UDAYAN care | Where young lives shine

Consultation on Trauma Informed Care

Concepts and Practices for Children in Alternative Care

A Report
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Acknowledgements

The consultation on 'Trauma Informed Care: Concepts and Practices for Children in Alternative Care' was organised by Udayan care on 17 March 2017 in New Delhi. I am overwhelmed by the response and support received from each one of you to this consultation.

First and foremost, it is my duty to thank and acknowledge with huge gratitude the support received in terms of financial help from Ms. Gerlinde Büchinger-Schmid, a passionate supporter of Udayan Care. Without her support, we would not have been able to organise this consultation. I am thankful to the Ministry of Health and Family Welfare, Government of India, for deputing Shri Oma Nand, Director of Mental Hospitals to grace the consultation with his presence and share the activities on mental health care implemented in the country. I also thank Dr. Manju Mehta for agreeing to be the chief guest of the event at a very short notice.

The Consultation would not have been possible without the guidance of our dear friend and supporter, Dr. Monisha Nayar-Akhtar, who has guided us throughout the process. Her keynote address, the facilitation of the case group work and her day long inputs in the consultation have indeed enlightened us in terms of deeper understanding of trauma informed care (TIC). I am also thankful to the panel members – Dr. Deepak Gupta, Dr. Naveen Grover, Dr. Rajesh Sagar and Dr. Jitendra Nagpal who brought insights and steered the deliberations in the right direction.

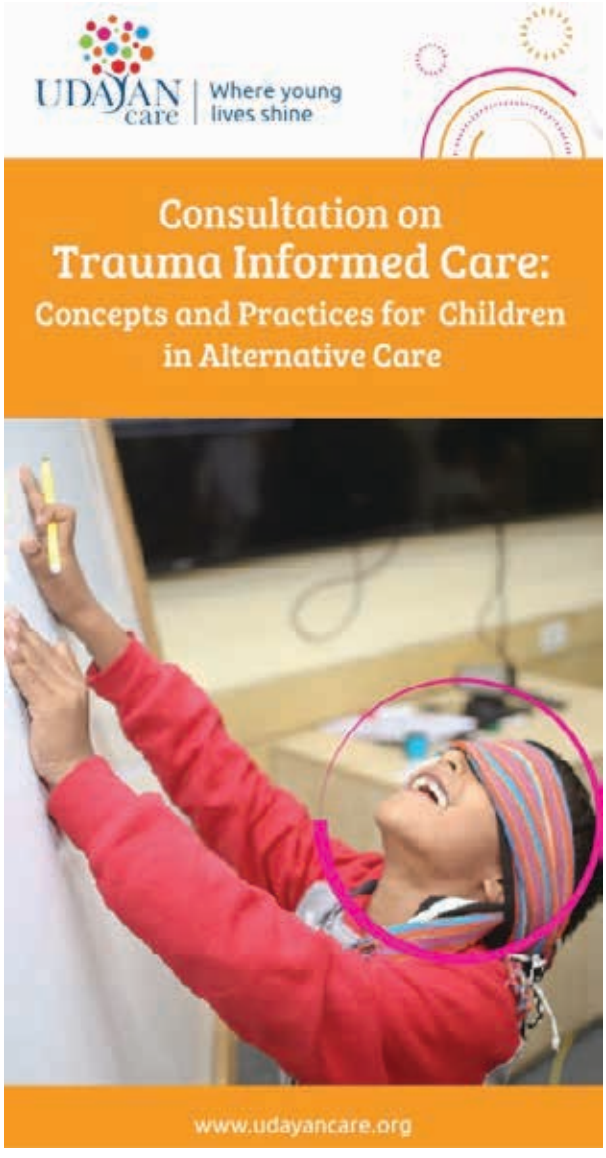
As always, I owe my gratitude to the participants from various NGOs and child rights organisations, all the CWC members, the DCPU officers, the psychologists, counsellors and practitioners for bringing hope in our belief that TIC is critical to all settings of child and youth care in India, and together we can and will move towards building a long term action plan on this. I would extend my gratitude to all the staff, volunteers and mentor parents of Udayan Care for making this consultation a beginning in the right direction. We are especially thankful to our volunteers Aditya, Maninder and Deepali for taking notes during the proceedings.

