central Mental Health Authority (CMHA), bearing your signature or thumb impression. It should be registered with the Mental Health Review Board (MHRB) in the area where you live.

Nominated Representative

A nominated representative is a person chosen by a person suffering from mental illness to make decisions regarding their treatment when they are not capable of taking such decisions themselves.
The nominated representative cannot be a minor.
If a minor is suffering from mental illness, in such cases their legal guardian-parent will be the nominated representative.
It is the responsibility of the nominated representative to protect the interests and rights of the person.
The nominated representative must ensure that the advance directive of the person is followed.

Rights of people with mental illness

1) Right to access mental health care

The Act states that every person shall have the right to mental health care

This means that good quality mental health services should be available without discrimination, in adequate quantity, accessible and in a manner that is acceptable to the person suffering from mental illness and their family

No person should have to travel far for treatment, there should be a facility for treatment of mental illness in that person's district itself, if there is no facility for treatment of mental illness in a person's district, the administration/government will pay the cost of his treatment

2) Right to self-determination
Under Section 4 of the Act, every person, including a person with a mental illness, has the capacity to make decisions about his or her mental health care or treatment if the person has the capacity to understand the information.

This includes the right to be admitted as an independent patient in a mental health establishment.

3) Right to live in the community
Every person suffering from mental illness should have the right to live in society, to be a part of it and not be isolated from society.

Where the family has abandoned the person, the State will provide legal aid and facilitate the exercise of his right to live in the family home.

If a person suffering from mental illness, who has recovered after treatment and who no longer requires hospitalisation, and who does not have a home or does not know the whereabouts of the family, such persons will also be provided a halfway home or any such shelter by the State.

4) Right to dignity
Every person shall be protected from cruel, inhuman or degrading treatment in any mental health institution, shall not be discriminated against and shall not be subjected to physical, verbal, emotional and sexual abuse and has the right to information

They have the right to see original medical records and to confidentiality

They have the right to complain about their treatment to the Board or to the Mental Health

5) Right to Advance Directives
One of the most important changes is that it gives a person the right to make an advance directive clearly stating how they wish to be cared for and treated for mental illness, and how they do not want to be treated or cared for.

An advance directive will only be valid if the person suffering from mental illness is not capable of making their own decisions (as determined by the doctor) and can take over the decision whenever they are able to make decisions again.

6) Right of Nominated Representative
A mentally ill person has the right to nominate a representative in an advance directive.
The nominated representative will have the right and duty to obtain information and assist the person in making decisions.

7) Right to equality and non-discrimination
Every person with mental illness shall be treated at par with persons with physical illness in the provision of all health services.

8) Right to information
A person with mental illness and his/her nominated representative shall have the right to be informed about the act, admission, treatment and side effects.

9) Right to privacy
A person with mental illness shall have the right to privacy with regard to his/her mental health.

Central Mental Health Authority

All mental health establishments in the country are registered with this authority. They maintain information on all mental health establishments based on data provided by state mental health authorities.
They also develop quality and service provision standards for mental health establishments under the supervision of the central government.
They monitor these establishments and receive complaints.
They maintain a list of all registered mental health professionals, including social workers.
They train law enforcement, mental health professionals and other health professionals about the Mental Health Care Act.
They advise the central government regarding mental health.
They will appoint an expert committee to prepare a guidance document for clinicians and mental health professionals, including procedures for assessing, when needed, the capacity of individuals to make mental health care or treatment decisions.

State Mental Health Authority

The State Mental Health Authority registers all mental health establishments other than those specified in Section 43.
They develop quality and service norms for various mental health establishments in the state.

They monitor these establishments and receive complaints about them.
They register clinical psychologists, mental health nurses and psychiatric social workers in the state to work as mental health professionals.
They train law enforcement and other related personnel about the contents and implementation of this Act.

Mental Health Review Board

Mental Health Review Boards are constituted by the State Authority.
They have the power to register or review any direction.
The Mental Health Review Board may appoint a nominated representative.
The Mental Health Review Board may take a decision against the decision of the medical officer in charge of the mental health establishment or the mental health professional on receiving an application from the person with mental illness or his nominated representative or any other interested person.
The Mental Health Review Board may also visit prisons and seek clarifications from the officers in charge of medical services.

