

# Psychosocial Counseling for Trafficked Youth



Specialized Training Manual on  
**Psychosocial Counseling  
for Trafficked Youth**

- handling the trauma of sexual exploitation



**IPEC** Trafficking in Children-South Asia (TICSA)



Specialized Training Manual on  
**Psychosocial Counseling  
for Trafficked Youth**

International Labour Organization  
International Programme on the Elimination of Child Labour  
ILO-IPEC

April 2002

The ILO's International Programme on the Elimination of Child Labour (IPEC) is dedicated to the progressive elimination of child labour worldwide, emphasizing, as a matter of urgency, the eradication of its worst forms. IPEC works to achieve this through country-based programmes which implement concrete measures to end child labour; and through international and national advocacy and awareness-raising aimed at changing social attitudes and promoting ratification and effective implementation of ILO conventions relating to child labour.

This manual was written by Mark J.D. Jordans, Center for Victims of Torture of Torture (CVICT) Nepal/Transcultural Psychosocial Organization, Amsterdam.

The training methodology was piloted in Nepal in 2001/2002 and will be adapted and field-tested in more countries of South Asia by ILO-IPEC's Trafficking in Children - South Asia (TICSA) Project.

The manual and training are supported by the United States Department of Labour.

The designations employed in ILO publications, which are in conformity with United Nations practice, and the presentation of material therein do not imply the expression of any opinion whatsoever on the part of the International Labour Office concerning the legal status of any country, area or territory or of its authorities, or concerning the delimitation of its frontiers.

The responsibility for opinions expressed in signed articles, studies and other contributions rests solely with their authors, and publication does not constitute an endorsement by the International Labour Office of the opinions expressed in them.

Reference to names of firms and commercial products and processes does not imply their endorsement by the International Labour Office, and any failure to mention a particular firm, commercial product or process is not a sign of disapproval.

ILO Publications can be obtained through major booksellers or ILO local offices in many countries, or direct from ILO Publications, International Labour Office, CH-1211 Geneva 22, Switzerland. Catalogues or lists of new publications are available free of charge from the above addresses.

Published by the International Labour Organization, Kathmandu, Nepal.

First published 2002

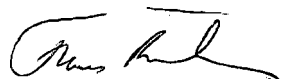
# Preface

The ILO Convention on the Worst Forms of Child Labour (182) adopted in 1999 defines trafficking of children for sexual and labour exploitation as one of the worst forms of child labour. The Convention calls for countries to take immediate action to secure the prohibition and elimination of all worst forms of child labour, and has been widely supported by 117 countries of ratification (as of March 2002). Among those countries, the Government of Nepal showed its strong commitment and took an initiative to eradicate the worst forms of child labour within a defined period of time. The ILO's International Programme on the Elimination of Child Labour (IPEC) launched a Time-Bound Programme (TBP) together with the Government of Nepal in 2000 with special focus on bonded child labour, domestic child labour and child trafficking.

The ILO-IPEC project titled Trafficking in Children South Asia Project (TICSA), which forms part of TBP, has been providing technical assistance to prevent and withdraw/rehabilitate children from trafficking. Through the implementation of the project, it has increasingly been recognized that these children need special attention and emotional support after the rescue/withdrawal. For those children, it will take time to overcome their traumatic experience and to prepare them for their return to school or to start learning new vocational skills. Above all, self-confidence, trust and hope need to be re-established in their minds. TICSA has devoted special attention to these critically important questions, and has developed professional treatment/care for children. It helps them to overcome their emotional problems and to fully recover and develop their capacity and talents.

Experiences in psychosocial counselling provided in shelter homes and transit homes for traumatized children in most South Asian countries have been limited and, in part, inconclusive. It is essential to provide adequate support to the target children. TICSA, therefore, supported the development of the present *Specialized Training Manual Psychosocial Counseling for Trafficked Youth* by the Center for Victims and Torture (CVICT) in Kathmandu. This manual is offered to social workers and counsellors who help the children in rehabilitation centres in South Asia. It has been field tested and introduced by way of a four months' intensive training programme in Kathmandu in the fall of 2001.

We hope that this manual will inspire other programmes and interventions in the field of psychosocial counselling of trafficked children and adolescents, and that it will improve quality of psychosocial care that accelerate healing process of children so tragically abused by trafficking.



Frans Röselaers  
Director  
ILO- IPEC  
Geneva

# Table of Contents

Preface		i
Table of Contents		ii
Introduction		iii
Structure of the Manual		iv
Session I	Social and Emotional Problems related to Counseling Trafficked Youth	1
Session II	Trauma	3
Session III	Stress and Relaxation	7
Session IV	Functional Complaints	9
Session V	Working with Groups	11
Session VI	Advanced Communication Skills	13
Session VII	Counseling for People with HIV/AIDS	15
Annex I	Psychosocial Counseling - An Overview	17
Annex II	Psychopathology - An Overview	18
Annex III	Sexuality - A Theme to be Explored	23
Annex IV	Trauma Recovery	25
<b>References</b>		<b>27</b>

# Introduction

## Psychosocial Counseling for Trafficked Youth

It is widely recognized, in literature as well as in practice, that people who have experienced life-threatening or otherwise traumatic experiences have an increased risk of suffering from psychological distress. People who have been trafficked for sexual exploitation have often been traumatized by a number of terrible events. The vulnerability is heightened when the victims of trafficking and sexual exploitation are young people or children, posing an extraordinary challenge to help them in their healing process. To assist them in dealing with the psychosocial consequences, individuals working with them need to be trained to provide such assistance.

As this is a new field of expertise in Nepal, the need seems to lie in *how to provide training* on these issues. This manual therefore forms the basis for a training course for counselors-to-be working with trafficked youth. It supplements an existing general training manual by providing a more in-depth thematic and specialized focus related to (trauma-) counseling for trafficked and sexually abused youth and it is recommended that it is used in conjunction with this.<sup>1</sup>

The experiences that trafficked youth have been forced to go through are torturous and against the most fundamental human rights. After rescue, their problems continue as they are confronted with difficulties, practically, socially and emotionally, hence the rehabilitation process needs to take into account many complex problems.

The reactions to the traumatic experiences among the survivors include anger towards abusers, hopelessness about reintegration in a society that tends to stigmatize victims of sexual abuse, feelings of depression, physical complaints, re-experiences of the traumatic events, etc. Psychosocial counseling, as one factor of the overall rehabilitation process, can be a valuable addition to assist the survivor to deal with such psycho-social problems.

This material is developed in the hope that it can contribute to the assistance of trauma survivors in their struggle to build self-confidence.

---

<sup>1</sup> General Manual and Training Handbook on Psychosocial Counseling for Children in Especially Difficult Circumstances, Second Edition UNICEF. Mark Jordans, 2001

# Structure of the Manual

When this manual refers to counseling and counselors it concerns *psychosocial* counseling (as opposed to other forms of counseling such as legal counseling, educational or vocational counseling). Furthermore the term refers to the form of counseling that is mostly adapted by other manuals with similar objectives, namely a combination of components of client-centered counseling and problem-solving counseling. In this manual the term “*youth*” is applied for pre-teen children and adolescents, though the emphasis lies on the latter. “*Survivor*” is commonly used by those working with minors who have been trafficked. “*Child*” is anyone under 18.

The manual is divided into different sessions, each dealing with a topic that is relevant for counseling trafficked youth. Each session describes in detail the activities to be conducted and all the materials needed, *transparencies* for giving lectures and *handouts* for additional reading materials for the participants.

This manual is designed for a training course for ILO-IPEC - supported NGOs that work for trafficked youth, with the aim to integrate improved psychosocial counseling in their rehabilitation process of victims. However, the manual can be more generally used, by extracting sessions or as a whole, for different training courses on psychosocial counseling, as well as for different groups of trauma survivors, such as children withdrawn from other worst forms of child labour.

Trafficking of youth occurs for different purposes, most notably for sexual exploitation. The manual has been designed with this particular group of victims of trafficking in mind.

While using this manual in Nepal (or other non-Western societies) it should be kept in mind that originally the concept of counseling is Western. Though in practice it has proven to be effective in Nepal, it remains important that one is aware of local, social and cultural reality and strengths, to which counseling can be an addition.

This manual does not pretend to cover the full scope of the issues discussed. It is written for training para-professionals and counselors for whom these issues are new.

# Social and Emotional Problems Related to Counseling for Trafficked Youth<sup>2</sup>

## Introduction

This session will shed light on problems that trafficked youth might experience, *as a result* of being trafficked and/or sexually abused. More than any other group, trafficked youth are confronted with severe social and emotional problems. These problems deserve explicit attention because understanding the scope of these issues is essential for understanding and conducting psychosocial counseling for this particular group. Social and emotional problems are often the largest obstacles for reintegration and psychological well-being. Therefore, initially, topics such *as loss of safety, distrust, stigma, future, and fear* need to be addressed. These issues might even be the sole focus and function of counseling.

## Activities

**Time** - 3 hours

**Materials** - Flipchart, markers

### Procedure

- 1 The trainer explains to participants that the social and emotional problems the trafficked youth might be experiencing are a primary focus during counseling (see introduction).
- 2 The participants are asked to brainstorm on possible social emotional problems of trafficked youth and discuss why particularly trafficked youth might experience each of these problems. If needed, the trainer gives additional information or additional problems (see handout 1.1 to be provided only at the end of this session).
- 3 To sensitize and encourage understanding of the intensity of some of these feelings, the participants are asked to close their eyes (or otherwise focus their attention).

The trainer asks them to imagine they have been sexually abused (at any level the participants feel comfortable with).

After some time the trainer asks them to imagine how they would feel having to tell their family about what happened.

After some time the trainer asks them to imagine how they would feel if everybody in the village/community knew what had happened.

After some time the trainer asks them how they would think about the future.

After some time the trainer asks them to imagine how it would be to engage in a (sexual) relationship again.

*Note:* the participants should not be forced to imagine anything if they feel they cannot or do not want to. This should be respected by the trainer. Furthermore other imaginations can be added or the above ones can be adapted. Finally the trainer should finish the exercise with a relaxation technique (e.g. deep breathing).

<sup>2</sup> Trafficking, in this manual, refers to a form of exploitation in which a person is moved for sexual exploitation. The session could also be used to counsel children who have been sexually abused.



- 4 The trainer asks the participants how they felt during the imaginations. The trainer should make a link to previously identified social emotional problems (for example in the above imaginations these could be anger or grief about the event; fear of other's reactions; feeling stigmatized; worried about the future).
- 5 The participants are asked to conduct a group role-play<sup>3</sup> on feeling stigmatized, worried about the future and feeling unsafe respectively. Each should last approximately 20 minutes.
- 6 The trainer initiates a group discussion on the problems described in *handout 1.1*; *how should these be handled in the counseling process?*

## Resource Materials

### *Handout*

#### 1.1 Overview of social emotional problems

### Synthesizing

The trainer gives an opportunity for asking questions and summarizes the session with the following points:

**Summary** - Being subjected to humanly degrading experiences (in particular structural sexual abuse), might have psychosocial consequences; vulnerability to a variety of interpersonal and intrapersonal problems and feelings varying from low self-worth to feelings of sense of guilt and depression.

**Critical Note** - Besides these social and emotional problems, the trafficked youth might experience many different and additional problems, which are practical (e.g. how to earn money now) or medical concerns. As mentioned in the introduction of this manual, psychosocial counseling should go hand-in-hand with other rehabilitation services that aim to relieve practical problems.

### Evaluation

Ask the participants to rate (on 0 – 10 scale) their understanding/awareness about social emotional issues of trafficked youth *related to counseling*.

<sup>3</sup> A group role-play means that all participants are the counselor and one is the child/young person. The counselors get a chance in turn to ask a question, summarize, reflect etc. In this way the counselor changes continuously while the young person remains the same. All get a chance to practice but at the same time to learn from how others do counseling. This should be followed or interrupted by feedback from the trainer.

**Handout 1.1****Social Emotional Problems<sup>4</sup>**

All the topics listed below deserve a good deal of attention within the counseling process.

**Safety**

Traumatic events rob the individual of a sense of control, possibly resulting in deep feelings of insecurity (e.g. 'if I have no control it can easily happen again'). Trafficked youth might feel unsafe towards other people. Their own emotions and thoughts can reflect a feeling of insecurity towards the new situation. They have been forcefully separated from attachments/ relationships. Establishing a new sense of safety is therefore the first priority. This can be done by focusing on establishing trusting relationships through counseling; assisting in mobilizing support systems; providing medical attention and providing a safe shelter and environment that prevents them from being re-victimized. Only when a basic sense of safety is established can any other form of assistance be effective.<sup>5</sup>

**Guilt**

The young person might experience feelings of guilt because:

- ▶ S/he is talking to you and disclosing a secret.
- ▶ The act of abuse has happened to her/him.
- ▶ S/he may feel the abuse was her/his fault.

**Distrust**

Distrust of others is very common because of feelings of being "victimized" and having no one to protect her/him. The trafficked person is often betrayed by people close to her/him.

**Stigma**

The feeling that one is negatively valued purely by the fact that one is sexually abused is called 'stigma'. It entails that the person is disgraced in the eyes of the community or society, which makes reintegration in society often impossible (e.g. nobody wants to marry a sexually abused person). This might further develop intense worries about the future.

**Relationships**

Feelings of shame are very critical in cases of sexual abuse. The relationship with peers, which is important to an adolescent, needs to be maintained even after disclosure. The counselor, together with the adolescent, can help encourage this;

- ▶ Meeting friends personally in school and in the community to encourage them to continue to support the adolescent. Stressing that the abuse was not her/his fault.
- ▶ Talking to parents/teachers of the adolescent encouraging them to allow peers to visit her/him in the centre to maintain proper peer relationships.
- ▶ Meeting new peers in the centre through healthy group life experiences.