I do hope that we shall continue this collective journey with all our supporters, friends and colleagues, and integrate TIC into child and youth care practices in India

Dr. Kiran Modi
Managing Trustee
April 2017

Executive Summary

'Trauma is when people live with more fear than hope' - Anonymous



The **Sustainable Development Goals (SDG)** adopted in 2015 has set out a vision for a world where all children are happy, healthy and protected. Goal 3 particularly mandates **"Good Health and Well-Being,"** for all, thus ensuring healthy lives and well-being for all children. This mandate essentially includes mental well being too. In vulnerable situations, the focus on ensuring mental well being becomes more critical. Millions of children get separated from their natural families due to multiple reasons and whenever it is not possible to return to their birth families, children live in alternative care like adoption, foster care, child care institutions or aftercare. Biological separation, abuse and neglect often result in traumatic experiences for children. The experiences of early childhood days get carried forward into the period of adolescence resulting in prolonged stress, anxiety and lack of self esteem and confidence.

Trauma is not an event in itself: it is a response to one or more stressful events that negatively impact the ability to cope with it. As children get older, traumatic experiences of the past often push them towards substance abuse, smoking, overeating, or even taking to crime and delinquent behaviour. For children under alternative care, dealing adequately and sensitively with trauma becomes essential.

Trauma informed care or TIC is an "organisational structure and treatment framework that involves understanding, recognising, and responding to the effects of all types of trauma", and it also emphasises physical, psychological and emotional safety of the targeted persons. It is a child friendly process that requires caregivers to understand basic concepts and the impact of trauma on children's development and learning ways that can effectively mitigate the ill effects without causing any further trauma. **TIC provides a new paradigm under which the basic premise of child care is transformed from 'what is wrong with you' to 'what has happened to you'.**

While most Western and European countries have elaborated and developed trauma-based care, this area of child care is still at a nascent stage in India and most South Asian countries. It is, therefore, imperative to initiate discussions, dialogues and debates around this subject that will sensitise the stakeholders and strengthen their knowledge and competencies.

Children living under alternative care bring with them the experiences of a past full of deprivation, neglect and abuse. As a result, they experience complex trauma and devastating after effects, which make the tasks of caregivers very challenging. Developing trust and attachment with these children is not an easy task, as it needs investment of time, right skills, patience and sensitivity on the part of caregivers. Significantly, if the foster or adoptive parents or caregivers themselves cause distress and are uninformed about the nature of trauma, the children living in alternative care can easily become re-traumatised and will not have anyone to go to for comfort.

The consultation examined specific problems that arise in **different settings in the context of children living in alternative care: the juvenile justice enforcement system (including courts and police stations), child care homes, foster families, adoptive families, educational institutes, mental health service providers, hospitals and other service facilities.** Once children leave the care setting and transit into independent life, the chance of re-traumatisation is high, as the system of aftercare is still nascent in India. In each stage of life, the caregivers, service providers or decision makers have a unique role to play in terms of extending full care, protection and support to the children and the young adults. This is possible only if the caregivers and others in similar role understand the concept of trauma care. It is also important to understand the real reason as to why a certain child behaves in a particular way. If those responsible for the care of children such as police officers, CWC members, Juvenile Justice Board members, counsellors, school teachers, doctors and hospital staff understand the possible consequences of trauma and the ways to deal with them, they can easily identify the underlying causes of children's difficulties with learning, behaviour and relationship. This will allow such children to rely on a close caregiver for comfort and safety. Incorporating a trauma informed care approach is, therefore, an essential component of developing programs for addressing the needs and rights of children and youth living under alternative care.

In light of the above context, the **consultation on 'Trauma Informed Care: Concepts & Practices for Children in Alternative Care'** was organised by Udayan Care on 17 March 2017 (Friday) at Hotel Maple Express in New Delhi.