Duties of appropriate Government

Promoting mental health and preventive programmes.
The Government should plan, design and implement programmes for promoting mental health and prevention of mental illness in the country.
Creating awareness about mental health and illness and reducing stigma associated with mental illness
The provisions of this Act are given massive publicity through television, radio, print and online media including social media at regular intervals.
Programmes to reduce stigma/stigma associated with mental illness are planned, designed, funded and implemented effectively.
Sensitization and awareness training is imparted from time to time on issues under this Act including to police officers and other officers of the appropriate Government.

Appropriate Government to take measures in respect of human resource development and training:

- Identify the human resource needs of mental health services in the country, plan, develop and implement educational and training programmes in collaboration with higher education and training institutions to increase the human resources available for delivering mental health interventions and improve the skills of human resources to better address the needs of persons with mental illness.

- Train all health officials in public health service establishments and all medical officers in prisons or jails to provide basic and emergency mental health care.

- Within ten years from the commencement of this Act, strive to meet the internationally accepted guidelines for the number of mental health professionals on a population basis.

Duties of police officers towards persons suffering from mental illness:
(1) It shall be the duty of the officer in charge of every police station.

(a) to take into custody any person found wandering within the limits of the police station who, in the opinion of the police, is mentally ill and is unable to take care of himself.

(b) to take into custody any person within the limits of the police station who, by reason of his mental health, is a danger to himself or to others.

(2) The officer in charge of the police station shall inform the person why he is being taken or his nominated representative shall be informed if, in the opinion of the officer, such person is having difficulty in understanding.

(2) Every person taken under protection shall be taken to the nearest public health establishment as soon as possible, within twenty-four hours.

(3) No person taken under protection shall be kept in a police lock-up or prison under any circumstances.

(4) The Medical Officer of Public Health shall be responsible for the assessment of the person. It is his duty to specifically make arrangements for the assessment of the needs of the person with mental illness and to make arrangements for the assessment of the person.

(5) If after the assessment of the Medical Officer it is found that the person does not have any mental illness, he shall inform the Police Officer who shall then take the person to his home or admit him to a shelter.

(6) In case of a person suffering from mental illness who is homeless or found wandering, a First Information Report of a missing person shall be

registered. It shall be the duty of the concerned Police Station and Station House Officer to trace the family and inform the family about the whereabouts of such person.

Report to Magistrate of ill-treatment or neglect of a person suffering from mental illness in a private residence

(1) Every officer in charge of a police station who has reason to believe that a person residing within the limits of the police station is suffering from mental illness and is being ill-treated or neglected, shall immediately report the fact to the Magistrate within the limits of whose local jurisdiction the mentally ill person resides.

(2) Any person who has reason to believe that a person is suffering from mental illness and is being ill-treated or neglected by any person who has the duty to take care of such person, shall report that fact to the police officer in charge of the police station within the limits of whose jurisdiction the mentally ill person resides.

(3) If a Magistrate has reason to believe, on the basis of a report of a police officer or otherwise, that any person suffering from mental illness is being ill-treated or neglected within the local limits of his jurisdiction, the Magistrate may cause the mentally ill person to be produced before him and pass any order in accordance with the provisions of section 111.

Removal or admission of a person suffering from mental illness to a mental health establishment by a Magistrate

(1) When a person suffering from mental illness or a person who may have mental illness appears or is brought before a Magistrate, the Magistrate may order in writing that,

(a) the person be removed to a public mental health establishment for assessment and treatment, if necessary, and the mental health establishment shall deal with the person in accordance with the provisions of the Act; or

(b) authorise the admission of the person suffering from mental illness to a mental health establishment for a period not exceeding ten days to enable the medical officer in charge of the mental health establishment or the mental health professional to plan the treatment, if any, necessary to enable the person to make an assessment.

