

TELECOUNSELLING MANUAL

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We value the contribution of Mumbai police, protection officers, child welfare committee members, district legal aid members and shelter authorities who have helped us in coordination of survivors of violence in Covid-19 crisis. Last but not the least, we would like to recognize and respect the survivors of violence who contacted us through the helpline and had faith in our abilities to assist them.

GLOSSARY OF TERMS

Client	A woman or child survivor of violence using SNEHA’s counselling and crisis intervention services
CWC	Child welfare committee
FIR	First Information Report
GBV	Gender-based violence
IPV	Intimate-partner violence
NC	Non cognizable
PVWC	Prevention of violence against women and children
Khulanama	Divorce
Qazi	Muslim religious priest

PROGRAM ON PREVENTION OF VIOLENCE AGAINST WOMEN AND CHILDREN



SNEHA’s program on Prevention of Violence against Women and Children works towards ending discrimination against women and girls in public and private spaces and ensures participation and leadership of women to prevent violence in their communities. Violence against women is: “any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.”

Using a socio-ecological model as a framework for action at an individual, interpersonal, organisational and societal level, the program tackles the interplay of various factors through primary, secondary and tertiary interventions. Primary prevention activities are carried out through campaigns and group education with women’s and men’s groups, leading to individual voluntarism to identify, respond to and refer cases of violence against women and children. Secondary prevention is offered through delivery of comprehensive services. The services offered are counselling, crisis intervention and facilitating coordination with public health providers, the police and legal aid, home visits to engage perpetrators and other family members supporting abuse, and mental health counselling to minimise the impact of violence. Tertiary interventions include extended counselling and mental health interventions such as individual counselling and psycho-education, role education with perpetrators, couple and family counselling, and legal intervention for survivors with the aim of empowering them to make their own decisions and take control of their situation.

SNEHA’s telephone counselling and crisis intervention services were strengthened in times of COVID-19 on account of forced shutdown of the counselling centres in the lockdown period.

The telephone services include counselling and crisis intervention services on intimate-partner violence, domestic violence, rape and sexual assault, sexual violence by non-intimate partner, child sexual abuse and violence happening on any woman or child on account of their gender, sexuality, religion, disability, and economic status.

It has been hard for us to determine the cause and effect relationship between gender-based violence and mental health. In our experience, women predisposed to mental illness and undergoing violence show a higher likelihood of developing common mental disorders due to abuse and ambiguity in relationships. Whereas women who live with mental health conditions suffer violence on account of their inability to perform the role of a care provider in home settings. We've integrated counselling on gender-based violence with mental health in order to provide a comprehensive service.

A successful aspect of our approach to gender-based violence and mental health interventions has been that it is non-clinical and holistic. We believe that the social determinants of violence and mental health need to be understood in order to develop psychosocial interventions that work on the continuum of illness to wellness.

This manual has been developed as a guideline for SNEHA counsellors to provide telephone counselling, crisis intervention telephone services and mental health counselling to women and children survivors of violence with or without mental health conditions. Considering the complexities of gender-based violence and its associations with mental health, telephone counselling becomes more complicated and challenging.

The manual provides succinct and clear explanations of various aspects of counselling to be considered while providing telephone services. It provides explanations on technical management of devices, managing issues of consent, confidentiality and data protection, safety protocol to be followed for the survivors who seek counselling help, risk assessment, management of suicide and essential counselling principles to be followed while using the telephone helpline.

INTRODUCTION



Gender-based violence (GBV) is an umbrella term for any kind of violence perpetuated against individuals, that has its roots in gender-based power differentials. Women and children, and especially those hailing from marginalized groups such as lower socio-economic classes, women with disabilities, sexual minority women, women from minority castes, religions, races, etc are most at risk.

The Covid-19 pandemic has become a global health crisis and its sudden outbreak has led to loss of jobs, economic insecurity, uncertainty about the future and poverty related stress. The global nature of the pandemic and associated fear and uncertainty provide an enabling environment that may spark or exacerbate diverse forms of violence. In the past, crises and times of unrest have been linked to increased interpersonal violence, including incidence of violence against women and children.

Benefits of telephone counselling include:

- Survivors can access immediate support during crisis
- Crisis support and case management can be provided in areas that are inaccessible or unserved as well as to populations who cannot reach in-person services or crisis centres due to restricted mobility.

- Confidentiality is maintained so individuals are not worried about the stigma of seeking help
- The services may be more accessible to groups such as adolescents
- In some cases where face-to-face counselling is required, telephone services provide continuity in GBV service delivery as they can help to coordinate follow-ups, ensure between session contact, crisis communication, etc.

It is important to bear in mind the limitations of telephone counselling and crisis intervention services, as these services cannot substitute entirely in place of face-to-face counselling and interventions carried out in a physical space. The services may not allow the counsellors to carry out comprehensive case management and coordination of psychosocial support services. The helpline can serve as an immediate service for women to seek help to stop violence and undergo mental health counselling services. The follow-up services can help women if they desire to remain in touch with the counsellors. There may be certain limitations, in that they may not allow for the provision of comprehensive case management, psychosocial support services, or referral services. Hence, a mobile response should only be

considered when offline in person support cannot be provided, or, it can serve as a

stop-gap until in-person services are established.

What are important things to keep in mind when working with women survivors?