In addition to **Dr. Kiran Modi,** managing trustee at Udayan Care, the resource persons at the consultation were the following:

Dr. Monisha Nayar-Akhtar: A psychotherapist and psychoanalyst, Dr. Monisha teaches trauma and psychoanalytic process at the Psychoanalytic Center of Philadelphia and University of Pennsylvania, where she teaches courses on trauma, object relations and psychoanalytic process.

Dr. Manju Mehta: A scholar of psychology, Dr. Mehta has been involved in a range of activities such as clinical work, teaching and research at the All India Institute of Medical Sciences, and resource person with several organisations of repute.

Dr. Jitendra Nagpal: Dr. Nagpal is Program Director of Expressions India and a Senior Consultant Psychiatrist at Moolchand Medcity.

Dr. Naveen Grover: Trained at NIMHANS, Bangalore, Dr. Grover is currently a faculty member in clinical psychology at IHBAS.

The key objectives of the Consultation

- Initiate discussion and dialogue on importance of TIC in working with OHC children.
- Identify gaps and challenges faced by caregivers, service providers and decision makers in addressing situations of TIC to minimise re-trauma in children living in alternative care.
- Seek inputs from professionals, experts and practioners and form a core group that carries forward the agenda of incorporating TIC in all programs of and for children living in alternative care.
- To launch the 7th issue of Udayan Care's international bi-annual journal on Alternative Care: 'Institutionalised Children: Explorations and Beyond', (ICEB)

Dr. Deepak Gupta: Dr. Gupta is a Child and Adolescent Psychiatrist associated with Sir Ganga Ram and the founder of Centre for Child and Adolescent Wellbeing. He has been associated with Udayan Care since 2004.

Dr. Rajesh Sagar: Dr. Sagar is a Professor at AIIMS, a member of the National Academy of Medical Sciences and a fellow of International Medical Science Academy.

Sharing her thoughts with the audience, **Dr. Kiran Modi,** Managing Trustee, Udayan Care highlighted the context of child care in India. The country has over 170 million children in need of care and protection and an estimated 20 million children, who have lost one or more parents and are out of the safety net of family. But India has only about 75,000 orphanages and most of them are not equipped to provide quality care in a family-like setting, counselling or emotional bonding. Nearly all children living in alternative care have been exposed to some form of trauma. Dr. Modi explained that this consultation aims to give caregivers and service providers the understanding of the long term effects of such trauma and be sensitive in their day-to-day interactions with children, so that no child has to re-live the trauma.

The **Keynote address** was delivered by renowned psychotherapist and psychoanalyst **Dr. Monisha Nayar-Akhtar,** who explained the basic concepts of trauma and defined what constitutes a trauma informed care approach to the participants. After the keynote, **a panel of expert professionals consisting of Dr. Jitendra Nagpal, Dr. Naveen Grover, Dr. Rajesh Sagar and Dr. Deepak Gupta** was moderated by Dr. Akhtar. Dr. Sagar stressed upon the fact that a shift is required from seeing a child as a 'bad child' to seeing a child as one who has had 'bad things' happen to them with a trauma informed approach. Dr. Nagpal stressed upon the fact that there needs to be more work done in the context of family to orient family members on child rights and to balance the work being done in schools. Dr. Grover said that this Consultation will help initiate discussion on the critical nature of trauma informed care in the field of care and protection for children. Other factors of children's development were explained by Dr. Gupta who shared about the impact on the brain by trauma and how social workers can work to minimise negative effects on the child.

The seventh issue of **ICEB** (Institutionalised Children: Explorations and Beyond – An international journal on Alternative Care with focus on South Asia) was released at the inaugural session of the Consultation. **Dr. Manju Mehta,** the Chief Guest and former president of the Indian Association of Clinical Psychology, stressed upon the importance of continuing this discussion and taking it forward in view of its relevance for child care. **Mr. Oma Anand, Director of Mental Hospitals at the Ministry of Health and Family Welfare, Government of India** was the Guest of Honour.