(2) On the completion of the period of assessment specified in sub-section (1), the medical officer in charge of the mental health -

-establishment or the mental health professional shall submit a report to the Magistrate and the person shall be dealt with in accordance with the provisions of this Act.

Mental Health Care Act – What are the rights?

All admissions to a mental health establishment shall, as far as possible, be independent admissions, except when conditions exist which make supported admission inevitable. (Except minor children)

Every adult person shall have the right to give advance directions in writing or to appoint a designated representative in special circumstances and serious illnesses.

The person appointed as designated representative shall not be a minor, shall not be competent to discharge the duties or perform the functions assigned to him under this Act, and shall give his consent in writing to the mental health professional to discharge his duties and perform the functions assigned to him.

If a person suffering from mental illness is admitted under this section, he requires support from his designated representative almost hundred per cent. In taking decisions regarding his treatment, the designated representative may temporarily consent to the treatment plan of such person on his behalf.

Mental Health Care Act - What to do?

The determination of mental illness of a person shall not alone be construed or taken to mean that the person is of unsound mind, unless he has been so declared by a competent court.

Every person, including a mentally ill person, shall be deemed to have capacity to make decisions regarding his or her mental health care or treatment.

Where a person makes decisions about his or her mental health care or treatment that are considered inappropriate or incorrect by others, this shall not mean that the person does not have capacity to make mental health care or treatment decisions.

Prohibited procedures

In no case shall the following treatments be subjected to any person suffering from mental illness under this Act-

(a) Electro-convulsive (shock) therapy without the use of muscle relaxants and anaesthesia

(b) Electro-convulsive (shock) therapy for minors

(c) Sterilisation of men or women, when such sterilisation is for the treatment of mental illness
(d) Chaining in any manner or form

Barriers and privacy

(1) A person with mental illness shall not be kept in solitary confinement and physical restraint may be used where necessary only if-
(a) it is the only means of preventing imminent and immediate harm to the person concerned or to other persons.
(b) it has been authorised by the psychiatrist in charge of the treatment of the person in the mental health establishment.
(2) Physical restraint shall not be used for a period longer than is absolutely necessary to prevent the immediate risk of significant harm.
(3) The medical officer or mental health professional in charge of the mental health establishment shall be responsible for ensuring that the systematic nature of the restraint, the justifiability of its imposition and the duration of the restraint are duly recorded in the medical notes of the person.
4) In no circumstance shall restraint be used as a means of punishment or deterrence and a mental health establishment shall not resort to restraint solely on the ground of shortage of staff in such establishment.
(5) The nominated representative of the mentally challenged person shall be informed of each stage of restraint within a period of one hour.
(6) A person who is restrained shall be kept in a place where he or she cannot cause harm to himself or other persons.
(7) The mental health establishment shall include all stages of restraint in the report on mental health to be sent to the concerned Board.
(8) The Central Authority may make regulations for the purpose of implementation of the provisions of this section.

Mental Health Care Act - What Not to Do?

The Act lays down the term "independent patient or an independent admittance".
No person or authority shall classify any person as having a mental illness except for the purposes directly related to the treatment of mental illness or for other matters falling under this Act or any other law for the time being in force.
No person or organisation shall establish or operate a mental health establishment unless it is registered with the Authority under the provisions of this Act.
Section 12 does not allow any medical officer or psychiatrist to use electroconvulsive therapy as a treatment.

20 Pre Marriage Counselling

A word from the team

In communities and contexts we work we have encountered several issues within marriages that severely impacts the mental health of young couples. Often times young people get into marriages without always having a clarity on expectations regarding marriage, and sometimes find themselves struggling, without adequate skills to navigate the relationship and new challenges that arise with it.

Pre marriage counselling is a way to prepare couples with this understanding of oneself and the other as well as providing them with necessary skills that can help them in the relationship. This chapter lays the outline of three sessions that have been conducted with groups of young men and women regarding pre marriage counselling.

Group Session 1 - Ideal Marriage

Goal of the session – To help youth understand their idea of an ideal marriage, how they could prepare for it and understand what they think about their impending marriage.