**Fear**

Often the child/adolescent is threatened by the abuser not to say anything to anyone or is threatened during the act of abuse. The fact that s/he is talking to a counselor may therefore result in fear, which should be recognized by the counselor and eventually be dealt with. There might also be fear of repetition of the abuse.

## Shame

Feelings of shame about what s/he had to undergo or undertake are very common. As with other emotions the child should be allowed to ventilate these feelings. There might be feelings of shame because of:

- ▶ Feelings of arousal and/or enjoyment the victim may have experienced during the event.
- ▶ Feeling dirty and unworthy.
- ▶ Feeling s/he caused the abuse.

These feelings should be handled with *acknowledgement*, *explanation* (e.g. that arousal and enjoyment are uncontrollable), *reluctance* (e.g. that it is not her/his fault, and that it is the role of society and adults to protect children) and *patience*.

## Anger

Feelings of anger will often come much later in the process. This is a healthy reaction, which should be expressed and dealt with in counseling. Appropriate ways of expression and management of anger are, for example, journal writing, relaxation techniques.

## Isolation/Loneliness

Extreme isolation – a feeling of emotional detachment – reflects a sense of being different from others and the survivor's fear that her/

his 'real' or 'bad' self will be discovered by others. This isolation might reflect feelings of helplessness and inadequacy.

Especially in societies where survivors of sexual abuse are often not accepted, the adolescent has often been dealing with the situation (secretly) alone.

## Self-worth<sup>6</sup>

It is common for adolescents who are sexually abused to have low self-worth, because they have been structurally treated without respect and dignity. Following are some suggestions that can increase adolescents' positive feelings about themselves<sup>7</sup>:

- ▶ Praise them for all their appropriate or positive behaviour.
- ▶ Criticize as little as possible.
- ▶ Don't compare their behaviour with that of others.
- ▶ Find activities that they excel in and create the opportunity for them to conduct these, or activities with success built in.
- ▶ Keep expectations realistic.
- ▶ Reinforce effort not just task completion.
- ▶ Break tasks into small manageable components.

<sup>4</sup> From Jordans, 2001.

<sup>5</sup> Herman, 1992

<sup>6</sup> Actually enforcing the self-worth of youth is an element that can be present when counselling any youth, this can, therefore, be applied in other sections as well.

<sup>7</sup> McNamara & McNamara, 1993

# Trauma

## Introduction

Most children and young people who have been trafficked have been forced to experience highly traumatic situations. This might have been a one-time traumatic incident (T1), but more likely a continuous confrontation with traumatic experiences (T2). Though it is important to *know about* formal trauma treatments (such as Exposure, EMDR<sup>8</sup>, Testimony) they will not be the main focus in this training, for the following reasons;

1. These methods are especially useful for the T1 group, whereas trafficked youth is mostly within the T2 group.
2. The social and emotional problems can be so intense and disturbing that often these need first attention; only when these are dealt with dealing with the trauma begin. Therefore there is a need to conduct counseling focused on emotional support and problem solving (and psycho education if necessary).
3. These formal treatments need extensive training and expertise and the effects for children and adolescents in Nepal is not proven.

Still a basic understanding of the main components of trauma treatment are essential and might need to be partially implemented (and thus also trained for such).

These main components, in addition to emotional support, assisting in problem solving and psycho education, are: re-telling of traumatic events combined with relaxation. Though exposure will not be actively conducted, re-telling/re-experiencing might naturally come up during counseling. In such cases, the counselor needs to be prepared and able to assist and support in that process.

## Activities

**Time** - 4-5 hours

**Materials** - Flipchart, markers, meta-cards

### Procedure

1. The trainer explains what *trauma* is (*see transparency 2.1*).
2. The participants, in sub-groups, are asked to come up with events, situations, experiences that can be traumatic.
3. The participants are asked to brainstorm on the consequences/reactions after experiencing (a) traumatic event(s).
4. The trainer gives an overview of causes and reactions of traumatic experiences, additional to the outcomes from previous exercises. This includes an explanation of PTSD (Post Traumatic Stress Disorder) as an example of a trauma reaction disorder. (*See hand out 2.1*)

<sup>8</sup> Eye Movement Desensitization and Reprocessing, see handout 2.2

- 5 The participants are asked to write on meta-cards what they would *need* or *want* in order to overcome/deal with a traumatic experience or its reactions (they can either think of a personal traumatic experience or imagine one).
- 6 The trainer, making a link to the previous exercise, gives an overview of the *recovery* possibilities for:  
  
Psychosocial counseling for social and emotional problems due to trauma (*see hand out 2.2*) (this is the main focus of this training and continues in the previous session).  
  
Specialized treatment for PTSD and other trauma related disorders (*see hand out 2.2*).
- 7 Two participants (one counselor, one client) are asked to role-play on providing emotional support for a traumatized adolescent (15 year-old girl, trafficked for sexual exploitation), assisting with the trauma reactions she is experiencing, such as recurrent flashbacks, sleep disturbances and fear. The role-play should last 30 minutes, though during the role-play the trainer can ask another participant to be the counselor.
- 8 As mentioned in the introduction re-experiencing/retelling the traumatic incident(s) might occur and, although we do not conduct exposure or the like, we also do not ignore it. As described in *hand out 2.2* the counselor *should support* the process of retelling. To sensitize the participants to the experience of retelling and on how to provide support they are asked to conduct role-plays in pairs. One participant is him/herself retelling a painful /traumatic incident in his/her life while the other participant reacts as the counselor that provides support. After 15 minutes the roles are switched. At the end of the exercise the participants share their experiences of retelling incidents and of being a counselor.  
  
Note: Participants should in no way be pressured to tell an event that they do not wish to share.
- 9 The trainer asks the participants how they felt while retelling their experience to the counselor.
- 10 Finally, the group reads together the *hand out 2.3 Text to provide information during counseling*.

## Resource Materials

### *Transparency*

#### 2.1 Definitions and Nature of Trauma

#### 2.2 Process of Retelling

### *Handout*

#### 2.1 Overview of Trauma Reactions

#### 2.2 Overview of Treatment

#### 2.3 Text to Provide Information during Counseling

## Synthesizing

The trainer gives an opportunity for asking questions and summarizes the session with the following points:

**Summary** - This session dealt with the nature and consequences of traumatic events, as well as with the methods that assist in the person's recovery process.

**Critical Note on Trauma as an Explanatory Model** - These days the most popular explanatory model among Western clients and clinicians is the trauma model (i.e. people believe that suffering is caused by trauma). The trauma model is also becoming popular in South Asia among mental health professionals. It has the important limitation that it does not take into consideration the person's experience/habits/symptoms before the trauma happened and it has little consideration for other causes of the suffering. Many adolescents have suffered traumatic life events but not all have mental problems. Psychosocial counselors should be able to recognize signs of mental or emotional distress in youth (as a result of traumatic experiences).<sup>9</sup>

## Evaluation

Ask the participants to write on a meta-card *one specific thing* they learned during this session.

---

<sup>9</sup> Poudyal & Ommeren, 2000

## Transparency 2.1

# Trauma

Trauma is another word for an event that is horrific, that invokes extreme anxiety or extreme helplessness. During the trauma, the victim is in severe stress having intense fear because of threatened death, serious injury or threat to the physical and psychological integrity (well-being) of self or others.

Traumatic events may destroy the person's fundamental assumptions about safety, positive self-worth and meaningfulness in life. Examples are rape, war, earthquakes and torture.

## Transparency 2.2

# Process of Retelling

When the child or young person initiates or expresses a need to retell the trauma event(s), the counselor needs to support this. When guided well it can be an important aspect of the recovery process.

## **1 Support**

- Provide empathy
- Provide safety

## **2 Follow child's pace**

- Do not rush
- Do not push
- Do not interfere (unnecessarily)
- Check feelings, whether to continue or not

## **3 Explore in more detail**

- When child wants to
- When child initiates
- When child clearly shows relief

## **4 Simultaneous relaxation**

- Deep breathing
- Imaginary relaxation



**Handout 2.1****Overview of Trauma Reactions****Possible Reactions after Trauma<sup>10</sup>**

Reactions that are part of the diagnosis for Post Traumatic Stress Disorder are indicated with PTSD between brackets.

Feeling lonely

Shock

Fear

Suicidal tendencies

Shortness of breath

Passive

Restlessness

Recurrent thought about trauma (PTSD)

Mood disorder

Avoiding reminder of trauma (PTSD)

Forgetfulness

Amnesia of trauma (PTSD)

Hallucination

Nightmare (PTSD)

Stress

Sleep disturbance (PTSD)

Crying

Irritability/Anger (PTSD)

Reduced interest/Feeling detached

Hyper vigilant/Easily startled (PTSD)

Hyperactive (children)

Lack of concentration (PTSD)

**Post Traumatic Stress Disorder**

If, in reaction to being exposed to a highly

traumatic experience, an individual reacts with intense fear, distress and/or helplessness and other disturbing trauma reactions are present (see above and below) we can speak, in psychiatric diagnostic terms, of a disorder, namely Post Traumatic Stress Disorder (PTSD). Note that there are also other trauma reaction disorders but PTSD is the best known.

The three main components of PTSD are:

***Re-experiencing*** - this includes unwillingly reliving the incident(s) through intrusive thoughts, nightmares, flashbacks etc.

***Avoidance*** - this includes wanting to forget the incident(s), avoiding thought, feelings, situations or activities that recall the trauma, diminished interest in activities or people etc.

***Hyper-arousal*** - this includes physiological reactions (restlessness, exaggerated startled response, excessive alertness, difficulty concentrating) as a result of fear that the incident(s) will happen again.

**Comorbidity**

Trauma can increase the vulnerability for mental health problems. In addition to PTSD, here are some disorders that may occur after trauma:

- ▶ Depression
- ▶ Anxiety disorder
- ▶ Substance and alcohol abuse
- ▶ Dissociative disorder (e.g. 'hysterical fits')

## **Psychosocial Consequences from Trauma on Children**

*(Some symptoms have already been mentioned above)*

- ▶ General and specific fears such as fear of separation, fear of darkness
- ▶ Regression to a previous development phase, especially younger than 7, such as enuresis
- ▶ Behavioural problems such as aggression and disobedience
- ▶ Re-experiencing in daily activities, play or nightmares
- ▶ Psychosomatic problems such as stomachache and headache
- ▶ Problems in social interaction.

---

<sup>10</sup> Many of these symptoms also occur among people who have not gone through trauma. These symptoms are part of a wide range of disorders. Thus, even though the above symptoms can be a consequence of trauma, these symptoms do not necessarily result from trauma! (Poudyal & Ommeren, 2000)

**Handout 2.2****Overview of Treatment****By Psychosocial Counselors<sup>11</sup>**

Above all it is essential that the counselor creates an atmosphere and relationship of respect, confidentiality and safety. The counselor should treat the child/adolescent with understanding and dignity and should convey sincere concern and care. Do not rush the counseling process. Each aspect of recovery (as described below) needs attention for one or more sessions. Furthermore the counselor should largely follow a similar process as with any client (e.g. introduction, identifying the problems, goals setting, implement changes, evaluation). As described in *Annex IV – Trauma Recovery* the first focus should always be restoring the direct *safety* of the client.

**Supportive Counseling**

Through communication skills (such as summarizing, reflections, non-verbal communication) and empathy, the counselor can support the child in dealing with the emotional impact of the trauma and its consequences. Trauma survivors often complain about sadness, depression and anxiety/fear. Counselors should focus much of their attention on these emotions. The child might not want to talk about nightmares, abuse and/or torture. The emotions as a result of the trauma can be so intense that they need full attention during counseling; the counselor should therefore encourage the expression of emotions (e.g. anger towards abusers). Furthermore the child should be encouraged and, if needed, assisted in strengthening her/his constructive coping strategies and changing her/his destructive coping strategies.

**Problem-Solving Counseling**

The actual trauma incident cannot be changed through counseling, however *as a result of* the trauma incident there might be problems that *can* be dealt with in counseling. These problems can be intensely disturbing the young person's daily life and therefore should initially be emphasized over the actual trauma event. A variety of problems might occur, such as body pains, not knowing what to do in the future, sleep or concentration problems (there exists overlap with the emotional problems mentioned above) or social problems and practical problems if applicable.

**Giving Information during Counseling<sup>12</sup>**

The counselor can provide information about what trauma is and its possible reactions or generally how people react to high levels of stress. Giving such information is likely to reduce the child's feeling that s/he is strange, different or overreacting, which in itself is a stressor. It *normalizes* the responses. Giving information, which should be adapted to the need and level of each child/young person, can be through reading a text to the child/young person (*see hand out 2.3*) or explaining how the human body functions (e.g. related to stress). Giving information can be followed by exploring whether s/he recognizes such reactions/information and by encouraging her/him to express similarities and differences.

**Relaxation<sup>13</sup>**

A trauma event and its reactions are highly stressful for everybody. One way of reducing or coping with such stress is relaxation. The

counselor can therefore teach relaxation techniques to deal with current stresses in the child's life (e.g. s/he can conduct a preferred relaxation exercise when feeling stress, anxiety, fear in her/his daily life). Also, relaxation can be used in response to tensions that arise within a counseling session (e.g. after or during the retelling of the trauma event(s)). Finally, at the end of the session it is advisable to conduct relaxation so that the child does not leave the session feeling tense.