A. Integrated GBV and mental health response

Standard GBV case management	Crisis case management and adaptation
<ul style="list-style-type: none"> • Induction- introduce yourself, the organization, services offered and limitations • Take informed consent after informing about confidentiality and risks 	<ul style="list-style-type: none"> • Abbreviated introduction and consent. Introduce yourself in one sentence and inform about confidentiality. • Say “If you expect that we assist you by intervening with your family members or any other person, then your consent will be necessary.”
<ul style="list-style-type: none"> • Assessment of risk, history in detail, mental health screening, suicide risk assessment • Psychological first aid including active listening 	<ul style="list-style-type: none"> • Immediate risk and safety assessment, suicide risk assessment
<ul style="list-style-type: none"> • Case action planning • Summarize your understanding of the survivors needs. • Give information about what services and supports are available and what they can expect from them. • Develop and document a case action plan based on how she wants to proceed. • Psychoeducation about mental health services if she screens positive for mental health issues 	<ul style="list-style-type: none"> • Creating a safety plan • Suicide prevention protocol if required • Informing about services available for immediate needs.
<ul style="list-style-type: none"> • Implementing case action plan • Making referrals to internal professionals such as psychologists, lawyers, etc • Making external referrals to police, protection officers, etc • Advocating for and supporting survivors to access services and lead case coordination • Document 	<ul style="list-style-type: none"> • Explore support networks, and make referrals to individuals who can help with immediate concerns with consent. • Provide resources (material support, resources, hotline number, contacts of providers in destination location as applicable, encourage her to stay in touch if at all possible). • Share key messages: the survivor is not alone, not at fault, and affirm/validate survivor’s feelings.

	<ul style="list-style-type: none"> • For the last few minutes, stabilize the survivor so she is not leaving your session in a more traumatized state. • Document
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B. Important Guidelines

Competence with respect to device management

It is important for the counsellor to be knowledgeable and efficient at the use of the device that they are operating and familiarize themselves with different commands, recording the calls, etc to ensure that the conversation is smooth and there is no unexpected data breach or interruption.

Subject matter and legal knowledge

It is important for the counsellor to be knowledgeable about gender-based violence, the emotional impact of trauma, basics of mental health care, as well as the legal provisions and laws and organizational protocol regulating telephone use, privacy, information and documentation.

Taking informed consent

In a telephone counselling service, clients reach out to the service, which implies that we do have their consent to speak to them. However, informed consent needs to be taken before any interventions are undertaken. It is crucial to inform clients about the organization, processes of interaction, potential risks and benefits, confidentiality issues, data security, and take informed consent for carrying out interventions. This can be in the form of a written document that the client has to sign and send a photo of; the client can be asked to write a statement giving consent and send it on email or chat; verbal consent can be recorded with permission, for the purpose of documentation.

In some cases, family members, friends, neighbours or concerned well-wishers of a woman in distress may contact the helpline. In such cases, we clarify that we typically do not provide any interventions without the woman's explicit consent. We do provide psychoeducation to these well-wishers about available services, and recommend what they can do as bystanders in crisis situations, such as calling the police helplines for women to rescue her from the situation.

Managing attachment and rejection

Telephone and e-counselling can leave room for fantasy and speculation about the practitioner (and client). Agreeing to clear boundaries by checking perceptions and understanding, and by discussing the therapeutic relationship, are very important. For instance, the counsellor should be able to manage issues such as absence of a prompt response from the counsellor evoking feelings of rejection or abandonment in the client, to set boundaries and manage perceptions that the counsellor be constantly and immediately available to them.

Ground rules and boundaries with the client

Create an environment in which the counsellor is able to discuss the following:

- Timings and limits of availability
 - Duration of sessions
 - Number of messages sent and responded to
 - Routine of message responses
 - Routine timings of responses
- Understanding no social website

contact; Agreeing alternative procedures for contact in the event of IT failure or mobile phone signal failure.

Data protection and confidentiality issues

It is important to discuss the importance of maintaining confidentiality and data security with clients. This may involve educating them about how they can maintain safety using their own equipment. The data-recording setting can be disabled by counsellors to prevent the clients from recording calls, or this can be explicitly stated as a rule while taking informed consent. The counsellor needs to inform of how the organization will keep their data confidential. It is crucial to discuss limits to and breaches of confidentiality. It is absolutely mandatory to keep a formal record of consent given by clients agreeing to adhere to the terms and conditions of counselling and therapeutic practice.

Establishing the identity of the client

The absence of visual contact presents problems in verifying the identity of the client. Counsellors may need to learn to identify signs that a client may be older or younger than they purport to be by noting age congruence of language used and contextual information offered by the client. If possible, identification proof can be requested and clients can be asked to mail or send the same on chat. Be aware of legal and ethical differences when working with children and adults and take reasonable steps to verify the client's age accordingly.

Supplementary telephone and / or e-therapeutic resources

It is important to identify when a client might benefit from using additional online resources or if they ask for additional support to supplement telephone and/ or e-counselling, then provide them with appropriate online resources for a range of mental health and emotional difficulties.

For this, it is important to have a resource database of online and offline resources, and one must evaluate the integrity, security and effectiveness of such resources.

Complaints procedure

Clients should be informed about the complaints procedures available to them; such as how to make a complaint to the counsellor's supervisor or the director of the program.

Communicating using written text

While responding to emails or one text, one must adapt the style of communication to the needs of different clients while keeping a consistent writing style with each individual client. Writing must be professional and formal with all age groups, and must take into account the client's literacy, knowledge of the language, and cultural factors. Abbreviations, emoticons, different formats and slang with varied meanings cannot be used while counselling. It is best to avoid leaving any room for misinterpretation.

Safety protocol

- Telephone hotlines use technology that can be monitored by perpetrators/abusers, particularly in intimate-partner violence situations. It is important to establish protocols to promote callers' safe use of the hotline. These protocols should be communicated to the caller from the outset.
- No call back policy. Hotline staff should not call survivors back if there is an immediate risk to their safety, especially in situations of ongoing intimate partner violence. Ask survivors to call them back if you get disconnected.
- Remind survivors to delete the call record from the phone. One of the

risks with hotlines is that perpetrators, particularly in situations of IPV, may monitor a survivor's phone use.