Expected outcome for session – Introducing young men and women to the concept of pre-marriage counselling, young people openly discussed their aspirations and assumptions about marriage.

Expected time – 35 to 40 minutes
Group size – 8 to 10 young men or young women (separately)

Ask all the participants to sit in a circle
If you think of your life, what would be your most important milestones?
(Counsellor can share their own present or future milestone – birth of your siblings, clearing 10th grade, clearing 12th grade, graduation, post-graduation, first relationship, getting engaged, getting married, birth of children)
(Ask all participants to answer the question)
As all of us agree, marriage is an important milestone in our lives.
So why do you all think marriage is important? (Ask all participants to answer)

Expected answers: romantic partner, companionship, financial security, accepted form of having children, societal expectations/pressure

How do you all feel about getting married?
When do you feel would be the right time to get married?
Who would make the decisions regarding your marriage?
How would you cope with a situation where you and your parent's choices regarding your marriage don't match? It can be regarding when to marry, choice of partners or anything else.
(Please note maker makes a note of all the answers)
So according to you, how will your life change after marriage? (Ask all participants to answer)

So now all of you agree that marriage is an important milestone in your life and is going to change your life in many ways.
Let us do a small activity
I request all of you to close your eyes and think about what an ideal marriage for you would be. (give them a minute and ask all participants to share their answers)
(Summarize whatever the participants have shared)
So how did you build your idea of this ideal marriage? Is it based on something you have seen, experienced or heard of?
Ask all the participants to answer.

Expected answers – Religion, Bollywood, looking at their parent's marriage, marriage of someone they know.
Asking probing questions on every answer – If someone says movies influenced their idea of an ideal marriage, ask how were they influenced by movies? Is their perspective on an ideal marriage realistic?

In the past, we have prepared to make the best of the milestones event coming up our way. Like we studied hard for our exams, prepared ourselves for job interviews.

In a similar way, we must prepare for marriage. You have to understand your expectations from your life after marriage, your partner, your family and your in-laws, your finances and how that will affect your life. And you have to learn some skills like reciprocity, openness, learning to say no. These skills will not only help you for life after marriage, but also life in general.

I hope this discussion helped think about your vision of an ideal marriage. In the following 2 sessions we will help you think more about your life after marriage and teach you skills that will help you navigate it. We would not be telling you things you should and things you shouldn't do. We will only tell you things you might want to think about as you are starting this very important phase of your life. We would have 2 more sessions on this topic and each session would be 40 to 45 minutes long.
So looking forward to meeting you in the next session?

Session 2 – Expectations, Non-Negotiables and living with family

Goal of the session – Discussing the expectations that youth have regarding their marriage and helping them think about their non negotiables.
Expected Outcomes – The youth will get a better understanding of the expectations they have of their life after marriage, what are their non negotiables and what to do if their expectations are not met.
Expected time – 35 to 40 minutes
Group size – 8 to 10 young men and women (Seperately)

Material Needed – A4 sheets of paper, crayons, tablet/laptop to play the videos, flyers
In the last session, we understood your vision of your ideal marriage and we asked you all to think if your vision of an ideal marriage was realistic. From our idea of an ideal marriage, stem our expectations from our married life and partner.
So, what are your expectations from your spouse and life after marriage? (Give a paper, crayons to each participant and ask them to draw a picture their ideal life after marriage)
Ask each participant to explain their picture. Based on the explanations, ask them specific questions given below
Lifestyle- do they like going out? Food preference – vegetarian/no-vegetarian food
Financial responsibilities – do you want to work after marriage? If you are working after marriage, what support will you need for household chores?
What is the kind of emotional support would you need after marriage? (behavior of partner, temperament of your partner)
Do you feel that your expectations will change as time progresses?
How do you deal with unfulfilled expectations? (Ask 2-3 young people to answer)
Thank you for your answers! Here are some more ways you can deal with unfulfilled expectations.
1. Bear with and forgive your spouse
Your spouse, just like you, are imperfect. No matter how much you or they try to always be on point, that is not possible. So accept their flaws or weaknesses.
2. Check if Your Expectations are Realistic
3. Communicate Your Expectations
4. Initiate The Change You Desire – practice what you preach, if you want your spouse to be patient, than first you become patient with them. If you want to go out with your partner, you plan it. Don't leave it up to them.