**Retelling or Reconstructing the Story** (*see transparency 2.2*)

This is not something that the counselor initiates actively (as in exposure described in the next section, for reasons *see introduction* of this session) but instead is used when a child starts retelling the trauma event(s) or if the counselor has the impression that s/he expresses a need to share the trauma event(s). Retelling can have an important function in the recovery process from psychosocial trauma, for the following reasons:

- The effect of retelling is based on the idea that *avoidance increases re-experiencing* (which is almost always an undesirable trauma reaction). So decreasing avoidance, by retelling the story, is likely to also decrease re-experiencing.
- By retelling, the child reconstructs what has happened to her/him. S/he becomes capable of handling the situation (imaginary) and becomes more and more 'prepared' for the intensely unpleasant memories, which in turn reduces the fear of those memories.

The counselor's role is to respect the child's pace of retelling and provide support. *Support* can be given by emphasizing present safety, not unnecessarily interfering when the child is talking (e.g. letting go as opposed to asking too many questions), giving empathy. If the

child noticeably feels relief by telling what happened, the counselor can consider further exploring the event, for example by asking what the child did, thought, felt at different stages or incidents (possibly moving from the least distressing memories to the most distressing ones). The counselor should be aware of the risk of revictimizing the child, if s/he not guided properly. It is advisable to combine this with relaxation techniques. If the child feels the need, the counselor might go back to the trauma event(s) in later sessions.

**By Psychologists/Psychiatrists<sup>14</sup>**

**Exposure-based Interventions**

Exposure-based interventions are based on the premise that traumatized people fear trauma-relevant stimuli as well as the memory of the trauma. Exposing children to such memories facilitates change because they become more 'accustomed' to the trauma memories and become more capable of reconstructing an unbelievable event to integrate it into their life history. The child can be exposed in a step wise-fashion, where s/he has to imagine (or re-live) an increasingly disturbing trauma-related incident after which relaxation takes place. Only when the child feels s/he can handle one image sufficiently does s/he the same with the next, more confronting or painful, image. More direct techniques of exposure also exist (e.g. flooding).

**Eye Movement Desensitization and Reprocessing (EMDR)**

EMDR is a variant of exposure-based interventions. It combines having the child envision traumatic scenes, focus on sensations of anxiety, cognitive restructuring and engage in directed eye-movement. While visualizing the scene, the child rehearses a belief statement that summarizes her/his memories

(e.g. 'I am powerless') and at the same time her/his eyes have to follow the therapist's index finger moving from left to right. When asked to leave the image the child is asked to focus on the bodily experience of the image as well as on an incompatible belief statement (e.g. 'it is in the past' or 'I'm in control'). Ultimately the latter belief statements come to be associated with the traumatic image, resulting in less traumatizing memories. This is combined with relaxation techniques<sup>15</sup>. In EMDR, the directional eye movement or bilateral stimulation of the brain while the child focuses on the disturbing material of an event, helps her/him see disturbing material of traumatic event in a new and less distressing way.

### Testimony

Testimony is a procedure that puts in writing the full trauma story, in all its detail, of the survivor. This procedure encourages the person to recall and work through the trauma event(s). It is a statement about the survivor's lack of rights and freedom, which after finishing can be used for personal purposes (e.g. as 'evidence'), for political redress purposes (e.g. to human rights organization) or informative purposes (e.g. to the public).

Additionally, *group counseling* has been found an efficient intervention for traumatized persons.

### Treatment for Children

Some of the methods for recovery from psychosocial trauma as described above are also applicable for young children, such as individual counseling (emotional support, strengthening of coping etc.). Other methods are more specific.

Most important in the recovery process for young children is for them to be able to fall back on a secure parent-child relationship, which provides a feeling of safety. Furthermore, using play and drawings to encourage children to express their version or story of what happened to them (comparable to retelling, as described above), has been used frequently for traumatized children (mainly war-related traumas). As for adults, normalizing (without minimizing) is an important element of recovery, for children this can be achieved by reinitiating a 'normal' daily structure and routine. Finally, using a group as a means of expression and sharing can be effective for children too.

<sup>11</sup> Note that the concepts and skills of 1,2,3 should be taught beforehand, in a general psychosocial counseling training course. No. 4 is included in this manual.

<sup>12</sup> Also called psycho education

<sup>13</sup> See session 4; stress and relaxation for more information and exercises

<sup>14</sup> These are only some of the existing trauma treatments; these have been applied extensively and/or proven effective.

<sup>15</sup> Meichenbaum, 1994



**Hand Out 2.3****Text to Provide Information during Counseling<sup>16</sup>**

You have told me that you are not feeling well and that you have gone through a terrible experience. What you have gone through is so awful that most people have similar complaints afterwards. You might have been sexually abused, tortured, subjected to war-related crimes; these are situations of extreme stress. You might be relieved that you have survived or escaped and that you are safe now, but you might at the same time feel fear, anger, grief and sadness.

After some time memories of the dreadful events might come back to you, maybe through nightmares or maybe you are reminded by something you see or do. In your thoughts you might go over and over the details of the experience, even though you do not want to be reminded of the event, reliving humiliation or abuse. This might make you, once again, feel afraid, angry or unhappy.

You might even notice that you are doing things or not doing things that you did not or did do before the incident, giving you the feeling that you have changed. Maybe you

think that others can see or know what has happened to you and might not like or accept you anymore.

If you have been sexually abused, you must remember that what has happened is never your fault; you have no responsibility for what happened. You have been the victim of abusive people and systems.

It is important to realize that many people have similar reactions after such intense experience; it is normal to experience these feelings, nightmares, memories and to cry or be irritable. These reactions are extremely unpleasant, however you can find support and comfort from for example counseling, sharing with fellow survivors, ceremonies or rituals of your particular belief/religion. As a result of this many people have reduced the impact of the incident over time.

In the future you might face many difficult memories and hurtful feelings but you will also be able to enjoy life again and start feeling better.

---

<sup>16</sup> This text is based on de Jong & Clarke, 1993

# Stress and Relaxation

## Introduction

Almost all people experience some amount of stress in their lives, which can be related to their work, a personal relationship, school performance etc. Experiencing some stress is thus normal, however some people, such as trafficked youth, have gone through so many terrible situations that they experience huge amounts of stress. The stress can be related to insecurity about the future, to their health, to fears that it all will happen again. Whereas most people can relatively easily relax after feeling stressed, trafficked youth often have to deal with continuous distress, which may result in a variety of complaints, so they have difficulty attaining a stress-free period (relaxation). High levels of stress (especially if continuous) can cause physical complaints (e.g. stomachache), behavioural changes (e.g. irritability, sleep disturbances), social problems (e.g. conflicts with peers) and psychological problems (e.g. depression). It is therefore important for the counselor to know about stress and relaxation and to integrate it in the counseling process, if necessary.

## Activities

**Time** - 2 hours

**Materials** - Flipchart, markers, meta-cards

### Procedure

- 1 The trainer asks the participants to write on meta-cards when they feel stressed and what they do in response to reduce the stress.
- 2 The trainer explains what stress is (*see transparency 3.1*), how it can be recognized and its consequences (for examples of the consequences *see introduction and transparency 3.1*).
- 3 The trainer introduces relaxation as the opposite state of stress and conducts four relaxation techniques to reduce high levels of stress (*see hand out 3.1*). The trainer should emphasize that the relaxation exercises are an addition to already existing and constructive ways of relaxing or coping with stress.
- 4 For each relaxation technique one participant is asked to conduct/repeat it for the group in order to practice teaching these techniques.

## Resource Materials

**Transparency**

3.1 What is Stress?

**Handout**

3.1 Overview of Relaxation Techniques



## Synthesizing

The trainer gives opportunity for questions and summarizes the session with the following points:

**Summary** - This session looked at what stress is, how to recognize it and the effects that high levels of stress can have. It covered how to reduce stress through relaxation techniques.

**Critical Note** - The counselor should be aware of the fact that merely talking to a counselor can be highly stressful for the child/young person. Likewise, talking about past events of abuse or about its reactions might go together with high levels of stress. It is therefore important to notice signs of stress during the counseling session and to respond adequately, for example by conducting a relaxation technique. Secondly, as described in the previous session, the child/young person might have recurrent intrusive thoughts or re-experience traumatic incident(s), which might evoke more stress. In such situations it is good if s/he is able to recognize increased stress and respond by an effective method of relaxation. These issues should be addressed in the counseling process.

## Evaluation

Ask the participants which relaxation technique they feel most comfortable using when they are stressed and within a counseling session.

## Transparency 3.1

# What is Stress ?

Stress is the body's response to situations that pose demands, threats and constraints. People then react by protecting themselves or fleeing that particular situation. This is accompanied by increased muscle tension, heart rate etc. When the particular situation is over the individual can relax (in various ways). If a person cannot relax because of continued stressors, the tension remains, possibly causing physical complaints (which in turn might increase the worries or level of stress of the individual), behavioural changes, psychological and social problems.

High levels of stress can be recognized by symptoms such as poor concentration, easily changing moods, irritability, over-tiredness, headaches, tensed muscles, poor appetite, no energy, restlessness, sleep problems.<sup>17</sup>

When adolescents experience high levels of stress, young men tend to externalize e.g. through delinquent behaviour, while young women tend to internalize resulting in e.g. depression.

---

<sup>17</sup> It should be noticed here that these complaints can also be symptoms of another problem or be caused by another disturbance.

**Handout 3.1****Relaxation****Safe Place<sup>18</sup>**

Read the following instructions calmly and with a soft voice.

- 1 (If the child is sitting on a chair) put your feet on the ground.
- 2 Close your eyes.
- 3 Take a deep breathe, breath out, noticing your breathing.
- 4 Relax. Deeply relax.
- 5 Imagine a hallway with a door at the end. Walk to the door.
- 6 Open the door and walk down five steps. There is another door.
- 7 You are the only person with a key for this door.
- 8 **Image.** Unlock the door. You will find the most beautiful calm comfortable safe place you can imagine. It may be nature, it may be fantasy, it may be a place where you have been before.
- 9 Nobody can go there except you.  
*(Wait 30 seconds)*
- 10 Raise a finger if you can find that place.  
*(Wait 30 seconds)*
- 11 Can you find the place? If you cannot, we will stop and continue to talk.
- 12 Ok, you have found a nice place.  
*Pay attention to*
  - a. Colours, shapes, images.
  - b. Sounds, such as wind, birds, water.
  - c. Physical sensations such as touch, earth, texture .
- 13 **Emotions and sensations.** What emotion do you feel right now? Notice and feel it.
- 14 Right now, what do you feel in your body? Allow yourself to enjoy that sensation.
- 15 **Cue word.** Think of one word that fits the picture (e.g., “relax”, “trees”, “lake”).
- 16 Say this word to yourself while you notice the sensation.  
*(If response is positive, repeat above two steps 4 times.)*
- 17 Blank it all out. Now say the cue word to yourself and try to experience the positive emotional and physical feelings. Are you able to find it? Are you able to relax? You can do this at times of stress.
- 18 **Cuing with disturbance.** Ok, I'd like to ask you to bring up a minor annoyance. Notice the accompanying negative feelings. Now think of your safe place . Notice the colours, sounds, smells, touch. What emotion do you feel now?  
*(Continue until negative feelings disappear)*
- 19 **Self-cuing with disturbance.** Ok, bring up the disturbing thought once again. Now try to use the image or word of your safe place, doing the exercise on your own, to make yourself relax. Remember this safe place is always available to you. You can go there when you are upset alone. Also during sessions, when you want to go there, I can help you go there.

The counselor may tell the child to practice this exercise every day by calling up the positive feelings and associated word and image.

## Deep Breathing

This exercise, when done correctly, is effective and can be practised almost everywhere.

Take a deep breath (you should hear yourself inhale), follow the air going in.

Hold it for a few seconds

Exhale hard (you should hear yourself exhale, with sound - a 'noisy sigh'), follow the air going out.

Repeat the sequence six times. Do not be afraid of excessive breathing (hyperventilation), because it is unlikely to occur. However should you feel tingling in your fingers, that is a sign that you are in a stage of hyperventilation, then this exercise should be avoided.

## Guided Imagery

The following images can help you relax. You can use this example or create your own pleasant and beautiful place. Breathe easily and close your eyes. Let thought come and go. (The counselor reads the following text calmly and with a soft voice. )

“Imagine that you are lying down in the most comfortable field in the world. The sun is shining, it is nice and warm and there is a marvelous breeze blowing. The grass is very soft and you can even smell it as well as the flowers. In the distance you can hear some birds. Imagine their song. Close by are some coloured flowers. Now a butterfly is coming close to you and is landing on your hand. You can brush it off if you want. As you add to the imagination, tell yourself that you are going into a deeper and more pleasant state of relaxation. Now imagine that all the tension and anxiety remaining in your body

is traveling into your abdomen. There is none left except in your stomach. Now as you begin to count from one to three, it will begin to leave your body, you will get into a deeper and more pleasant state of relaxation. The cloud is now caught by the wind, and as it travels towards the horizon you will feel even more relaxed<sup>19</sup> .”

## Progressive Muscle Relaxation

The entire procedure generally takes about 15 minutes. This exercise involves growing familiar with the tightening and relaxation of muscles. It might be good to start with a breathing exercise. Introduce the exercise by asking the person to lie on the floor and read the instructions slowly with a soft voice, leaving time for the activities.

Feel how you touch the floor and how heavy you are. Press your left foot against the floor, feeling your muscles get hard. Now release the pressure and sigh. Feel your left leg become soft and relaxed. Feel the difference between your left and right leg. [Repeat for right leg.] Now press your left hand against the floor, feel the muscles in your arm get stiff. Release the pressure and sigh. Feel your left arm get soft and relaxed. [Repeat for right arm.] Now press your shoulders forcefully against the floor. Feel your shoulders become hard and stiff. Release the pressure of your shoulders and sigh. Feel how warm your shoulders are. Now lift your head up. Feel the muscles you need for this. Lower your head to the ground and sigh. Put your hands on your stomach and feel how relaxed it is<sup>20</sup> .

Put your hands at your sides, feel your whole body, feel the relaxation, take a few deep breaths and open your eyes slowly.