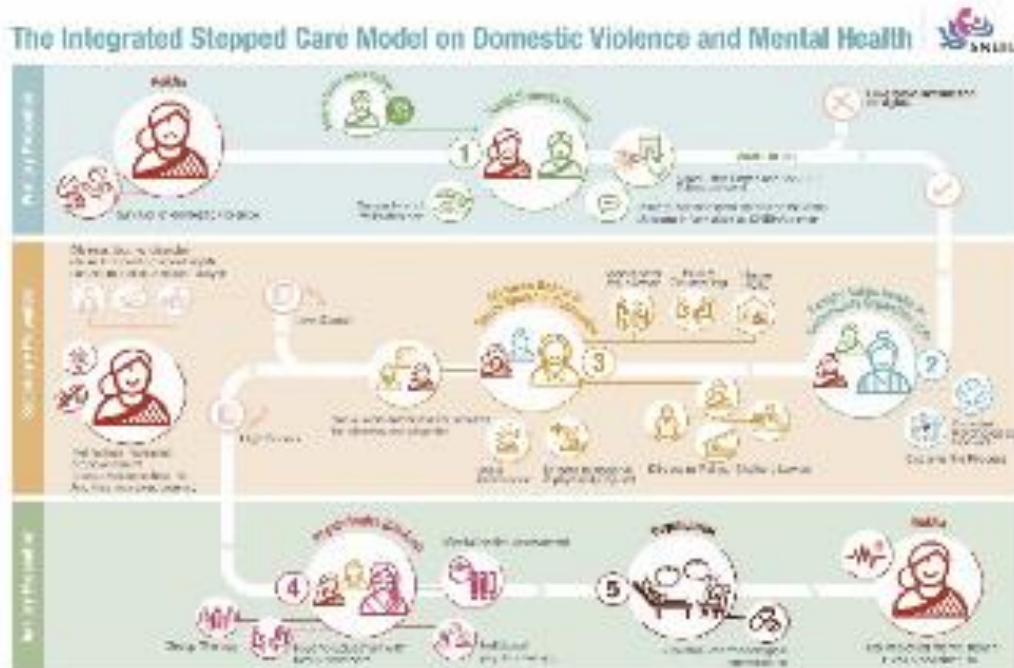
- Establish a code/red flag phrase. With survivors that receive ongoing support and case management via the hotline and have safety concerns at home, the survivor and counsellor should agree on a code that the survivor can use to signal to the hotline staff when the survivor thinks the call is being monitored and it is unsafe to talk. IPV perpetrators may not only monitor a survivor's phone use, but also the phone calls. If there are multiple hotline staff, the same code can be used across the program with different survivors to signal that they need to stop talking about violence and assume a different role/narrative, and then promptly end the call.
- Any requested calls back from the counsellor should be accompanied by a safety plan.

Intersectionality

While working with women survivors of gender-based violence, it is important to

be mindful of intersectionality. Counsellors should be trained in gender and sexuality which is inclusive of working with sexual minority women. They must acquire competency in working with women with disabilities, and telephone counselling platforms and information regarding the same must be access-friendly. Counsellors need be aware of their own biases and relative privileges with respect to issues of religion, caste and class, and pay attention to how the multiple identities that a woman may hold based on the above may add to her marginalization and risk of violence. Elderly women and adolescent girls may also face specific challenges based on their age cohort. Cultural competence and sensitivity is required to be able to work with women from diverse backgrounds. Counsellors need to be aware of acts relevant to marginalised groups such as the Disabilities Act, Transgender Rights Bill, Rights of sexual minority women based on the recent Section 377 verdict, Muslim laws and such others. The counsellors should be updated with resources for referrals such as NGOs for gender and sexual minorities, services available for religious minorities, dalit and adivasi women.

STEPPED CARE MODEL ADAPTED TO TELEPHONE COUNSELLING



At SNEHA we use a stepped care model integrating gender-based violence and mental health interventions. A structured model plays a very important role in complex interventions, especially for organizations that work closely with communities. The Stepped Care model refers to a step-wise system of delivering and monitoring treatment, so that the most effective yet least resource-intensive treatment is delivered to clients (in SNEHA’s case, women facing violence with mental health conditions) first; only ‘stepping up’ to intensive/specialist services as clinically required. The objective of a stepped care model is ‘having the right service in the right place, at the right time, delivered by the right person’. Most stepped care models are focused on making mental health care services more accessible. However, we have incorporated elements of

intervention for both gender-based violence and mental health in our approach. Two key features of our integrated stepped care model are

- It is comprehensive: the woman receives social, legal and rights-based interventions based on her needs, along with the mental health intervention.
- It aims to involve members of the community as well as trained professionals.

The section below mentions our protocols being adapted to telephonic interventions.

Recognition by primary health workers/ community staff

The community staff screen for gender-based violence and mental health

conditions in the communities they work with during their promotional/ prevention activities. They use a mobile application to map violence. Those with violence and mental health conditions are given information about and referred to the telephone intervention services after taking the survivor's informed consent. At this level, screening is basic and is based on yes/no questions about existence of any kind of violence, and of basic distress.

Assessment / Primary care interventions

The counsellors conduct risk assessment for violence and provide counselling and crisis interventions for the same, and refer to legal services, police, medical workers, etc as required. Mental health screening is carried out to assess the level of distress.

The treatment plan depends on the scoring derived for each individual. If the score is below cutoff, they provide psychological first aid. If the score is above cutoff and the client needs psychotherapy and then she is referred to clinical psychologists. (Risk assessment, mental health screening, psychological first aid, are described in subsequent sections)

Secondary / specialist services

Based on the extent of the problem, the client or patient is referred to a psychologist for therapeutic intervention, which is conducted over the telephone. If required, for clients with severe concerns, there are referrals and linkages made with psychiatrists and in-patient departments of hospitals.