Now all of us have understood our expectations from our partners. Now lets look inwards!

Let's do an interesting activity.

Divide the group in two teams - Team A and Team B. Both groups must discuss what qualities they must have in themselves to be good spouses to their future partners.
Give groups pointers they can consider – Nature, Behavior, financial contribution, mindset
Give both the groups 10 minutes to discuss the topic and then give them 5 minutes to present their discussion.

Ask the youth what did they learn from this discussion?

"As we have expectations from our partners, our partners and their families would also have expectations from us. For any relationship to be successful, it is very important to be self-aware of your strengths, your weaknesses, what you bring to the table and how you can become better."

The opposite of expectations is non-negotiables. Non-negotiables means something that is not open for debate for modification or discussion.
Ex – In a school, during exams, cheating is not negotiable. Cheating will lead to failure in exam. Similarly, relationships also have non-negotiables.
Look at these video clip and let me know your thoughts on it -

Youtube | Channel: Nijo Jonson | "Husband Demands For Dowry From His Wife | Nijo Jonson | Motivational Video"

There might be some things that you cannot absolutely tolerate in your marriage or relationships. Things that hurt you or make you feel bad about yourself.
Take a minute and think what those points are for you.
Ask the youth to share their non-negotiables. Ask them to explain each of their non-negotiables. Ask them to explain the "why" of their choice.
Check if the points cover Dowry and domestic violence. Explain that these are offences punishable by law. (We will give the girls a 2 pager with more details).

All of us want our marriages and relationships to go well, but sometimes things can go sour. When things go sour, knowledge of laws is not enough. You should be courageous enough to take action. And you should have enough savings/income so that you sustain yourself. So, while you are focusing on making your relationship work, also think about how you need to be prepared for the worst case scenario.
In India, it is said that marriage is not between two individuals but between two families. Support from your family and your partner's family can make your marriage flourish and at the same time family interference can also make a relationship sour.

Have you understood what your family's expectations are from your future partner? Do those expectations match your expectations? (example: your parents want a stay at home daughter in law but you want your partner to work after marriage)
What expectations do you have of your family after marriage? (Example- financial support after marriage)
Also, have you discussed the support that your family will require of you after marriage? (Ex- supporting your siblings financially)
If you have not had this discussion, please have it with them.
Think about all these points and we will meet you again in the next session.

Session 3 – Learning new skills

Goal of the session – Teaching youth some important skills which will help them with their married life
Expected Outcomes – Youth would learn more about the skills of decision making, negotiations and resilience
Expected time – 35 to 40 minutes
Group size – 8 to 10 youth
In this session, we are going to learn about different skills which will not only help you with your marriage but will also help you with other inter-personal relationships.
Explain this case study to the group
You want to go to a movie with your friends. Your partner is not okay with that because he doen't know your friends well. He asks you not to go to the movies. You feel that your partner is too controlling so you fight with him. Your partner gets upset and stops speaking with you. You also become upset and are not in a mood to go for the movie, so you stay back home.
What do you think went wrong in this situation? (Ask 2-3 participants to answer)

Now consider one more situation – Your friends are calling you for a night over. Your spouse/parents are not in favor of you going out. What would you do? (Ask 2-3 participants to answer)
Great!

Now let's do a small exercise to logically think through the problems.
1.Define the problem or the decision to be made – Should you go to the night out or not? If you go for the night out, you will disappoint your spouse/parents. If you don't go out, you will miss out on the fun with friends.
2.Consider all the possible options/alternatives to solve the problem or decision - Going to the nighout, not going to the night out, going for some time and coming back, trying to negotiate with your parents/partner to let you go. (Ask the participants to share more options)
3.Write down all the positives and negatives for each option/alternative. (do this with the group)
4.Weight all the positives and negatives for each option. (do this with the group)
5.Select the best alternative.(do this with the group – try to discuss the details of the solution)
6.Implement the solution. (do this with the group – focus on the how of the solution)
7.Monitor progress (discuss how you could monitor progress)
8.Review and learn from your experience (discuss how you will set up the review process)

What did you learn from this exercise? (Ask 2-3 participants to answer)
One of the important skills we need to learn deal with situations like these is negotiation skills.