<sup>18</sup> From Van Ommeren, M. 2001. Personal Ccmmunication.

<sup>19</sup> From Childhope, UNICEF. In: Jordans, 2001.

<sup>20</sup> Taken from de Jong & Clarke, 1993.

# Functional Complaints<sup>21</sup>

## Introduction

Sometimes people might have one or more (vague) physical complaint(s) that cannot really be explained by a doctor, nurse or health worker and, even if treatment is given, this proves ineffective or the person returns with other or similar complaints. It might concern people that are under high levels of (emotional) stress. These physical problems are called functional complaints if the bodily symptoms are the expression of some underlying personal, emotional or social problem. Although no actual physiological basis exists for the complaints, the symptoms are not considered voluntary; the person believes the symptoms are real. It is the counselor that hypothesizes that they are due to psychological distress<sup>22</sup> (*see handout 4.1 for reasons*). It has been found to be a major complaint among torture survivors in Nepal and, as the abuse of trafficked youth concerns the body, is probably also common among this group.

## Activities

**Time** - 3-4 hours

**Materials** - Flipchart, markers

### Procedure

- 1 The trainer introduces the session by explaining what functional complaints are (*see introduction*).
- 2 The trainer asks the group to brainstorm on the different complaints that might be experienced by trafficked youth.  
  
Note for trainer: examples are headache, dizziness, abdominal pain, backache, pain, gastric problems, weakness, muscle ache.
- 3 The group is divided into sub-groups to discuss for 20 minutes (and write on paper) *why trafficked youth might undergo functional complaints*. After the sub-groups' presentation the trainer can add from *handout 4.1*.
- 4 The trainer gives a lecture about *how to deal with functional complaints within the counseling process* (*see handout 4.2*).
- 5 The trainer asks three pairs to conduct role-plays (each 15 minutes) with an adolescent girl (16 years old) who has multiple recurrent physical complaints that disturb her a lot. She has just been rescued from a brothel in India where she has been for the last four years. This is the first time she talks to anyone about her complaints.

*Role-play 1:* Counselor takes the complaints seriously but has no knowledge about the existence of functional complaints.

*Role-play 2:* Counselor takes the complaints seriously but does not refer, only reacts with empathy and communication skills.

<sup>21</sup> The terms *somatizations* and *medically unexplained pains* are also commonly used but this manual follows de Jong & Clarke, 1993 in using the term *functional complaints* to indicate that the complaints have a 'function' to the person.

<sup>22</sup> Ringel, 1998

*Role-play 3:* Counselor takes the complaints seriously and tries to actively assist in resolving functional complaints (as previously explained in *handout 4.2*).

- 6 Afterwards the differences between the role-plays are discussed.
- 7 The participants are asked to conduct a 30-minute group role-play on an adolescent that has been in the centre for a while and has constant stomachaches. She has just undergone medical examination but the result has not revealed anything. Start the role-play from this moment (directly after receiving the results) as well as identifying whether the person is experiencing any other problems besides the physical complaints. If so (and if applicable) the counselor should try to relate the complaints with the identified problems.

Note: This role-play includes (1) discussing the examination, (2) identifying other psychosocial problems and (3) giving information during counseling (e.g. about the relationship between psychological factors and physical complaints). This is generally not done in only 30 minutes but this is done here for instructive purposes.

## Resource Materials

### *Handout*

#### 4.1 Reasons for Functional Complaints

#### 4.2 What to do for Functional Complaints

## Synthesizing

The trainer gives an opportunity for asking questions and summarizes the session with the following points:

**Summary** - Some people have psychosocial and emotional problems that are expressed through physical complaints. This might be to receive attention, or because it is easier to talk about physical rather than about psychological complaints.

**Critical Note** - It is essential to remember that trafficked youth are prone to have functional complaints but also very prone to actually suffer medically explainable complaints. They have been sexually abused and may have been physically abused, which might have resulted in a variety of illnesses, pains and physical complaints that indeed need treatment from a doctor. This should always be the priority.

## Evaluation

Ask the participants to write down how they would now and previously respond to an adolescent who has recurrent and vague physical complaints.

**Handout 4.1****Reasons/Causes for Functional Complaints<sup>23</sup>**

1. Incorrect beliefs about the body. Lack of knowledge of physical problems.
2. They expect treatment only for physical complaints and thus only seek help for physical suffering. (Relates to help-seeking behaviour or fear of stigma.)
3. It might be easier to talk about physical complaints rather than psychosocial or mental problems. (Also relates to help-seeking behaviour.)
4. Lack of awareness (knowledge) about psychosocial problems.
5. Bodily sensations associated with anxiety, depression, grief or trauma
6. For (primary or secondary) gain (not having to do main responsibilities, such as not having to work; rewards such as *attention*) this is usually *unconscious*, so try not to judge it! The person does genuinely have the symptom and counseling can help.
7. If the person *fakes* the complaint (consciously) we call it *malingering* (the person does not experience the complaint and we are obliged not to give treatment for the complaint).
8. It might be a way to express problems in a certain culture.

---

<sup>23</sup> Based on Poudyal & Van Ommeren, 2000





**Handout 4.2****What to do for Functional Complaints**

Be flexible about order of implementing following steps<sup>24</sup>:

- 1 Make sure that you *understand* the child's complaints and respect these, whatever your hypothesis. Explore the *child's explanation* of suffering in detail; explore onset, timing and experience of the pain.
2. Refer for symptom-focused *medical examination*.
- 3 After sharing and discussing the results try to figure out the *child's reaction* in relation to the fact that the medical examination showed no serious disease. Does s/he have questions? Do not minimize the complaints, instead acknowledge the suffering!
- 4 *Identify and explore* what the child, besides physical complaints, experiences (or has experienced) as *problems* (social, emotional, personal).
- 5 *Giving information during counseling*. Explain that emotional reactions or intense stress/worries can result in physical complaints or educate the child in case of incorrect medical beliefs. (*See session 2; hand out 3 for example*) Do not argue over this with the child, understanding such links is not essential.
- 6 *Bridging* the psychosocial problems to the physical complaints (as previously explained to the child under point 5). If this is difficult you can also emphasize how the physical complaints affect the child's life, which in turn might be related to the causing problem (e.g. the explanation might be that the constant headaches lead to stress and sleep disturbances, which might give you the hint that maybe the stress is leading to the headaches).
- 7 Assist in dealing with any identified psychosocial or emotional problems (whether or not seen as causing physical problems by the child). This can be done through supportive counseling and problem solving focused counseling (what are the problems, what are the goals, how to make changes etc.). It is important to link this with existing social support systems.
- 8 Generally it is important to remember the following:
  - If possible, avoid medication because it reinforces the view that something is wrong with her/his body.
  - Use relaxation techniques to reduce tensions during the counseling process or when the client experiences tensions in her/his daily life.
  - Identify ways to better handle the pain and/or situation (coping).

<sup>24</sup> Based on Van Ommeren et.al. 2001

# Working with Groups

## Introduction

Working with groups can be very useful for victims of abuse and trauma survivors. And especially for youth, for whom peer groups are very important, it is an effective intervention. Even more so for youth who are already living in a group setting, such as in centre based programmes. It can facilitate daily aspects of life in the group as well as commonly shared difficulties and problems. The group functions simultaneously as a mechanism for support and feedback. It strengthens possibilities for change, as collective goals are often more committing than individual ones. Furthermore working with groups is a strong tool to enhance and practise social skills because it involves learning to understand and respect other people's viewpoints as well as learning to balance one's interpersonal interactions. Two main components of working with groups are *modeling and group cohesion*. The former refers to a process of learning behaviours and attitudes through observing other people's behaviour and attitudes and its consequences. Group cohesion refers to the group formation process; a group, through disagreements, feelings, leadership etc, slowly shapes itself in an organization with norms and values to which it belongs. This feeling of belonging (or group cohesion) in itself can be of great support. It is important to always sit in a circle and create an atmosphere of openness, equality and warmth.

## Activities

**Time** - 4-5 hours

**Materials** - Flipchart, markers

### Procedure

- 1 The trainer introduces the importance of working with groups of trafficked youth (*see session's introduction*) as well as its main principles (*see handout 5.1*).
- 2 The trainer explains that for trafficked youth (and for this level of training) theme-centered group work is most appropriate and gives a short lecture on this form of group work (*see hand out 5.2*).
- 3 The trainer conducts a brainstorming session on *suitable themes for working with groups of trafficked youth*. The outcomes are written on flip chart.
- 4 The trainer gives a lecture on focusing during group work (*see handout 5.3*).
- 5 One participant is asked to be the mediator in a role-play (20 minutes) with the theme *future* for a group of trafficked youth in a centre-based programme. It concerns the second session, the introduction, purpose and rules have already been set.

(One participant can be asked to observe the mediator, noting down what s/he does and its effect (focusing, communication skills, and interaction pattern). Another participant can be asked to observe the group of youth, noting down their reactions and interactions (interaction patterns, sub-groups and group dynamics).

After the role-play the observers, trainer and participants share their comments and experiences.

- 6 The trainer asks one participant to mediate a group session (15 minute role-play) on the theme *loneliness* with a group of trafficked youth. The mediator should work with/on the different levels and skills of *focusing*.
- 7 The final role-play (20-30 minutes) concerns a group where all the participants have experienced rape; the theme of the session is *men*. Before the role-play the trainer gives different participants a slip of paper on which different roles are described, for example:
  - a Reluctant to talk about this issue
  - b Very sceptical about men because they behave like animals and cannot control their sexual instinct
  - c Emotional because of memories of the man that raped her
  - d Rational; if one man was bad it does not mean that all are bad
  - e Resentful; blames society, men and even women for their role in rape
- 8 The trainer concludes the session by explaining briefly the process of working with groups (*transparency 5.1*).

## Resource Materials

### *Transparency*

5.1 Process of working with groups – an overview

### *Handout*

5.1 Basic principles of working with groups

5.2 Theme-centered group work

5.3 Focusing during working with groups

## Synthesizing

The trainer gives an opportunity for asking questions and summarizes the session with the following points:

**Summary** - It is known for adolescents to 'grow in groups'. For traumatized youth there might be even more need for reflection of feelings, thoughts, and worries with peers who have gone through similar experiences. It is for that reason that social emotional problems or issues can be discussed in groups, as (part of) a psychosocial intervention or as an activity within a centre.

**Critical Note** - This session is basically only an introduction into group counseling. Though the skills and process are very similar to that of individual counseling, there are also huge differences that require skills and practice of the mediator. Because one session is not sufficient to become group counselors, this session has been called "working with groups," which *is* something that can be implemented after this introduction.

## Evaluation

Ask one participant to mediate a short group discussion on what the other participants learned in this session and what they like/do not like about working with groups as an intervention for trafficked youth.

## Transparency 5.1

# Process of Working with Groups - An Overview

## **Beginning**

- Introduction of group members
- Setting the atmosphere
- Defining the common rules for the group process
- Explaining the purpose of the group intervention

## **Exploration**

- Exploring the common problems or issues
- Exploring the group member's expectations

## **Goals**

- Setting the goals for the group process
- Structuring the themes and topics

## **Working together**

### **(through exploration of a theme)**

- Sharing, discussing, confronting
- Exploring alternatives
- Solution-oriented action

## **Termination**

Generalizing the learning outside the group

**Handout 5.1****Basic Principles of Working with Groups****Group Dynamics**

A group is more than the sum of its individual members; with time it becomes a unity that has its own rules, norms and values. It becomes a system in which each member fulfils a role (e.g. some may have leadership roles, others silent supporters) and in which a structure of interactions is observable on the basis of such roles or interpersonal relations (e.g. conflicts between people, sub-groups). Each member brings to the group his/her personal thoughts, habits and feelings that together create interesting dynamics.

**Communication Skills**

Group mediation is based on a set of communication skills that also form the basis for individual counseling. These skills are essential to create the right atmosphere and to make everyone feel heard, understood and supported. The main skills are:

- 1 asking open and closed questions
- 2 reflecting feelings that one or more members are expressing (empathy)
- 3 reflecting content by paraphrasing what one or more members are saying
- 4 summarizing large parts of interaction to give structure and understanding
- 5 repeating key words or parts of a sentence to encourage continued expression
- 6 non-verbal communication (see also below).

**Interaction Patterns<sup>25</sup>**

It is essential for the mediator to notice the flow of information in a group. This gives the

mediator an understanding of existing sub-groups or coalitions and power relations. Specifically this means observing who talks when and to whom and who interrupts whom and when? Who criticizes, who encourages etc? To do that it is essential to also observe non-verbal communication during the interaction; whom is given full or no attention, who is given eye contact during silence in disagreements, whether people raise their voice, if people are sitting in a way that expresses disinterest or disagreement etc. It is also important for the mediator to be aware of his/her own non-verbal communication. Similarly, it is also essential for the mediator to be aware of her/his place in the interaction patterns. For example is the mediator directing the conversation in a way that all interactions go directly to him/her and from him/her directly to individual members? Or are the members talking to each other with periodic interjections of the mediator, mainly directed to the group as a whole<sup>26</sup>?

**Interpersonal Influence**

One of the main reasons for working with groups is that the individual group members can learn from each other. This can be direct coping skills or knowledge but it can also be other people's perspective and attitude. Learning also takes place because participants receive feedback after reflecting ideas or thoughts, which gives information on how someone is perceived by others. Self-disclosure, sharing personal experiences, emotions and ideas with the group, is commonly an important instrument for interpersonal influence.

## **Support**

Especially for groups who have a similar problem in common, the mere fact of being together with others who have gone through the same may give emotional support (e.g. 'I am not the only one who feels so sad'). It may result in a feeling of being understood, something that people who have not gone through similar experiences are maybe not able to provide.