RISK ASSESSMENT



Risk assessment questions for women survivors of gender based violence

Physical assault

- Client has been physically assaulted by the perpetrator
- Perpetrator has physically used a weapon against the client
- Perpetrator has assaulted the client outside the family environment
- Perpetrator has assaulted another family member
- Perpetrator has assaulted non family members
- Client reports escalation in the seriousness or frequency of violence

Threats

- Perpetrator has threatened to assault or harm client
- Perpetrator has threatened to use a weapon
- Perpetrator has threatened to kill client
- Perpetrator has threatened violence against non-family members
- Perpetrator has threatened violence against other family members

Displacement from home

- Perpetrator has thrown client out of the house
- Perpetrator has forced client to move out of the house

- Perpetrator has removed the client by cheating

Risk involving children

- Perpetrator has taken away client's child
- Perpetrator has abused client's child
- Perpetrator has threatened to harm or abuse client's child

Restricted mobility

- Perpetrator has held client somewhere against her will
- Client is isolated (geographical reasons or restricted access with family or friends)
- Client is isolated by family, neighbourhood or community

Legal issues

- Perpetrator has breached an intervention/ restraining order
- Perpetrator has a prior arrest for murder/ manslaughter/ rape or sexual assault

Mental and physical illness

- Perpetrator is abusing under the influence of alcohol or drug dependency

- Perpetrator has attempted or threatened suicide or self-harm
- Client experiences depression or has other mental health issues
- Client has verbalised suicidal ideation, or has attempted suicide or self-harm
- Client under the influence of alcohol or drug dependency
- Client is dependent on perpetrator for care (illness, infirmity, age, dementia)
- Client has a disability that impairs physical activity or mobility
- Client has a disability that impairs cognitive or sensory functioning (deaf, blind, intellectual, dementia, etc)

Non-compliance

- Client is non-compliant with intervention in high-risk situations

Disability

- Client is dependent on perpetrator for care

Based on the above questions, one can determine whether the client shows Standard risk, Medium risk, or High risk. Safety planning for each level of risk is crucial and is the beginning of all intervention processes.

SUICIDE RISK ASSESSMENT AND PREVENTION



Understanding suicide

Suicide is the act of killing oneself, or death caused by self-injurious behaviour with any intent to die as a result of that behaviour.

Suicidal ideation could be passive / intermittent / persistent or impulsively triggered by a situational stressor. Most people who attempt suicide perceive that they have run out of resources and ways to overcome their troubles and want to bring an end to the pain or suffering. Sometimes, self-harm or suicidal attempts could be engaged in to gain attention or be manipulative in nature. The counsellor has to be very careful before establishing this as a causal factor and approach suicidal ideation and its attempts with a non-judgmental attitude.

Determining risks and signs

- Please note that risk assessment does not 'PREDICT' risk with certainty
 - The purpose of risk assessment is to help structure and formulate a safety plan and aid the treatment intervention.
- In general, the following factors are most likely to predispose people towards the risk of suicide:
 - Demographics – Women
 - Low Socio-economic strata
 - Middle aged and young adults
 - Mental disorders (example, depression, panic attacks, psychosis)
 - Substance use
 - Impulsivity
 - Chronic physical illness and/ or pain
 - Trauma
 - Abuse and Domestic violence. Witnessing family violence
 - Poor support system and lack of support from family members.
 - Family history of suicide
 - Grief and bereavement /Loss of a close family member/spouse /friend etc.
 - Separation/divorce/break-up in a relationship.
 - Victim of bullying.
 - Unemployment/Loss of job and financial stressors

- Easy access to the means (though there has to be suicidal ideation present)
- Past history of self-harm or suicidal attempts- people who have attempted suicide in the past are more at risk)
- A strong sense of hopelessness and worthlessness
- Loneliness and perception of being a 'burden'.
- Feeling that there is no other alternative than committing suicide and nobody can help the person get out of the suffering
- Feelings of guilt/ shame/anger
- Constriction in thought processes- eg, " Only if I have my spouse back, is my life worth living"

Protective factors

- Social support and family engagement.
- Religious or cultural beliefs
- Community involvement
- Access to services- Help lines, mental health interventions etc
- Person's perception of consequences of suicide
- Personality determinants
- Problem solving skills
- Safe environment

High risk

- Persistent thoughts of committing suicide with definite plan
- Multiple and severe immediate risk factors
- Multiple and severe clinical factors
- Very few protective factors

Moderate risk

- Persistent suicidal ideation with no definite plans
- Moderate to severe clinical risk factors
- Limited but preset protective factors

Low risk

- Occasional stray thoughts of suicide or dying
- Mild clinical risk factors
- No immediate risk factors
- Presence of adequate protective factors

Warning signs

- Drastic changes in behaviour.
- Suicidal threats- could be overt – self harm that is apparent , verbalizing acting on suicidal thoughts or may be subtle- writing or posting stories, poems , quotes about death or suicide, ending of pain etc.
- Expressing statements such as :
 - "I want to go to sleep and not wake up"
 - "I just can't take it anymore"
 - "I hate my life"
 - " Nobody cares if I live or die"
 - " People won't have to suffer because of me"
 - " I wish I was never born"
- Withdrawal from peers, reduced socialization.
- Dropping out of activities/hobbies/ education
- Reduced sleep or insomnia
- Appetite disturbance
- Extreme mood swings and erratic behaviour
- Closing of bank accounts, social media accounts with or without goodbye notes.
- Making a will (coupled with suicidal ideation)
- Giving away prized possessions.
- Increase in substance use

How to go about doing risk assessment?

- Assess the intent and the seriousness of the attempt (Understand if the client has determined to die, has vague intent or no intent.)
- Ask about past history of attempts or ideation.
- Ask about how they feel at the time of assessment
- Check if the attempt was planned or impulsive
- Check the means of harming self and the lethality of attempt
- What was going on in their mind at the time of suicide?
- Also, ask about homicidal ideation (sometimes clients might worry about the well-being of their children or dependent people after their death and might plan of killing them first before killing themselves) –Probe about the same by asking questions such as “ Do you think others are also suffering along with you? Have you considered harming anyone else?” “Do you want to take anyone with you?”
- Do you have thoughts of harming or killing others?

Questions to ask and not to ask

- Begin with asking about passive thoughts followed by active thoughts and attempts.
- Ask the client if she can stop thinking about killing herself if she wants to?
- Ask if there has been a time when she attempted to do end life but someone or something stopped the person from doing so?
- Determine if the person is planning to attempt it further, the means and the plan.
- Probe about suicide directly as talking about it doesn't instill suicidal thoughts but gives the

client an avenue to open up without being stigmatized. Ask about the suicidal ideation from time to time as people might be in and out of it.