The participants also actively took part in a group work in order to develop a nuanced understanding of TIC and be able to apply it in the case situations as well as to discuss practical ways of becoming informed on trauma care in each dimension of the child protection work. The Consultation ended with a vote of thanks to all participants and resource persons and a resolve to continue the discussion and deliberations on this important aspect of child and youth care in India. The event certainly was the beginning of a long term agenda on protection for children living in alternative care.

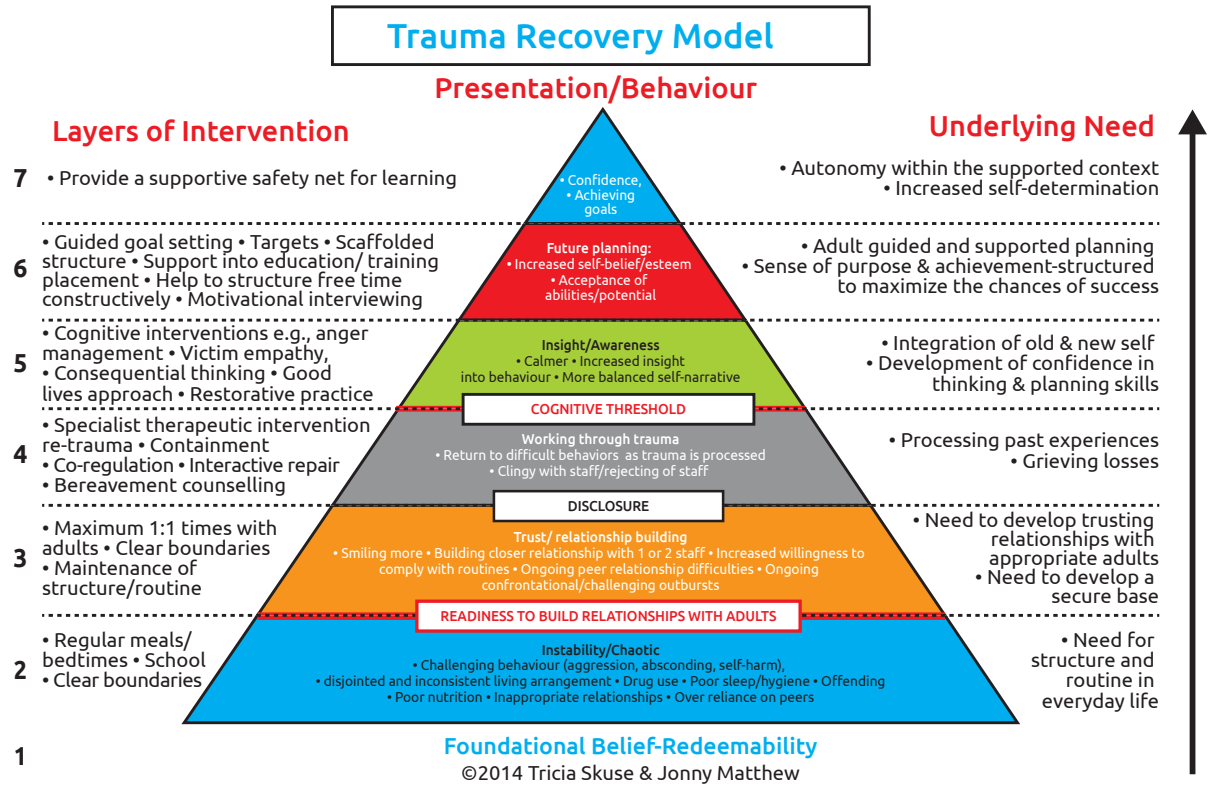
The **first chapter** of this report is a research paper that gathers information from existing literature on TIC and documents some good practise around the subject. The second chapter of the report is a documentation of the proceedings of the Consultation and the last chapter and also includes the recommendations that emerged from the deliberations.

Chapter 1

Trauma Informed Care: Evidence and Models: An International Perspective

Most children living in alternative or residential care have more mental health problems than those in family type foster care. Often it has been observed that children living in institutions go through attachment difficulties, relationship insecurity and difficult sexual behaviour, which have their roots in the trauma experienced by them before coming to the care system. While in care, caregivers handle issues of children's anxiety, unpredictable behaviour, and defiance, lack of attention, hyperactivity, self injury and/or food and weight maintenance behaviours. Specialised attention is required to address these concerns. Globally there has, thus, been a strong shift away from residential and institutional care to family and community forms of care. Most western countries have made the shift from institutional care to foster care in the twentieth century itself.