## **Active Mediation**

The mediator guides the flow of communication, giving equal opportunity to speak to all members, and has an overall view of the group process and dynamics. S/he uses communication skills, avoids providing solutions, makes sure that different viewpoints are being heard and clarifies

where necessary. Here the term "active mediation" is used because it entails the mediator giving direction if needed, however s/he lets the process go as much as possible without interrupting.

## **Expression**

As in individual counseling, working with groups is mostly directed to the expression of feelings and thoughts. Whether it concerns a solvable problem, preparing for potential problems in the future, or reactions to unpleasant experiences, the expression of the disturbing thoughts and feelings are the basic component within the group setting. On the basis of such expressions, discussions, exchanges and interactions are continued, hopefully resulting in the desired outcomes.

---

<sup>25</sup> It is important to be aware of possible cultural differences in interaction patterns, and the mediator should respect these.

<sup>26</sup> The latter example is desirable in the context of the group work taught in this session.

**Handout 5.2****Theme-Centered Group Work<sup>27</sup>**

In this session the focus is on theme-centered group work because it is very suitable for discussing and sharing issues with a group of youth who have gone through very similar and disturbing experiences. Basically theme-centered group work means that one or several relevant topics are selected and the group meets to explore issues around that identified theme. This group work aims to help individuals understand how their stories are different and similar to others in the group.

Theme-centered group work is based on changing attention between the individual ('I'), his/her interaction with the group ('we') around a certain theme. In this respect we can talk of *dynamic balancing*<sup>28</sup>, referring to the strategy of leading the process from the

individual (stories about personal experiences) to the group (how group members relate to each other) to the theme. The theme provides a structure to the meetings that is often satisfying for the youth (who generally need more structure than adults) and the mediator (who has the theme to fall back on). Keeping the above in mind, it is also important to be aware of the changes that occur throughout the process. It is not beneficial to strictly follow the theme if the group or its individual members need a change of topic.

Themes for trafficked youth can be for example; family issues, anger, isolation, stigma, future, respect, trust, aggression, self-esteem, safety, humiliation, sexuality (*see annex III for sexuality as a theme*).

<sup>27</sup> Based on Ivey, Pederson & Ivey, 2001, in turn based on work of R. Cohn.

<sup>28</sup> This term is taken from R. Cohn in Ivey, Pederson & Ivey, 2001.





**Handout 5.3****Focusing during Working with Groups<sup>29</sup>****Introduction**

Focusing refers to the mediator's skills to direct his/her attention to certain aspects of the process or interactions, in order to give those more emphasis. Because many persons are involved, many things are going on at the same time. It is the mediator who needs to decide what to give attention to and what not.

**How to Focus?****Pacing**

Pacing refers to the skill of staying with what has been said. The mediator focuses the attention on the present subject or statement by acknowledging understanding and by exploring the issue. Basic communication skills are the instrument to pace.

**Leading**

Leading is a more active way of focusing the attention and often follows pacing. This means that the mediator slightly changes the direction of the conversation by asking another question about the issue or by diverting the attention to another member's reaction to what has been said. The mediator may, for example, ask for the present feelings of the individual or the group.

**Linking**

Linking means that the mediator is able to focus the attention on similarities and connections between people and topics. This may mean that the mediator links a certain story to the overall theme, to common issues or to what someone has said about that issue at an earlier stage. It also refers to the process of making connections between other aspects of focusing (see below).

**Who to Focus on?**

The mediator needs to pay attention to what is happening to individual members in the group, to the overall group and to the reactions and interactions of two or a few people (sub-groups) within the larger group.

Sometimes the mediator needs to focus on the individual,<sup>30</sup> for example when one person is in clear emotional distress or when the mediator asks one person's opinion on an issue.

Sometimes sub-groups form an essential part of the overall group process, for example when some members are disagreeing and others agreeing or when two members have a conflict or when a few people with similar experiences or opinions are connected with each other. The feelings and issues of the sub-groups may be very relevant for the group process or the individuals involved.

In this session the emphasis lies on theme-centered group work, which entails a group focus, within which individuals can develop and gain.

**What to focus on?****Content**

On what information does the mediator focus his/her attention? The most obvious focus is the content of what has been said by the group members. Content in this respect refers to the words, the message, the meaning, the feelings, the opinion and the attitude people are conveying. Focusing the content is related to the theme, problems or concerns that are central to the group work. This, as with pacing, is mainly achieved by using basic communication skills.

### **Context**

Sometimes aspects of the 'external world' that individual group members bring with them can be enriching to the process and important to see the issues in the most relevant perspective. Such aspects can be cultural, spiritual, religious, moral, economic or social background. These are issues that are directly or indirectly related to the theme of the group as well as the individual within the group. Other examples are family, health, community etc. The mediator then focuses on how such context issues influence the individual, sub-groups or the entire group in dealing with a common topic (e.g. how do you deal with this crisis from your spiritual

tradition?). The mediator needs to be aware that group members always bring their personal context with them, in which any changes need to take place.

### **Time and Situation**

Especially for trafficked youth, the stories they tell may be related to past experiences (there-and-then). Expression of these experiences can be very valuable for the group and the individual, however to achieve actual changes in current feelings and situations, it is also important to link the stories to the present (here-and-now). Focus on the present is important to receive feedback about immediate behaviour and situations.<sup>31</sup>

---

<sup>29</sup> In adapted form based on Ivey, Pederson & Ivey, 2001.

<sup>30</sup> Sometimes focusing on individuals within the group is the primary method of group counseling. In this session however the emphasize is on the group work.

<sup>31</sup> Most of the information above on focusing also goes for individual counseling. Then, instead of group and sub-group the counselor may focus on individual, family or community.

**Example on group work on the theme “future”:**

<b>Transcript</b>	<b>Process Comments</b>
<i>Muna:</i> I am very frustrated that I have to live here in this centre instead of my village, as if I am a prisoner, as if I have done something wrong. I like the centre and all the people, but still.	Self-disclosure, focus on the present
<i>Mediator:</i> You feel angry because you think it is not fair that you can't go back home?	Reflection of feeling Focus on individual through pacing
<i>Muna:</i> Yes exactly. When I was still living with my parents and going to school, everything was so much easier. I never had to worry about the future.	Self-disclosure Focus on theme and the past
<i>Mediator:</i> How do you feel now about the future?	Focus on individual through leading (open question), focus on the present
<i>Muna:</i> I don't know what will happen, nobody wants me anymore. So where to go, what to do?	
<i>Mediator:</i> The thought about the future seems to upset you. Sunita and Indira, I see you are nodding your heads. Do you recognize these feelings?	Reflect feeling, focus on the theme Focus on subgroups through linking
<i>Indira:</i> Yes I do recognize it. I also feel that way Muna. Thinking about the future sometimes makes me cry. For me it helps to then sit alone and recite mantra, which calms me down.	Self-disclosure Coping strategy
<i>Mediator:</i> Indira I hear you say that thinking about the future makes you also sad. However you find some comfort in your religion. (Indira nods her head). Do others in the group also find comfort in their religion or spirituality?	Reflection of feeling and content  Focus on group through leading Focus on context



# Advanced Communication Skills

## Introduction

This specialized manual should be used as an addition to more basic skills. Though counseling trafficked youth concerns mainly those basic skills, there is also a need for more advanced communication skills. Such advanced skills, as described in this session, can only be acquired after considerable practice because they are often the most difficult for the counselor. It involves good insight and perspective from the counselor. Furthermore, they should only be based on a trusting client/counselor relation as well as on a non-judgmental attitude. However difficult, the effort pays off in an elevated level of counseling; these advanced skills can bring the counseling process onto a more profound level. It can provide the survivor with support and empathy, deal with core dilemmas or changes in her/his situation.

## Activities

**Time** - 3-4 hours

**Materials** - Flipchart, markers

### Procedure

- 1 After giving an overview of this session (transparency 6.1), the trainer divides the group into sub-groups. Each sub-group gets one or two of the advanced skills (giving information during counseling, feedback, self-disclosure, challenging, reflection of meaning and advanced empathy) to:
  - Read the text on that skill in handout 6.1.
  - Brainstorm on the function, benefits and timing of that skill.
  - Imagine, discuss and practice (role-play) a situation in counseling that includes the advanced skill.
- 2 The sub-groups present in plenary the outcomes of the exercise and show a role-play that includes the advanced skill. The trainer adds or corrects if necessary.
- 3 The trainer asks the group to divide into couples of two each and conduct a role-play/task on the following:

*Giving information during counseling* - A client feels that she is bad and inferior because she has AIDS and believes that the illness is a punishment (from God).

*Feedback* - A client makes major improvements in her fear of being alone; she was able to stay at home alone for an entire night.

*Challenging* - Come up with a challenging-sentence to the following statements and continue with exploration:

'My husband is good to me most of the time – he has only hit me twice. I don't think we need to talk about that, do we?'

<sup>31</sup> From Ivey & Ivey, 1999.

'No, my family and my village are not important to me. I have been without them for a long time now; I also don't need them now. I don't think they can help me anyway'

*Advanced Empathy* - A survivor is talking about some important personal issues (such family and (non-) marriage). She is talking about them very briefly, though the counselor observes that she would like to say more but feels restrained.

*Reflecting Meaning* - A trafficked woman who is HIV-positive is preparing herself for the end of her life. Come up with 5 questions or reflections that elicit meaning.

## Resource Materials

### *Transparency*

#### 6.1 Advanced communication skills - an overview

### *Handout*

#### 6.1 Advanced skills to enhance the counseling process

## Synthesizing

The trainer gives an opportunity for asking questions and summarizes the session with the following points:

*Summary* - This session dealt with a set of skills that can only be practiced when the counselor can really understand the survivor's perspective and when a good level of trust has been built up. Reflecting meaning, advanced empathy, feedback, self-disclosure, giving information during counseling and challenging can be highly effective in achieving changes which basic communication skills might not achieve, though this depends on the counselor's level of skill and experience as well as his/her comfort with using such skills. Counseling trafficked youth needs some degree of specialization, which can partly be exercised through such advanced skills.

*Critical Note* - Though counselors should not want to impose their ideas, thoughts or information on the client, they do want to exert influence to achieve change in the situation of the client. Such influence can be exerted through the advanced skills learned in this session, though it might be considered as contradictory to not imposing ideas, thoughts and information. However, instead of a contradiction the advanced skills can be seen as a continuum of interpersonal influence<sup>31</sup> (e.g. ranging from repeating key words to reflection of feelings to closed questions to feedback to challenging). As the advanced skills should as much be based on respect and understanding of the survivor and her/his perspective, they should not (if well used) impose anything, but rather emphasize issues that are central to the problem.

## Evaluation

The trainer asks the participants the following questions to ensure understanding:

'What is the difference between reflection of feeling and reflection of content?'

'What is the difference between giving advice and giving information?'

'Is challenging the same as disagreeing with the client?'

## Transparency 6.1

# Advanced Communication Skills - An Overview

### ***Giving Information during Counseling***

Sometimes the counselor gives objective/ factual information that is obviously not known to the child and that is important in the discontinuation of the child's persistent misbeliefs.

### ***Feedback***

Feedback means that the counselor comments on achievements and/or observations related to the youth's advancement.

### ***Self-disclosure***

Self-disclosure means that the counselor uses personal information or experiences to support the counseling process.

### ***Challenging***

Challenging means noting and reflecting discrepancies, incongruities and mixed messages of the child, in order to achieve awareness and changes.

### ***Reflection of Meaning***

When the counselor paraphrases issues/ statements related to the meaning of the child's life.

### ***Advanced Empathy***

When the counselor reflects his/her understanding of the youth beyond what the child is actually saying. Showing this is called *advanced* empathy.

**Handout 6.1****Advanced Skills to Enhance the Counseling Process****Giving Information during Counseling** (also see hand out 2.3)

When the counselor has the impression that part of the cause of the child's problems is due to unawareness or lack of knowledge about certain information, providing that information might reduce the problem. Giving information might be very effective to change destructive and false beliefs that a child has (e.g. headaches as a sign for being possessed by bad spirits, being 'bad' because of having been sexually abused). Giving information might reduce stress if the child, as a result of ignorance, makes wild fantasies about what is going to happen to her/him. The provision of relevant information makes the child more prepared for the situation, which in turn increases the capacity to cope. Giving information however is *not* convincing, advising or imposing, rather the counselor always respects the child's perspective but provides additional objective information from another perspective (appropriate to the context of the child). Additionally, providing information might improve the counselor/survivor relationship and trust. Similarly, it might, to some degree, meet the direct expectation of the child who is unaware of the non-directive nature of psychosocial counseling.

**Feedback**

1 *Feedback* - is concerned with providing survivors with information *on how others may view them*. The idea behind counseling is not that the counselor is the expert on the child's life and problems; therefore the feedback should be non-judgmental (as much as possible at least). Though not an expert of the

child's life and problems, the counselor does function as a way for the child to try out and reflect ideas, feelings and thoughts. It is for that reason that s/he can benefit from an outside opinion on such ideas, feelings and thoughts. (e.g. 'I understand that you are worried what others might think of you now, but I also hear that you have become more assertive in getting what you need; that's very good.')

2 *Feedback* - is concerned with providing information *on performance*. It is also the counselor's function to have an overview of the entire counseling process with its progress and obstacles. Sharing of such observations might be beneficial to the child because it might reinforce certain steps or it might encourage her/him to make changes in that process. (e.g. 'The way you are talking now, I see that you are using your patience to deal with this situation, something we have earlier identified as your strength.')

For both forms of feedback it is important that the counselor is concrete and specific, focuses on the child's strengths and open to her/his reactions.