Suicide prevention/ intervention

- Establish a trusting relationship with the client.
- Encourage the client to talk about the problem.
- Give client hope .
- Increase protective factors
- Refer to a psychologist if the risk is moderate or high
- Ensure safety of the client.
- Increase the frequency of the contact with the patient
- Document
- Provide psycho education to the family members/caregivers about suicide that includes close monitoring and seeking help in the event of crisis.
- Helping the client with identifying triggers and modifying ways of expression.
- Break confidentiality if the client mentions suicidal ideation or intention.

Severe risk

- In patient admission and close monitoring.
- After discharge, continuous follow up and psychiatric consultation.
- Keep away the possible means that the client might use for self-harm.
- Continued therapy and psychoeducation to family members about monitoring the person

Moderate risk

- Close supervision and psychiatric consultation.
- Supportive therapy.

- Monitoring for the risk of overdose and the medication prescribed should be given/supervised by the family members rather than leaving it up to the client.
- Objects that can be used for self-harm need to be kept away from the client.
- In cases where violence from the perpetrator might predispose the client to suicidal ideation and/or attempts, ensure her safety by either shifting her to a safe place such as a shelter home, or helping her by limiting the perpetrator's access.

Low risk

- Do not take the client's intent to harm themselves lightly
- Consider psychiatric consultation if there is a co-morbid mental illness
- Advise supervision and establish a support system
- Psychotherapy

Do's

- Be confident, optimistic and focus on establishing a good rapport with the client
- Listen with empathy and engage in reflection, non-judgmental responses.
- While reflecting, continue to gather an idea of the signs and symptoms .
- In some cases, you can have a 'no harm contract' , with the client assuming responsibility to not act on his/her suicidal thoughts and seeking help if and when in crisis. This does not guarantee the client's safety.
- If a client lives alone and has no family support, talk to her about eliciting social support and get community members, for example, a caring neighbour, friends, relatives to be available for her and if required, supervise her.

Don'ts

- Tell the client about how small or insignificant her problems are
- Call her weak or a coward for having suicidal thoughts
- Blame her
- Use guilt or threats to prevent suicide
- Promise to keep her plan a secret
- Be afraid to ask directly and specifically about suicidal ideation and attempts
- Take any suicidal expression lightly
- Give superficial or false promises or reassurance

With the client (please remember these might work only after the client is in moderate or low risk zone)

- Help the client identify the triggers and warning signs.
- If the attempts seem to arise out of extreme anger/impulsivity, create a list of distraction activities.
- Have a list of family members/friends who would help or be available.
- Apart from addressing the core issues, also work on coping skills.
- Do ask the client how likely they are to use the safety plan or the strategies you have discussed.
- Develop a hope kit

MENTAL HEALTH SCREENING



To screen for common mental health concerns, one may use the Patient Health Questionnaire 9 and Generalised Anxiety Disorder 7.

The Patient Health Questionnaire 9 (PHQ 9) is a self-report screening instrument for depression. Scores of 0-4 suggest no symptoms (no treatment required), 5-9 suggest mild symptoms (can be managed with psychological first aid), 10-14 suggest moderate symptoms (monitor and refer only if longstanding and impair functioning), 15 to 19 suggest moderately severe symptoms (refer to psychologist as treatment is required), and 20 to 27 suggest severe symptoms (treatment is very necessary).

The Generalised Anxiety Disorder 7 (GAD 7) questionnaire is a self-report instrument to screen for anxiety. Scores of 0-4 suggest minimal symptoms (no help required), 5-9 suggest mild symptoms (monitor and refer only if longstanding and impair functioning), 10 to 14 suggest moderate symptoms (refer to psychologist as treatment is required), and 15 to 21 suggest severe symptoms (treatment is very necessary).

Thus, as a rule of thumb, if a client scores 15 or above on the PHQ 9 and 10 or above on GAD 7, it suggests the presence of

clinical depression and anxiety, and individuals should be referred for professional support- psychotherapy, and/or psychiatric services.

It is important for counsellors to understand basic mental health conditions in order to be able to recognize these. Their role is NOT to diagnose- diagnoses can only be done by psychiatrists or clinical psychologists. But understanding warning signs can facilitate referral.

Common mental health conditions related to trauma are:

Major Depressive Disorder

Individuals with depression show a low mood, reduced interest and pleasure in previously pleasurable activities, sleep and appetite disturbances and sudden weight loss weight gain, feelings of hopelessness, worthlessness and helplessness, social withdrawal, irritability, and thoughts of dying or suicidal ideation, that are persistent for more than 2 weeks and affect functioning.

Anxiety disorders

Post-Traumatic Stress Disorder (PTSD) often manifests as experience of flashbacks of traumatic incidents, nightmares, hypervigilance for threat in

the environment and exaggerated startle response, avoidance of situations that remind about traumatic events, numbness or emotional detachment, social withdrawal, anger. Anything that reminds individuals of the trauma, which could be a word, sound, tone, visual, etc, can lead to a 'trigger' which causes heightened arousal and extreme anxiety.

Generalised Anxiety Disorder involves excessive worry about everything that is difficult to control, rumination, along with physiological symptoms of anxiety.

Panic Disorder involves the experience of panic attacks, which are bouts of acute anxiety accompanied by physiological sensations such as increased heart rate, muscle tension, headaches, dizziness, trembling, sweating, palpitations, thoughts that one is 'going crazy' or 'getting a heart attack.' Individuals may worry about having panic attacks and engage in avoidance behaviours to preempt these.

Complex PTSD

Complex PTSD may develop after prolonged and repeated exposure to interpersonal trauma from which there doesn't seem to be an escape. Individuals may show symptoms of depression and PTSD but may also show mood regulation issues, complex attachment styles, learnt helplessness, experiences of dissociation, difficulties trusting others and their own

version of self, chronic low self-worth, tendencies towards self-harm, etc.

Severe mental health conditions

Schizophrenia

Some individuals (possibly those with a biological predisposition towards schizophrenia) may develop symptoms such as hallucinations (hearing voices), delusions (fixed false beliefs), suspicion, odd patterns of thinking, being out of touch with reality, extreme deterioration in functioning with difficulties in self-care.