Lets do an interesting exercise.
Setting up the Arm Exercise – Never say "WRESTLE"!
You must never say the words "arm wrestle."Here's what you do:
· Have everyone find a partner.
· Ask partners to "assume this position." Demonstrate with a volunteer, and hand link position with both of your elbows on the table.
· Explain, "This is a very easy exercise. There are two things you must know.
1- you get a point if the back of your partner's hand touches the table
2-you want to get as many points for yourself as possible.

The Debrief:

- By a show of hands, ask how many points each person got. "0 points?" "1-5 points?" "6-20 points?" "More than 20?"
- Behavior questions: For a team that got a LOT of points, ask, "What did you do?" If everyone gets locked, ask "How did you lock? Why? Could you have done anything differently?" Offer to show how some teams generated many points: by either flip-flopping their hands backward and forward or by repeatedly tapping one player's hand on the table and agreeing to share the points.
- Reasoning questions: For pairs who got many points, ask how or why they did what they did. How did they come to that? Who said what to whom? What were you thinking? Did the person who came up with the idea offer to tap the back of their partner's hand on the table, rather than their own?
- Assumptions questions: For teams that got very few points, try to tease out the assumptions they made that limited their success, such as:
  - We assumed no communication
  - We assumed we had to keep our hands together
  - We didn't trust each other
  - We assumed the rules were set

At the end of the activity, discuss how difficult it is to dismantle assumptions and develop a collaborative approach when folks assume that more for one person means less for the other. The aim should be win-win situation for both.

And even if you do all things right, there is a possibility that things might not go your way. In such situations, you have to be resilient. Psychological resilience is the ability to cope mentally and emotionally with a crisis, or to return to pre-crisis status quickly.

Life is constantly changing and evolving. This means that from time to time, things just stop existing. Losing a job, ending a marriage are examples of changes that many people have experienced. We lose out on something important, a big plan collapses, or we are rejected by someone. Another way of expressing this feeling of loss is that a door is being closed. However, the end of one thing is always the beginning of something new. We have the option to stay focused on what is not here anymore (the doors that have been closed) or become aware of the new avenues that unfold. Optimism is about the latter option. It is about also seeing the doors that are being opened. It is about holding a favorable view about the future, taking closing doors into consideration and turning them into something beneficial.

Then the Facilitator will share a personal story of how they overcame challenges in their life through resilience.

Now let's do an interesting activity called Door Opens, Door Closed.
Think about a time in your life where someone rejected you or you missed out on something important or when a big plan collapsed. These would be points in your life where a door closed.

So, what was the door that closed on you? Think about this for 30 seconds
Now think about what happened after: what doors opened after? What would have never happened if the first door didn't close?
So, what was the door that opened for you? Think about this for 30 seconds

Now, reflect upon your experiences and respond to the following questions:

- What led to the door closing? What helped you open the new door?
- How long did it take you to realize that a new door was open?
- Was it easy or hard for you to realize that a new door was open?
- What prevented you from seeing the new open door?
- What can you do next time to recognize the new opportunity sooner?
- What did you learn from this whole experience?

Ask 2-3 youth to share their experiences of open doors and closed doors and then make them answer 2 of the above questions each.

"Now think of one closed door you are facing right now." Give the group 30 seconds to think of an answer.
Now think what can be an open door for you? Give the group 30 seconds to think again

I hope this approach helps you solve the issues you are facing currently. These three sessions give you glimpse of things you need to keep in mind as you start your married life. If you are engaged, you can come for more indepth counselling with you partner. You can share about this service with friends and family too.

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