**Self-disclosure**<sup>32</sup>

Self-disclosure means that the counselor shares personal information and experiences relevant to the counseling session or the survivor's situation. Self-disclosure may encourage the child to talk, create additional trust and establish a more equal relationship<sup>33</sup>. Self-disclosure can also be comments that are related to the counselor's present feeling in response to what the child is saying and the counselor's personal experience of what s/he is expressing (e.g. 'I



understand what you are feeling, I have also experienced ...').

### Challenging<sup>34</sup>

Counseling refers to a process in which a person retells a story or a problem situation, in order to achieve some change as a result of that process. To be able to make changes the survivor might have to work on issues or problems that are not obvious to her/him or that s/he is not aware of. The mere telling of the story then might not be sufficient because this concerns a repeated explanation of the problem, not an exploration of what is less obvious to her/him. This often concerns incongruities or discrepancies in the survivor's messages. If such incongruities or discrepancies are thought by the counselor to be essential in the existence of the experienced problem, then the counselor might need to make these obvious to the child. This is called challenging.

*Challenging* can be experienced as confrontations by the child and therefore need to be conducted cautiously and appropriately. Instead of harsh confrontation, the remarks should be an invitation or stimulation to explore certain ways of thinking and acting that might keep the child entangled in a problem situation.

*Challenging* is done to make changes in the survivor's:

- 1 dysfunctional perspectives and beliefs (e.g. I am from a lower caste so I am less intelligent; nobody loves me or cares for me);
- 2 self-limiting internal actions (e.g. not being able to make decisions, over-analyzing, etc) and;
- 3 problematic external behaviours (e.g. aggressiveness)<sup>35</sup>.

*Challenging* might involve questions or remarks to:

- 1 clarify problems that are expressed vaguely;
- 2 talk about issues that the survivor is reluctant to talk about;
- 3 give an opposing (more adequate) perspective to a certain situation;
- 4 reflect discrepancies.

*Challenging* might refer to *discrepancies between observations and what the child says*, e.g. 'you say that you are very happy at the moment, but you make a sad and somewhat passive impression when you talk to me. Am I observing that correctly?'

*Challenging* might refer to *conflicting messages* that the survivor is expressing; e.g. 'previously you have been telling me that you want to go home; today you say that you don't want that anymore. Can you tell me a little more about that?'

*Challenging* might refer to *discrepancies between what the child says and what s/he does*, e.g. 'On the one hand you tell me that you are never angry, on the other hand you frequently tell me about your fights and conflicts with people. What do you think about that?'

Some ways of stating the discrepancies the counselor notices are; 'On the one hand you ... on the other hand ...' or 'Your words say ... your actions say ...' Just stating the discrepancies or incongruities might, but also might not, be enough. The reflection can then be followed by exploration of the issue at hand by open questions, reflections and summarizing. Further, the counselor can give feedback on how the child is dealing with the challenge, trying to emphasize positives (which in itself can challenge the child at times).

To measure the effect of the challenging, the counselor can consider the following scale of reactions<sup>36</sup>:

- 1 *Denial.* The child may deny any of the discrepancies that the counselor has noticed and reflected. (e.g. 'I am sure that I have no disease, why should I?')
- 2 *Partial Examination.* The child may work on part of the discrepancy but present ineffective emotion or behaviour instead. (e.g. 'Yes, I sometimes have headaches and other pains, but it is nothing serious')
- 3 *Acceptance and recognition, but no change.* The child accepts and explores the discrepancy but fails to come up with solutions, alternatives or turning the awareness into concrete action. (e.g. 'I guess I might have serious health problems, but what can I do about it, it is too late now anyway')
- 4 *Generation of a new solution.* The child moves beyond recognition to implement changes. (e.g. 'I have to go see a doctor, maybe he has medicine')

### Reflection of Meaning<sup>37</sup>

Reflection of comments and issues that suggest or are related to what the child finds important in life, to what are the values in her/his life, to what is the meaning of her/his life. It is the meaning that structures someone's life and that can be important to discover and include within the counseling process. Reflecting such meaning might provide the child with understanding of reasons for certain feelings or behaviour.

#### Examples

*Survivor:* 'Especially after what happened to me it is very important for me that people like me, that they accept me as I am, no matter what I have gone through'

*Counselor:* 'You find it important to be respected by other people, is that what you mean?'

*Counselor:* 'What does that mean to you?'  
'Why is that important to you?'

### Advanced Empathy

Reflection of the meaning of the child's message, intention or feelings 'behind' the words. This refers to information (often feelings) that s/he is saying only half or is hinting at. The counselor retrieves the additional meaning from the message. This is called advanced empathy because the counselor is able to take the child's perspective even beyond what s/he is factually saying and understand what was not said directly or the context in which a message fits. As with basic empathy, advanced empathy is often expressed by reflection of feelings.

#### Examples

*Counselor:* 'I understand that you are very angry about what has happened to you. At the same time I also seem to get the impression that you are confused about your feelings.'

*Survivor (angrily):* 'I don't want to go back to my village, I know what they think of people like me!'

*Counselor:* 'You are afraid of how people there might judge you because you have been trafficked'.

### Comments

Above are descriptions of several advanced communication skills for counseling. These skills might, at first, seem confronting with earlier learned basic counseling principles, such as not giving advice, suggestions or too much direction. Indeed, these advanced

communication skills are more directive, however it remains essential that they do not include the counselor's ideas of what is good or bad or what should or shouldn't be done. Instead the counselor's provision of objective information or impressions can serve as valuable reflections for the process of change.

Similarly, the advanced skills described above are very close to interpretations. To avoid or ensure that the counselor is not using his/her frame of reference to make reflections or give information, it may be valuable to use *checks* after using such advanced skills, such as; '[advanced skill] ... do I see that correctly?' or '[advanced skill] ... is that information

useful to you?' or '[advanced skill] ... what do you think about that?' Such checks give the child the opportunity to take the counselor's interjection as s/he wants.

It might be reasoned that advanced empathy is a form of challenging. Though advanced empathy can clearly have a challenging effect, it is reasoned here that the intention of each is different, and therefore described separately. The intention of empathy is not to challenge discrepancies but instead to provide emotional support in expressing advanced understanding of the survivor's situation. Having said that, in form and effect there are obvious similarities.

---

<sup>32</sup> The use of self-disclosure is controversial. It is up to the counselor to decide whether s/he thinks it is appropriate to use or not. It should be understood, though, that using this skill does not mean that the counselor should become the survivor's friend or that the counselor starts talking about her/his own concerns that are not related to the client's situation or process.

<sup>33</sup> Ivey & Ivey, 1998.

<sup>34</sup> The counselor needs to be especially aware of the cultural relevance and appropriateness of using challenging. For example, is it appropriate to challenge someone that is older than the counselor in an Asian society?

<sup>35</sup> Based on Egan, 1998

<sup>36</sup> Based on Ivey & Ivey, 1998

<sup>37</sup> Ivey & Ivey (1998) describe meaning as 'the underlying, major constructs that we use to organize our experiences: our thoughts, feelings and behavior'

# Counseling for People with HIV/AIDS

## Introduction

Besides the numerous traumatic experiences that trafficked youth often have been through, in addition to the social emotional problems preventing smooth reintegration, there are other possible consequences of being trafficked. Some sexually abused youth are HIV-positive or may have full-blown AIDS. Hence, in addition to previous traumatic experiences, HIV/AIDS in itself can be traumatic, resulting in severe emotional distress. Since HIV/AIDS is often not well accepted in societies in South Asia, it often results in social problems. All this creates a situation for the adolescent that is extremely hard to cope with.

The participants will not become HIV/AIDS counselors, but instead psychosocial counselors who are able to deal with people who have HIV/AIDS. To properly train the participants for this, three elements of training are included in this session:

- 1) Information about the prevention and nature of HIV/AIDS,
- 2) Counseling skills and
- 3) Value clarification.

## Activities

**Time** - 4 hours

**Materials** - Flipchart, markers

### Procedure

- 1 The trainer asks the participants to imagine themselves as someone affected by HIV/AIDS. After a few minutes ask the participants to explore his/her related feelings, attitude and belief and to write these down on a sheet of paper. Secondly ask them to imagine other people's attitude and beliefs to this situation. Discussion of the outcomes should clarify people's attitude towards HIV/AIDS.
- 2 The trainer explains what HIV/AIDS is, using *handout 7.1*.
- 3 The trainer gives a lecture on how psychosocial counselors can help people with HIV/AIDS. See *handout 7.2* for information.
- 4 Counselors are often seen as the ideal person to bring bad news (such as being HIV-positive) to someone, as they are capable to support the person emotionally (often shocked and afraid), while at the same time being able to listen and understand his/her reaction. To practice this and the subsequent situation, the trainer asks two people to conduct a role-play, while others observe:
 

Role-play on counseling for someone *who is going to get tested for HIV (pre-test counseling)*.

Role-play on *telling someone s/he has HIV/AIDS, which includes dealing with the initial reaction of the person*.
- 5 Group role-play on conducting *counseling for people with HIV/AIDS*, for a client who has accepted s/he has full-blown AIDS and will die soon (e.g. s/he is afraid to die).

## Resource Materials

### *Handout*

7.1 What is HIV/AIDS?

7.2 Counseling for people living with HIV/AIDS

## Synthesizing

The trainer gives an opportunity for asking questions and summarizes the session with the following points:

**Summary** - Psychosocial counselors working with trafficked youth will probably have to deal with people with HIV/AIDS in different stages and situations, ranging from utter shock and disbelief to a preparation for death. The client needs to deal with a variety of social, emotional and practical problems and hopefully the counselor can be a steady assistance for that painful process.

**Critical Note** - As mentioned in the introduction of this session, the trafficked youth living with HIV/AIDS in many ways live through a double tragedy and trauma. More than with many other problems, the counselor needs to be aware of his or her own feelings in the process of assistance. It can be an emotionally draining experience and the counselor might feel a heavy load of responsibility as the final provider of comfort. Although it is important to be able to guide the survivor, the counselor needs to be aware of the risk to become over burdened. It is therefore important that the counselor finds a way to cope with his/her own emotions (of sadness and powerlessness) and distress, for example by talking to a colleague (supervisor).

## Evaluation

The trainer asks each participant to identify what they might find difficult in actually counseling someone who has HIV/AIDS or someone who has just found out about it. These concerns are collected by the trainer who reads them one by one, each time followed by the group's response to each of the raised concerns.

**Handout 7.1****What is HIV/AIDS<sup>38</sup>?**

As counselors dealing with people with HIV/AIDS, it is not only necessary to understand and be able to deal with the psychosocial aspects of the situation, but also to understand and be able to explain what it means to have HIV/AIDS, and how to prevent getting it or transmitting it. To understand what HIV/AIDS is, a very brief explanation is given below, and information regarding prevention is given in the box below.

AIDS results from HIV (human immunodeficiency virus) infection. Infection with HIV produces a variety of manifestations that range from no symptoms at one end of the spectrum to full-blown AIDS (acquired immune deficiency syndrome) at the other end. HIV/AIDS makes the body susceptible to a broad array of medical conditions (infections, tumours etc) because the virus attacks cells of the immune and nervous system so that the body cannot protect itself.

HIV is mainly present in blood, semen, cervical and vaginal secretions. Transmission of HIV most often occurs through sexual intercourse or through the transfer of contaminated blood from one person to another. If the result of the test shows the person is HIV-positive, it means that the person has been exposed to the virus, has the virus within her/his body, has the potential to transmit the virus to another person, and will almost certainly eventually develop AIDS. Those with a negative HIV test result have either not been exposed to the HIV virus and are not infected or were exposed to the virus but have not yet developed symptoms (a possibility if the exposure occurred less than a year before the testing). AIDS is fatal and so far there are no medicines that can cure AIDS. Treatment mainly focuses on slowing down the effect of the disease and on prevention of transmission (Kaplan & Sadock, 1997).

**Prevention and Transmission of HIV/AIDS****Safer Sex Practices (examples only)**

***Safe***           massage, hugging, dry kissing, masturbation, using instruments (not shared).

***Low Risk***       wet kissing, mutual masturbation, intercourse with a condom, oral sex with condom or barrier.

***Unsafe***           intercourse without condom, unprotected oral sex, sharing sex instruments, semen, urine or feces in the mouth or in the vagina.

**Safer Blood Practices (examples only)**

It is essential that all objects that have been in contact with blood should not be shared (e.g. needles for drug users, razors in barbershops). This also includes surfaces and objects in medical practices. Blood and organ donations are only safe after testing for HIV.

<sup>38</sup> If at any point you have questions or doubts about the information given here, please go to a physician for more information. This handout is only meant as guidance.



**Handout 7.2****Counseling for People with HIV/AIDS**

Although the basic skills and concepts of psychosocial counseling are applicable for counseling people with HIV/AIDS, the very particular problems that this group might require additional skills and knowledge. When talking about counseling for people with HIV/AIDS this manual refers to counseling for people who are referred to HIV testing and people who have HIV/AIDS, from the moment of getting the test result to death, as a result of having been exploited for commercial sexual purposes.

**Pre-test Counseling**

As HIV testing in itself can be very distressing and because the result of it might have far-reaching implications, it is advisable to prepare the person to be tested as much as possible. This can be done by discussing or explaining what HIV/AIDS actually is and what it means to be tested positive or negative. It is also important to take away misunderstandings or misperceptions (e.g. that it would be the survivor's fault if s/he is tested positive). The counselor should also give space for the survivor to discuss her/his fears and worries and at the same time explore possible reaction to testing positive (e.g. s/he might have suicidal intentions as a result). The survivor may be encouraged to express how s/he views HIV/AIDS and its effect on someone's life, to which the counselor can react if necessary.