Bipolar disorder

Some individuals (possibly those with a biological predisposition towards mood disorders) may develop symptoms of mania, such as excessive talking, racing thoughts, decreased need for sleep, excessive energy, high impulsivity, sudden increase in risky behaviours, sudden grandiose self-image and expansive mood, etc, which may or may not be followed by episodes of depression.

Trauma sequelae in child survivors of sexual abuse or violence

Children who have undergone trauma may show signs such as excessive fear of certain people or places, clinginess, sudden interest in sex or sexual behaviours, sudden behaviour change and acting out, reduced interest in activities, academic difficulties, withdrawal, bedwetting, irritability, nightmares, etc.

BASIC COUNSELLING SKILLS ON THE TELEPHONE



Empathetic responding

Empathetic understanding requires you to look at the callers' experiences from their perspective and communicate to them that you acknowledge their feelings and the emotional experiences that they are going through, using active listening and reflection of feelings, validation, paraphrasing etc.

Non-judgmental and unconditional positive regard

It is crucial for the counsellor to be aware and mindful of their own biases and to ensure that one works on them. The client should not be judged or blamed for their actions or the abuse suffered by them. All clients are seen as human beings who inherently have the ability to find solutions to their problems with the right guidance. Their autonomy needs to be respected.

Active listening

The technique of active listening allows the caller to express their distress without interruption, and encourages them to continue with statements such as "yes, please continue" or interjections such as "hmm, okay" that suggest you are listening. This helps the client to feel heard and understood. Using these verbalisations from time to time is important in the

context of telephone counselling as the client can't see the counsellor and notice body language. It is also important for you to try to keep your work room free of distractions and to avoid multi-tasking, so that you can pay active attention. Active listening also helps to gather more information about the concerns and their impact on the client.

Reflection of feelings with content

Reflection of feelings and content is important to help the callers to get in contact with their emotions so that they can develop better understanding about their inner experiences. The counsellor must pay close attention to the caller's tone to recognize the emotions that they are experiencing when they are expressing their distress. Then they may respond using statements such as- "It seems that you are feeling angry because your husband blamed you for something that you hadn't done," or "I can sense that you are feeling hurt and betrayed by your mother's response." Your response should include the feeling and the situation that seems to have elicited it. This technique helps clients to feel understood and also helps to clarify feelings and situations better.

Validation

This involves communicating to the client that you acknowledge their emotional experiences as valid and as normal reactions to their situation. This can be done through responses such as “It is natural to feel angry when someone attacks you” or “It is understandable that you are feeling hurt given everything that has happened.”

Asking questions

Asking closed ended questions is appropriate when you want factual information or want the caller to specifically answer in terms of ‘yes’ or ‘no.’ Open-ended questions are useful where you want to obtain detailed information about the caller’s thoughts, feelings, and actions. Using questions from time to time helps counsellors to get accurate and necessary information relevant to working on the case, helps the client to understand what information is most relevant, and also reassures the client that you are listening. The tone adopted should be one of seeking information rather than interrogation.

Paraphrasing or summarizing

At regular points during the session, it is helpful for the counsellor to paraphrase the key points mentioned by the client so far. This helps the client and counsellor to stay focused on relevant details, and to clarify what is important and check that nothing has been missed. The counsellor should also end the session with a summary of what has been discussed, so that agendas and goals can be set, and the client retains important information.

Important considerations in responding to trauma survivors

It is important at all times to trust the client’s experience and believe them, and explicitly convey that survivors are not guilty for the violence they have experienced. Nothing justifies violence.

It is important to work on survivor’s emotional awareness, by helping them to recognise their emotions, expressing emotions verbally, and ventilate their emotions at their own pace. Psychoeducation about trauma (i.e. providing information about what typically happens in trauma), is important. For instance, explaining the concept of learned helplessness, short-term emotional reactions of anxiety, fight and flight response, acting-out, long term hyperarousal, triggers and flashbacks, etc are key concepts to explain as relevant. For children or adult survivors of child sexual abuse, basic information about grooming (to help them understand how it is not their fault) can be provided, and parents would need to be explained typical trauma reactions such as overly sexualized behaviour, acting out, fear and avoidance, bed-wetting, possible academic difficulties, etc.

Education about abuse is (physical, emotional, economic and sexual), dynamics of power and control, terms such as gaslighting, the cycle of abuse in intimate partner violence, what constitutes child sexual abuse, are important to provide the client with an understanding that these are not acceptable and a vocabulary to explain what is happening to them. Using principles of feminist counselling may be beneficial. Clients can be helped to understand patriarchy and gender role conditioning (enough to know that she is not at fault for the abuse), informed about rights (the relevant acts, the legal resources available to her), informed about how to achieve justice (if she wishes for that). Sometimes, it may be helpful to discuss the social construction of violence and gender roles to reduce self-blame and explain actions and further empower the woman. Concepts related to gender and sexuality can help.

Feminist counselling also focusses on the woman’s agency in the decision making

process, and in keeping with that, clients are provided options but the decision on what option to select is left to them. It's important not to force decisions onto women- while moving away from a violent home may be the best solution, more often not, it's not possible for women to move out and many continue to live in violent homes.

Empowering clients also involves helping clients to build their own social support networks, understand their protective factors and build on them, work on building their decision making and assertiveness and boundary setting skills, and building their self-esteem and confidence in themselves. With respect to children, empowering parents and building their confidence and skills to support their children who may have been abused, is crucial, and can be done by teaching basic parenting skills, appropriate and inappropriate responses, and how to advocate for the right support for their child.

Clients who present with common and severe mental disorders (without a history of GBV)

In our work with GBV and mental health, we have often been approached by clients who present with acute symptoms of a

common or a severe mental illness without a co-morbid history of gender based violence. As per our protocol, our counsellors first address their concerns and administer the relevant screening inventories to the client. Depending on the client's scores and concerns, the client may be referred to the consultant psychologist. After an initial consultation with the psychologist, the client is then referred to a mental health professional or a mental health helpline in her city/area. In cases where women with mental health conditions not presenting with any complaints of violence access the helpline, then the counsellor can help the client by making appropriate referral.