**Breaking the News**

**Emotional support** - The counselor might/should be involved when the results of the HIV testing are given. In the case of HIV-positive testing the survivor's initial reactions

will probably be shock, disbelief, fear of death, afraid of social consequences, rage etc. The severity and intensity of the emotional distress may vary enormously, thus the counselor needs to be prepared for people that fully internalize or deny the (impact of) the news to people who become 'hysterical'. Ultimately, the counselor should show sincere caring and comfort by listening and being present.

**Providing Information** - The counselor might have to explain the test results and the implications if these are not clear to the survivor as well as explain the disease if that is not yet done. This can be done by asking what is understood of the test results. Again it is important to take away misperceptions, if present. Finally, when the survivor is ready, the counselor, if no other professional does, needs to give recommendations for prevention of transmission, which entails the follow-up of sexual partners and/or needle contacts where possible.

Two comments are necessary here. Firstly, the counselor should be very careful when actually telling the bad news. This should not be done too directly, without any introduction, but should also not be too lengthy. Silence is very adequate and it is appropriate to let the survivor be with her/his emotions. The counselor should not continue talking directly after the news has been given. Secondly, the counselor should ensure that the survivor leaves the session relatively emotionally stable (as much as possible under the circumstances) and ensure that there is proper support after the session (partly for safety reasons).



## Stages Relevant for Counseling

While counseling a person with HIV/AIDS one can often distinguish between different stages that are being worked through (Burnard, 1994).

- 1 *Crisis* - a stage of initial reactions (as also described above). This is often a very emotional period because the survivor is being told that her/his life is ending.
- 2 *Acceptance* – this is the stage where the person tries to understand and accept the fact that s/he has HIV/AIDS and reorient her/his life and adapt her/his perspective on life and her/his-self as well as with the limitations that HIV/AIDS poses. The survivor adjusts her/his life to a new situation to make the remaining of life as meaningful as possible.
3. *Preparation for Death* – a stage in which the person tries to synthesize her/his life and deal with issues of fear, pain and after death ideas.

## Reactions

*Social* - In parts of South Asia, HIV/AIDS still carries a stigma<sup>39</sup>. Society's attitude

towards HIV/AIDS is often such that the patients feel ashamed, feel guilty for their role in getting it or even believe it is a consequence/punishment for being or having done something bad. Both society's attitude and the resulting feelings of the survivor make social integration a huge obstacle. Employment and social events or contacts may become nearly impossible because of discriminating attitudes. Furthermore, neglect, isolation, blaming etc might be a direct result of having HIV/AIDS.

*Psychological - Emotional* - As a result of these social influences, personal beliefs and the implication of the disease, the person with HIV/AIDS is likely to be affected emotionally and psychologically. For example, the person might have lowered self-esteem, fear of disclosure, fear for relationships, hopelessness and loss of hope, feelings of loneliness, helplessness, fear of death etc. Furthermore, s/he is at high risk of depression and anxiety disorders (including PTSD). Having said all that, it also remains a fact that many people learn to cope very well with HIV/AIDS and its impact.

<sup>39</sup> Stigma is often the result of: 1) **ignorance** about the medical condition, 2) the negative attitude towards HIV/AIDS causing factors have, such as prostitution (**sex is often seen as dirty** and is often a taboo subject), 3) **false beliefs**, such as the disease being a punishment or consequence of the patient's actions or that it is considered the person's own fault.

# Annex I

## Psychosocial Counseling - An Overview<sup>40</sup>

### How do counselors *help* people with psychosocial problems?

**Aim** - To identify and implement strategies to resolve or reduce a problem situation or to reduce the impact of that situation.

Emotional Support	Problem – solving	Counseling process
<ul style="list-style-type: none"> <li>▶ Giving attention and encouragement</li> <li>▶ Providing acceptance</li> <li>▶ Being with the client/ <i>attending</i></li> </ul> <p>Non-Verbal Communication</p> <ul style="list-style-type: none"> <li>▶ Giving comfort</li> <li>▶ Communicating understanding/ <i>Empathy</i></li> </ul> <p>Reflecting feelings                      Reflecting content (<i>paraphrasing</i>)                      Advanced empathy                      Reflection of meaning                      Summarizing</p>	<ul style="list-style-type: none"> <li>▶ Identify and explore [Problems, situation, causes, perspectives, goals etc.]</li> </ul> <p>Leads to:</p> <ul style="list-style-type: none"> <li>▶ Understanding the problem situation and reflecting that to achieve awareness</li> </ul> <p>Prepares for:</p> <ul style="list-style-type: none"> <li>▶ Achievable steps towards change [Plan of action, alternatives, solutions, dis-/advantages etc.]</li> </ul> <p>Results in:</p> <ul style="list-style-type: none"> <li>▶ Increased level of preparedness in order to implement changes</li> </ul> <p>Brainstorming                      Goal setting                      Working with coping strategies</p>	<ul style="list-style-type: none"> <li>▶ Rapport building</li> <li>▶ Getting at the problem/ <i>assessment</i></li> </ul> <p>Questioning                      Repeating key words</p> <ul style="list-style-type: none"> <li>▶ Counseling goals</li> <li>▶ Implementation</li> </ul> <p>Alternative tools (e.g. relaxation techniques, play, drawings, writing, role-plays)                      Focusing                      Challenging                      Giving information                      Feedback                      Self-disclosure</p> <ul style="list-style-type: none"> <li>▶ Termination/generalizing</li> <li>▶ Follow-up</li> </ul>

<sup>40</sup> This page does not pretend to include all skills, concepts and ideas of psychosocial counseling, it just aims to give an overview of some main components and to get an idea how these are related to each other. Furthermore it should be noted that information in the three columns is overlapping and/or interchangeable.

## Annex II

### Psychopathology - An Overview<sup>41</sup>

This annex is additional information for the psychosocial counselor. As a psychosocial counselor is neither a psychologist nor a psychiatrist, this manual does not include a session on psychopathology relevant for trafficked youth. This is done because counselors do not need to make official diagnosis to assist the survivor in the way they have been taught, namely by helping them by providing emotional support and problem solving if necessary, which is done (as much as possible) from the child's perspective of the problems instead of from formal diagnostic criteria. Secondly, it remains at least debatable how much a psychiatric diagnostic system that has originated in the West is applicable in other cultural contexts.

However, it is also believed that the counselors are part of a group of mental health workers who need to have an understanding of developments in this field in order to further professionalize their knowledge (however not directly related to their skills). Therefore this annex, a brief overview of relevant psychopathology, is included.

It is good for participants to be informed, while refraining from using these terms and diagnoses unnecessarily. A description of the problems in solely psychosocial or day-to-day terms is adequate (e.g. bedwetting instead of enuresis; aggression instead of conduct disorder etc.).

To clarify some jargon in the following; a group of, often problematic and interlinked, behaviours is called *symptoms*, several symptoms together form a *disorder*. Though we can only speak of a disorder when it is causing *impairment* and *distress*. In order to decrease subjectivity and increase professionalism in psychiatric diagnostics, formal systems of psychiatric/psychological disorders have been created, of which the DSM-IV R and ICD-10 are the most commonly used worldwide.

The described disorders often need specialized treatments (e.g. medication, behaviour modification or psychotherapies), depending on the origin and intensity of the problems. Still psychosocial counseling can be the main intervention for change (e.g. abuse, depression, trauma-related disorders, conduct disorder) or an intervention that deals with the secondary problems of the disorders (e.g. social and emotional difficulties experienced because of a disorder such as enuresis or learning disorder etc.).

Included below are disorders that *might* be the result of being trafficked or structurally sexually abused *and* disorders that are important to differentiate between (such as mental retardation, epilepsy, psychoses).

#### **Mental Retardation<sup>42</sup>**

The essential feature of mental retardation is significantly sub-average general intellectual functioning. It is accompanied by significant limitations in adaptive functioning in at least two of the following skill areas: self care, communication, home living, self direction, social/ interpersonal skills, use of community resources, functional academic skills, work, leisure, health and safety. The onset must occur before the age of 18 years. It is found in about an estimated 3% of the population.

*General people's* I - Q is 90-110 (68% of population has IQ between 85 and 115; 16% has an IQ above 115)

If the I-Q is under 70 - *mental retardation* is defined.

Four degrees of severity can be specified, reflecting the level of intellectual impairment:

- 1 *Mild mental retardation* - As a group, people with this level of mental retardation typically develop social and communication skills

during the age of pre-school years and have minimal impairment in sensory motor areas and often are not distinguishable from children without mental retardation until a later age or are not diagnosed specially in a country like Nepal where school children drop out of school at an early age and nobody can detect it. The IQ level of mild mental retardation is 50-55 to approximately 70.

- 2 *Moderate retardation* - Most of the individuals with this level of mental retardation acquire communication skills during early childhood years. They profit from vocational training and with moderate supervision can attend to their personal care. They can also benefit from training in social and occupational skills but are unlikely to progress beyond the second grade level in academic subjects. They may learn to travel independently in familiar places. The IQ level of moderate mental retardation is 35-40 to 50-55.
- 3 *Severe mental retardation* - During the early childhood years, they acquire little or no communicative speech, during the school age period, they may learn to talk and can be trained in elementary self-care skills. They profit to only a limited extent from instruction in pre-academic subjects, such as learning sight-reading of some survival words. In their adult life they may be able to perform simple tasks in closely supervised settings. The IQ level of severe mental retardation is 20-25 to 35-40.
- 4 *Profound mental retardation* - The Profound mentally retarded lead a vegetative life. Most individuals with this diagnosis have an identified neurological condition that accounts for their mental retardation. During the early childhood years, they display considerable impairments in sensory motor functioning. Optimal development may occur in a highly structured environment with constant aid and supervision and communication skills may improve if appropriate training is provided. Some can

perform simple tasks in closely supervised and sheltered settings. The IQ level of profound mental retardation is below 20 - 25.

Various causes exist including birth complications, viral diseases and hereditary causes.

## Attention Deficit

### Hyperactivity Disorder

Attention Deficit Hyperactivity Disorder (ADHD) is mainly categorized as not being able to concentrate or sustain attention, not listening when spoken to, not following through instructions and not finishing tasks, difficulty organizing tasks, easily distracted, hyperactivity, impulsivity, often fidgeting with hands, excessive talking, difficulty to play calmly, difficulty awaiting his/her turn etc. Often ADHD is related to conduct and learning problems or enuresis.

Often medication is used, (often the drug Ritalin). It affects the nervous system in the body. Possible side effect is shaking hands. Behaviour modification programme and cognitive-behavioural intervention have also been efficient treatments.

It is mostly believed to have biological causes (genetic, neurotransmitters).

### Disruptive Behaviour Disorder<sup>43</sup>

The criteria for this disorder are:

1. Has anger tantrums
2. Often quarrels with adults
3. Refuses to agree to rules set by adults
4. Purposefully does things that disturbs or annoys others
5. Blaming others for own mistakes/faults
6. Easily irritated
7. Often angry, easily starts fights
8. Hateful
9. Deliberately destroys property

This behaviour in children may be caused by various factors, such as:

*Psychosocial influences* This can be inadequate child-parent interactions because of the parent's often unpredictable behaviour or because of the negative modeling the parents set (from harsh authoritarian to over-permissive/no control). Furthermore this includes marital problems, broken families, family size and social/cultural group.

*Learned behaviour.* Aggression as a way to deal with conflict or high stress situations is often found to be learned behaviour. A child sees similar behaviour being conducted by people surrounding the child, such as family or peers.

*Biological/constitutional influences.* This includes genetic factors as well as the autonomic nervous system.

It is important that attention is given to the aggressive behaviour. Often it will have functioned as a successful coping mechanism in the past (so changing it will be difficult, though keep in mind that you are trying to change behaviour and not a person). The first task then is *to create awareness* about the behaviour and later about the dysfunctional consequences of the behaviour ('why it is not good'). For example because it is not adaptive behaviour in society, it creates a higher risk for intergenerational cycles of aggressive behaviours, because it doesn't solve the problem, because it results in new negative feelings within the person and within the people it is directed to.

Treatment possibilities (depending on age and severity):

- Medication
- Behaviour modification techniques
- Counseling; problem-solving focused
- Social skills training or parent training for learning new behaviours

### Mood Disorder - Depression

The reasons for depression can be numerous, though the changing world of adolescence can go together with intense feelings of insecurity and self-doubt possibly resulting in depression. Depression is characterized by several symptoms, that can be categorized as following (Sue, Sue & Sue, 2000);

*Affective symptoms* like sadness, unhappiness, apathy, anxiety

*Cognitive symptoms* like pessimism, inability to concentrate, loss of interest and motivation, suicidal thoughts

*Behavioural symptoms* like low energy, crying, irritability, neglect of personal appearance

*Physiological symptoms* like loss of appetite and weight, sleep disturbances, loss of sex drive, disturbance in menstrual cycle for women.

### Epilepsy

Epilepsy is a general term that refers to a set of symptoms that always includes intermittent and brief periods of altered consciousness,

Period	Character
Infancy	Difficult, fussy, hard to soothe
Pre-school	Externalizing symptoms (people around the child feel distress)
5-6 years	Pattern of negative, hostile and disobedient behaviour (anger, blaming etc)
12-18 years	Anti-social behaviours that violate the rights of others - juvenile delinquency (stealing, sexual assault etc)
Adulthood	Anti-social personality disorder

accompanied by attacks, and excessive electrical discharge in the brain. It can be a symptom of a brain dysfunction or heredity, brain tumor, injury, drugs etc can cause it. The epileptic attack and unconsciousness may last a few seconds or much longer; it may occur very often or very rarely. Alcohol, fever, hyperventilation, lack of sleep, emotionally charged situations can all provoke an epileptic attack. As an epileptic attack can be quite a frightening and dramatic image, it is often regarded by society with suspicion or negative stereotyping.

*Petit mal epilepsy* refers to a brief disruption of consciousness in which the person loses contact with his/her surroundings and is temporarily absent (often unrecognized by others).

*Grand mal epilepsy* (tonic-clonic seizure) refers to a disruption of consciousness that starts (aura phase) with sensory sensation (such as hallucinations, dizziness), then the person becomes unconscious and falls to the ground (tonic phase), then body muscles rapidly contract and relax, producing violent and sudden movements (clonic phase), and finally the person relaxes his/her muscles and the loss of consciousness remains for a few more minutes (coma phase). (Sue, Sue & Sue, 2000)

### **Dissociative [conversion] Disorder<sup>44</sup>**

People with dissociative disorders have a partial or complete loss of the normal integration between memories, awareness of identity, awareness of immediate sensations and control of bodily movements. Dissociation is a person's mechanism to remove themselves from trauma or protect themselves from trauma related conditions; in a way it is escaping a stressful and/or emotional situation or thought. The dissociative symptoms are not a result of any physical disorder and the symptoms can convincingly be linked to stressful events or problems.

*Dissociative Amnesia* - the sudden inability to recall (personal) information of events that are or were stressful, which is too extensive to be explained by forgetfulness.

*Dissociative Convulsion* - sudden, unexpected and violent movements, resembling an epileptic seizure though no loss of consciousness or other physical symptoms like urinating, bruises, tongue biting (that all indicate epilepsy).

*Possession Disorder* - the individual is (unwillingly) convinced that s/he has been taken over or controlled by a spirit, ghost, deity etc, often resulting in change of identity or convulsions. (Kaplan & Sadock, 1997)

### **Anxiety Disorder (including PTSD)**

Anxiety is a term that refers to feelings of fear resulting in disruptive patterns of behaviours. Anxiety disorder is often a result of stressors (either common or traumatic) that the individual is not capable of handling sufficiently. Anxiety can have a *cognitive aspect*, namely in a person's thoughts (e.g. worry, panic, fear of losing control); *behavioural aspect*, namely in a person's actions (e.g. avoiding anxiety-provoking situations) and *somatic aspect*, namely changes in a person's physiological reactions (e.g. heart palpitations, cold hands, frequent urination, muscular tenseness, increased perspiration, etc). Anxiety disorders may range from recurrent and unexpected panic attacks, post-traumatic stress disorder (see also session 2 of this manual), extreme unrealistic fearful reactions to very specific situations or objects (phobia).

### **Somatoform Disorder**

This is the category that encompasses session 4 of this manual (functional complaints). Somatoform disorder describes the physical symptoms that suggest a medical condition though the symptoms cannot fully be explained medically and seem to be the result of unexpressed stress or emotions. The symptoms cause actual disturbances in the individual lives and are not intentionally produced. The individual may experience many different physical complaints affecting many organ systems (*somatization*); the individual may strongly and recurrently believe that they have a specific disease and therefore preoccupation with bodily functions (*hypochondrias*); the individual may

have a false belief that his/her body or body part is defective (*dysmorphic*); the individual is experiencing pain that has no medical base or is excessive for what might be expected, mainly because of psychological factors (*pain disorder*).

As mentioned in the introduction of this annex, the cultural validity of the classification summarized here is at least debatable. That holds again true for this category, specifically as it is based on a Western idea of psychological conflicts that are presented in physical complaints (*psychosomatic* perspective; e.g. because of high levels of stress I have constant headaches). Though in South Asia the overall belief is more *somatopsychic*, which entails that physical complaints produce psychological and emotional problems (e.g. because of a constant headache I feel sad and lack energy). This difference of perspective always needs to be kept in mind. (Sue, Sue & Sue, 2000)

## Psychotic Disorders

One speaks of psychotic disorders if an individual's sense of reality is severely disturbed. Unfortunately, psychotic people are often called 'crazy' or 'mad'. They have *delusions* and *hallucinations* and often affective disturbances, disorganized speech, bizarre behaviour and social

withdrawal. Delusions are false personal beliefs that are firmly held and that confuse thought and reality. Examples of delusions are; thinking that one is famous and powerful (e.g. God); thinking that one is being controlled by others; thinking that one is being persecuted, followed or mistreated (e.g. someone is planning to hurt him/her). Hallucinations<sup>5</sup> are perceptual/sensory distortions, which means that one hears, sees, feels or smells things that are not actually present in the individual's environment. Examples of hallucinations are; hearing voices in ones head (mostly unwanted voices that may be very threatening for the person); seeing people or objects that are not present. Generally, psychotic people are easily recognized because of their strange behaviours, such as waving hands, shouting aloud, walking in the middle of the road. Psychosis can be for a short while and occur once or several times in ones life or it can be for longer periods of time. After detecting someone as being psychotic, treatment entails the use of medication (and support in continuous taking of the medication) and in addition to that the person should be protected from harming self or others, should be kept busy (distraction as a way of coping) and the family and community should be educated not to be angry, hurtful or abusive to the person.

<sup>41</sup> The descriptions are based on professional literature though as much as possible written for the level of para-professionals, the target group of this manual.

<sup>42</sup> Partly based on DSM-IV and Poudyal and Van Ommeren, 2000; lecture of Dr. Nirakar Man Shrestha

<sup>43</sup> Disruptive behavior disorders combines Oppositional Defiant and Conduct Disorder.

<sup>44</sup> For the description of the dissociative disorder the ICD - 10 classification has been used.

## ANNEX III

### Sexuality: A Theme to be Explored<sup>46</sup>

This manual is designed for a target group that has been trafficked for sexual exploitation and thus that has been structurally sexually abused. Therefore, sexuality seems to be one of the core issues of the overall problem and needs to be discussed as such (although a faulty system and abusive individuals are the actual problem). At the same time the trafficked youth's lives, continue after their resources, which means they may come across sexuality again (though hopefully in a different situation). For both reasons it may be important that sexuality as a theme becomes a topic of discussion, within society, within families or within the counseling process; of course as *appropriate and according to cultural standards*.

Sexuality is something that develops as children get older. Their bodies become ready for reproduction and around adolescence they start being sexually aroused. These are *natural phenomena* and are part of a healthy development.

In some societies sex and sexuality are not issues that are openly discussed, they are taboo topics, possibly because sex is regarded dirty or *culturally inappropriate* (e.g. no sex before marriage). This results in limited sexual activity before marriage, in the fact that it is not much talked about and in the stigma that sexual abuse often carries.

Sexual activity can also be viewed merely as a pleasurable event and as such it can subsequently become an element of an emotional *relationship between partners*. Still, if trafficked youth choose to be sexually active again after having been rescued, one must understand the emotional burden that they might carry.

#### ***Why does sexuality need to be explored?<sup>47</sup>***

Psychosocial counselors for youth that have been trafficked need to have understanding of the problems related to sex or sexuality that the youth might experience.

Counselors need to have an understanding and be able to discuss with the youth any issues related to sexual transmitted diseases.

Generally, having an understanding about sexuality might be needed to understand the situation of sexually abused individuals.

Counselors need to feel 'comfortable' with the topics, issues and words around sexuality, in case the child/young person wants to discuss issues related to sexuality.

The counselor might need to review his/her personal attitude towards sexuality and/or discussing sexuality openly.

In a culture where discussing sexuality is not always appropriate, there might be a specific need to do so for individuals who experience problems; counselors need to be prepared for that.

#### ***Which issues and problems related to sexuality are relevant for sexually abused youth?***

Sexually abused individuals might have developed an aversion towards sex and/or anything related to it.

Sexually abused individuals might have developed an attitude that sex is wrong, aggressive or disgusting.



Any sexual activity might be a traumatizing experience, in which the individual re-experiences the initial trauma of sexual abuse.

Difficulties in dealing with sexuality might cause problems in intimate relationships.

One needs to be aware of the cultural sensitivity of the stigmatizing effect of sexuality related issues - such as lost virginity - resulting in a variety of psychosocial problems.

---

<sup>46</sup> This text is only a brief introduction to a topic that is complicated biologically, culturally and emotionally. It only serves as an introduction for a discussion.

<sup>47</sup> The following text is the result of a group discussion on sexuality, as part of the pre-testing of this manual, which was followed by role-plays related to sexuality as a topic within a counseling session.

## ANNEX IV

### Trauma Recovery<sup>48</sup>

The recovery process after trauma involves the reconstruction of destroyed systems of care, protection and meaning in order to restore support. As trauma is recognized by disempowerment and disconnection from others, the recovery process should be based on empowerment and the creation of new connections. During the helping process the counselor needs to be aware of the possibly intense emotional reaction the survivor's story might evoke in him/her; this could include terror, helplessness, wish to rescue or deny, blaming etc. The recovery process can be described by the following three stages:

#### **Restore Safety**

The establishment of safety should be the first and only focus in the beginning and can be conceptualized by working on control of the body (which includes basic health needs such as eating and sleeping as well as control of self-destructive behaviors<sup>49</sup>) and moving towards control of the environment. The latter includes a safe living situation and a plan for self-protection.

#### **Exploring Trauma<sup>50</sup>**

In small steps, at the child/young person's pace, the survivor and the counselor can uncover the previously dissociated or repressed aspects of memory or affect. The purpose is to create a mastery experience, rather than a symbolic reliving of the trauma experience. It entails describing and exploring the trauma event(s), which often lead to feelings of grief and loss but also to a feeling of acceptance and capacity to deal with the negative aspects of the trauma and give it a place in the person's life story.

#### **Reconnection**

Reconnection refers to the process of reintegration into society at large through creating new connections and relationships or restoring old ones. Peer support is the major link to reconnection because it allows resolutions of issues of secrecy, shame and stigma. Also the therapeutic relationship with the counselor is a reconnection into a durable and trusting relationship. The victims who are unable to overcome their social isolation often show the worst recoveries.

<sup>48</sup> This is a description of the recovery process, the methods to achieve these are described in Handout 2.2 as well as general counseling skills. This text is taken from Herman, 1992.

<sup>49</sup> Self-destructive behaviours can be understood as symbolic or quite literal re-enactment of the initial abuse, which serve the function of regulating intolerable feelings, in absence of more adaptive self-soothing strategies.

<sup>50</sup> This is closely related to 'retelling' as described in session 2.



# References

- American Psychiatric Association. 1994. *Diagnostic and Statistical Manual of Mental Disorders. Fourth Edition [DSM IV]*. Washington, DC.
- Childhope and UNICEF. *Basic Training on Psychosocial Interventions for street children service providers. A trainer's manual*. Philippines.
- Burnard, B. 1994. *Counseling Skills for Health Professionals. Second Edition*. Chapman & Hall, London.
- Egan, G. 1998. *The Skilled Helper. A Problem-Management Approach To Helping. Sixth Edition*. Brooks/Cole, California.
- Herman, J.L. 1992. *Trauma and Recovery. The aftermath of violence – from domestic abuse to political terror*. Basic Books, New York.
- Ivey, A.E., Ivey, M.B. 1999. *Intentional Interviewing and Counseling. Facilitating Client Development in a Multicultural Society. Fourth Edition*. Brooks/Cole, California.
- Ivey, A.E., Pederson, P.B., Ivey, M.B. 2001. *Intentional Group Counseling. A Microskills Approach*. Wadsworth,
- Jong, de. T.V.M., Clarke. L. (Eds.) 1993. *Mental Health of Refugees. Prepublication Version*. WHO/UNHCR, Geneva.
- Jordans, M.J.D. (Ed.) 2001. *General Manual on Counseling for Children in Especially Difficult Circumstances. Second Edition*. UNICEF Nepal, Kathmandu.
- Jordans, M.J.D. (Ed.) 2001. *Training Handbook on Psychosocial Counselling for Children in Especially Difficult Circumstances. Second Edition*. UNICEF Nepal, Kathmandu.
- Jordans, M.J.D. 2001. *Internship on Psychosocial Counseling for Children*. Center for Victims of Torture (CVICT), Kathmandu.
- Kaplan, H.I., Sadock, B.J. 1997. *Kaplan and Sadock's Synopsis of Psychiatry: Behavioral Sciences/ Clinical Psychiatry. Eighth Edition*. Lippincott Williams & Wilkins, Baltimore.
- McNamara, B.E., Mc Namara, F.J. 1993. *Keys to Parenting a Child with Attention Deficit Disorder*. Barron, New York.
- Meichenbaum, D. 1994. *A Clinical Handbook/ Practical Therapist Manual for Assessing and Treating Adults with Post Traumatic Stress Disorder (PTSD)*. University of Waterloo, Ontario.
- Sue, D., Sue, D.W., Sue, S. 2000. *Understanding Abnormal Behavior. Sixth Edition*. Houghton Mifflin, Boston.
- Van Ommeren, M., Sharma, B., Prasain, D., Poudyal, B.N. STET. *Helping Torture Survivors in Nepal: A Public Mental Health Perspective (Prepublication Version)*. Forthcoming in: Jong, de. T.V.M (Ed) *Trauma and War: A Public Mental Health Approach*. Plenum, New York.
- Poudyal, B.N. & Van Ommeren, M. 2000. *CVICT Psychosocial Counseling Internship Program*. Center for Victims of Torture (CVICT), Kathmandu.
- Ringel, M. 1998. *Practical tips for managing patients who somatize*. Patient Care, 32,131 – 156. In: Sue, D., Sue, D.W., Sue, S. 2000. *Understanding Abnormal Behavior. Sixth Edition*. Houghton Mifflin New York



**Trafficking in Children - South Asia (TICSA)**

**International Programme on the  
Elimination of Child Labour (IPEC)  
International Labour Organization**

International Labour Organization  
IPEC - TICSA Programme  
GPO Box 8971  
Pulchowk, Kathmandu, Nepal  
Phone # 977-1-522259, 542148, 550691  
Fax # 977-1-550714, 531332  
Mobile # 9810 39594  
Email: KATHMANDU@ilo.org

<http://www.ilo.org>