Sometimes our clients often seek out our help for their mental health concerns and do not wish to inform their family members of the same. If it is determined that the client is at a high risk for self-harm, the counsellor needs to inform the client about our ethical requirement to break confidentiality and ask her to let us intervene with her family members/partners/close friends. If the client still insists on not involving the family, then our protocol is to inform the nearest police station or another non - governmental/ government organization (that may be able to help the client) in the client's city/area.

PSYCHOTHERAPEUTIC INTERVENTIONS ON THE TELEPHONE



Wherever possible, all counsellors are required to conduct mental health screening of all clients. The instruments used for screening are (PHQ 9 and GAD 7), which are administered by the counsellor after prior training in their administration. Based on the scores on these, if clients show a score higher than the cutoffs, they need to be referred to a psychologist. The roles of a psychologist are as follows:

- Conducting diagnostic evaluation on the telephone- based on a clinical history, and assessment tools or varied screening instruments- as applicable. Along with assessment of the severity and extent of common mental disorders (CMDs), the psychologists also evaluate clients for severe mental disorders (SMDs). There are some limitations with respect to conducting Mental Health Examination on the telephone as certain non-verbal cues cannot be seen for the information given, kind of speech and gestures. Wherever possible, a video call can be done to facilitate diagnosis.
- Providing individual psychotherapy for women with mental health issues, using a non-directional, client-centred, feminist approach is used by the counsellors . For long term counselling use of Trauma Focused Cognitive Behaviour Therapy that incorporates elements of feminist counselling and is rooted in intersectionality is used. Psychologists also engage in suicide prevention.
- Working with the family to provide psycho-education and caregiver intervention
- Co-ordinating with and providing inputs to the counsellor and the community organiser regarding follow-ups.
- Liaising with public hospitals to refer those women who require medication to psychiatrists, (after duly educating the clients and their families about the need for medications wherever applicable, about aiding treatment compliance).
- Conducting group therapy sessions. At SNEHA, we have also conducted group therapy sessions on the telephone, by connecting women with similar concerns together with their consent and organizing a conference call moderated by the psychologist.

STAKEHOLDER INTERVENTIONS AND REFERRALS



How can the counsellors assist the survivors to access police help?

Often clients are referred to the police in situations of crisis, especially in times of the lockdown when the counsellors are not in a position to physically accompany them. In such instances the counsellor's role involves:

Preparing the client

Preparing the client well before sending her to the police station to either file an NC, FIR or submit an application. Anticipate and prepare her for any kind of possibility like, having to wait for a long time and to be able to convince the police to take her complaint. This prepares the client to access the police station without fear. The counsellor explores her support network and requests any other family member or neighbor to accompany her. The counsellors coordinate with SNEHA volunteers to accompany her to the police station. The counsellor requests the client to give them a call once they reach the police station so that the counsellor can talk to the police and explain to them the client's situation.

Crisis management

When there is extreme crisis or threat to client's life, counsellors ask the client to report the incident to the police through 103 helpline. They are helped with filing applications of non-cognizable offences online or sending them through couriers.

How can the counsellors work with family members of clients?

In some cases, if the client and counsellor decide that talking to the perpetrator and conducting joint sessions can be beneficial (and safe), this is done over the telephone. However, at these times, caution needs to be exercised so that any pre-litigation information is not shared, conversations are not recorded by the perpetrator, etc. This is done with a written consent of the client.

If the client doesn't wish that the perpetrator is contacted or if it is unsafe to do so based on the safety assessment, other support systems are contacted for the client with her permission. A conference call can be arranged with other family members, friends or neighbours who the client feels safe with and who are willing to help her out, and the client, and the counsellor can inform them about how

they can assist in her well-being. While doing so, it is imperative to take the client's consent and ensure she is on the call as well, and to only share information that is relevant for them to know and help, while maintaining confidentiality about other details.

How can the counsellors work with healthcare providers to help the client?

Medico-legal cases

In cases of physical and sexual violence, the counsellors refer the client to a public or a private hospital for filing a medico-legal case. The client is educated about the importance of filing the medico legal complaint, which will not only help her for her treatment but also build evidence in the case if the client wishes to pursue filing of a legal case in the future.

Cases requiring psychiatric intervention

The clients with mental health concerns are referred to psychiatrists. In these cases, psycho-education about the need to see the psychiatrist, about the nature of mental health concerns, busting myths in order to reduce the internalized stigma individuals experience, is necessary. Counsellors often work with the psychiatrist and possibly a family member in this area. They help clients to ensure that their records are kept confidential and not misused by husbands/ partners as evidence against them.

How can counselors engage community members to help the client?

Crisis intervention

Community engagement can be useful in crisis cases, especially if the organization has close ties with the community. Contacting community volunteers to intervene in crisis cases can help in the absence of team members on site, and this also helps to make the community vigilant about violence and more equipped to handle it. The counsellors coordinate interventions with field staff or community volunteers in different situations:

- Writing an application and accompanying the woman to the police station in coordination with the counsellor
- Accompanying the client to the hospital for MLC and medical test
- Accompanying the client or arranging transport for them to help them reach a shelter home or safe place.
- Providing temporary shelter if they have the capacity to do so, or temporary food and rations, until more sustainable arrangements can be made.

What can counsellors do if the survivor needs immediate shelter ?

- Inform the woman about the availability of shelters, the conditions and rules of these shelters, and of her rights in the shelters. The counsellors contact
- Liaison with shelter homes and facilitate admission on behalf of the client, and convey the client's needs to them (including the need for psychiatric support)

LEGAL INTERVENTION ON THE TELEPHONE



Legal aid on the telephone

The role of lawyers is indispensable in addressing gender-based violence. Women generally do not opt for legal recourse, nevertheless it is imperative to educate women on legal provisions that can be availed in situations of violence. SNEHA provides pre-litigation counselling and litigation assistance in the following areas:

- The Protection of Women against Domestic violence, 2005 – respite orders
- Divorce and maintenance
- Child custody
- Criminal cases
- Protection of Children against Sexual Offences, 2012.

The role of SNEHA’s lawyers is in two major areas:

Pre-litigation counselling

Pre-litigation counselling is defined as any activity that happens regarding a legal claim prior to a lawsuit being officially filed. The lawyer educates and provides information to the survivor about the existing laws and legal provisions that she can avail. The lawyer spends a significant

amount of time working on cases during the pre-litigation state to try and settle it fairly without having to file a lawsuit. They work in coordination with the counsellors to engage in discussions and negotiations with the perpetrator or natal families to achieve a mutual and an amicable settlement. If the client needs a khulanama according to the Muslim law, then the counsellors negotiate with the Qazi to help the client get necessary documents required for the process.

Understanding client’s Priorities/needs

In cases of grave physical violence, the lawyer guides the survivor to access a medical facility, preferably a government hospital for medical treatment or aid, and is also explained about the importance of the medical process. Her medical report becomes the basis to file a complaint at the police station. At times the survivors are not in a position to physically access the police station. In such cases, lawyers guide them to register an online complaint on the police website. In cases of sexual violence, repeating stories of trauma multiple times is not recommended, especially if clients have already shared the stories with the counsellors. In the first meeting either physically or on the phone, the lawyers assess whether appropriate protocols and procedures of law have been

followed by the police and health care providers to lodge a first information report. In instances where the client has been referred with the first information report, criminal law procedures are explained in simple terms.

Co-ordination with relevant Stakeholders

In the eventuality of the police refusing to file the First Information Report (FIR), the lawyers speak to concerned police officers of the respective police stations, and insist the registration of FIR. In cases of non-compliance, higher authorities from the police station such as the deputy commissioner of police or additional commissioner of police (DCP, Additional CP) or the crime against women cell, are contacted by the lawyers on the client's behalf as and when necessary.

In sexual violence cases, the lawyers connect the client with the police, child welfare committee (CWC), public prosecutor, judges, medical officers, shelter homes, district legal services authorities and other non-government organisations through phone or in person. This is done for entitlement to the manodhairya compensation, filing report of interventions carried out to child welfare committee (CWC), adoption process, assistance from police or public prosecutor for cancellation of bail, to track the status of investigation, follow-up in charge sheet, conducting court orientation for client and family members, etc

Drafting Written Application

The lawyers help in drafting the application to be submitted to the police station or the protection officer. The history of violence is captured appropriately in a chronological order. The lawyers suggest the sequence and flow in an order that helps to make the document cohesive and compelling.

Litigation

SNEHA is registered as a Service Provider under the Protection of Women from Domestic Violence Act, 2005 (PWDVA,2005) As a service provider, SNEHA holds the authority to file a Domestic Incident Report (DIR) and coordinate with the Protection Officer for the DIR to be registered in the court for the survivor to file for six orders under the PWDVA, 2005. The respite orders are as under

- Protection from any act of domestic violence
- Residence orders – right to reside
- Monetary reliefs
- Custody orders
- Compensation orders
- Interim and ex-parte order

SNEHA's lawyers litigate cases of divorce and maintenance, child custody, criminal cases and cases under protection of children against sexual offences, 2012 in the family and metropolitan magistrate court.

Creating Evidence

The lawyer's role is to support the client in creating and substantiating evidence for filing her case. For clients who have been facing continuous violence for years, but have not gathered any evidence /proofs, are provided guidance in creating/collecting evidence in case the client is ready to file a legal case. The evidence required for filing a case such as previous non-cognizable offences, , medical papers of assault and physical injuries, birth and marriage certificates, proof of residence, partners' occupational details and bank accounts are collated. In sexual violence cases, lawyers assist the survivors and their family members in submitting an immediate application, drafting of written arguments and appealing to levy the appropriate case laws, and send a report to child welfare committee or district legal aid services.

Filing and tracking the case

The lawyer regularly provides updates on the telephone about the next court date/availability of judges, their transfers etc and accordingly plan/schedule their meetings in office during normal course of time. They also represent them in court for securing interim and final orders. The lawyers prepare the survivor and her

family members to give evidence in magistrate court and sessions court. Registration of FIR is not ultimate goal, providing support to victim and her family throughout investigation process and trial is most important. This involves informing the client of the progress of the case, outcome of the case – acquittal or conviction.

SELF-CARE FOR TELEPHONE COUNSELLORS



Telephone counsellors may struggle with compassion fatigue, vicarious traumatization and burnout.

Compassion fatigue describes “the overall experience of emotional and physical fatigue that social service professionals experience due to chronic use of empathy when treating patients who are suffering in some way” (Newell & MacNeil, 2010).

Vicarious trauma (also known by the closely related term “secondary traumatic stress”) results from a social worker’s direct exposure to victims of trauma. They may experience it as they keep hearing stories of trauma and terror. Such exposure may also trigger the immediate re-experiencing of painful occasions from the counsellor’s own personal history.

Burnout is a term that was first applied by Freudenberger (1975) to describe what happens when a counsellor becomes increasingly “inoperative.” This may take many different forms, from simple rigidity, in which “the person becomes ‘closed’ to any input,” to resignation, irritability, anger, fatigue and even symptoms of depression and anxiety.

The following precautions taken by the organization can help prevent the same:

- Services of a staff counsellor to be provided
- Regular team meetings and supervision to discuss challenging cases
- A realistic case load, and good complaint redressal and conflict management system for staff

Counsellors can practice the following:

- Specific timings allotted to telephone counselling, and clear timings and a rota created
- A good understanding of professional and personal boundaries and the extent and limits of one’s responsibilities
- Reflective practice- maintaining a journal of thoughts, feelings, reactions after challenging cases, self-work to understand what about those cases troubled them
- Seeking supervision and therapy for self when required
- Working on building a healthy work-life balance, and cultivating hobbies and relationships outside of professional ones, with adequate time for rest.

- Learning about vicarious trauma, burnout and compassion fatigue, and keeping track of when they feel the same, and being mindful of personal triggers.

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