The AMH Addictions and Mental Health Division (AMH) Policy[1], Oregon, USA defines **trauma as a hidden epidemic.** Trauma informed care (TIC) is defined as providing the *foundation for a basic understanding of the psychological, neurological, biological, and social impact that trauma can have on individuals, especially children.*



[1] https://www.oregon.gov/oha/amh/trauma-policy/Trauma%20Policy.pdf

TIC incorporates proven practices into current practices to deliver services that acknowledge the role that trauma can have. Re-traumatisation is defined by the AMH policy as the stage when psychological trauma is not recognised or addressed and re-traumatisation can either be overt, or less obvious.

Trauma-informed services are services and supports that are informed about and sensitive to trauma-related issues present in individuals who have experienced trauma. Service systems accommodate the vulnerabilities of individuals who have experienced trauma, and deliver services in a manner that avoids inadvertent re-traumatisation, and facilitates their participation in treatment.

"When programs and services incorporate an understanding of trauma and its impact on an individual's behaviour and ability to cope, the potential for misdiagnosis and inadequate treatment planning is significantly reduced."

"Incorporating trauma-informed approaches into service delivery is an essential component to developing programs that most accurately address the needs of youth and their families."

(BC Provincial Trauma Informed Practice Guide, 2013 Susan Hunt, BC CYC & Nickole Reyda, RPN in Translating Principles into Practice).

Exposure to traumatic experience is common for children and adolescents living in alternative care. In a research paper titled '**trauma informed care: an ecological response**'[2], provides a comprehensive review of trauma-informed care – its evolution, current models and practice, and evidence base.

Developing a Trauma-Informed Child Welfare System' is a series authored by Child Welfare Information Gateway in 2015 that discusses the steps that are necessary to create a child welfare system that is more sensitive and responsive to trauma. Every child welfare system is different, and each State or

The Principles of TIC

- Trauma significantly alters baseline physiological arousal levels in children
- Trauma reduces capacity to regulate sub-cortical activation in children – children with experiences of trauma usually find it difficult to reason out and modify their behaviour or reactions. They are unlikely to learn from consequences.
- Trauma disrupts memory functioning in children – such children are likely to benefit from strategies which support stressed memory systems, including the introduction of visual and mnemonic cues to prompt short term memory rehearsal and recall, repetition of episodic and narrative structures and the establishment of routines to structure behavioural rehearsal.
- Trauma disconnects children from relational resources that can mitigate its effects – such children need opportunities to experience attachment relationships which offer consistency, nurture and predictability.
- Trauma restricts the attentional capacity of children.
- Trauma based behaviour is functional at the time in which it develops as a response to threat.
- Trauma limits children's response flexibility and adaptability to change, as children may get 'stuck' due to constant trauma triggers. Trauma undermines identity formation in children.
- Trauma diminishes social skills and isolates children from peers – Children with trauma backgrounds need support to engage positively with peers in social situations.

Retrieved from: www.childhood.org.au/for-professionals/our-trauma-informed-principles extracted from http://www.childhood.org.au/for-professionals/our-trauma-informed-principles

[2] http://www.air.org/sites/default/files/downloads/report/Trauma-Informed-Care-An-Ecological-Response-Guarino-2015.pdf

county child welfare system needs to conduct its own systematic process of assessment and planning, in collaboration with key partners, to determine the best approach. After providing a brief overview of trauma and its effects, this issue brief discusses some of the primary areas of consideration in that process, including workforce development, screening and assessment, data systems, evidence-based and evidence-informed treatments, and funding.[3] The same group has also published Bulletins for Professionals titled '**Supporting Brain Development in Traumatised Children and Youth'** in 2011 which summarises what child welfare professionals can do to support the identification and assessment of the impact of maltreatment and trauma on brain development; how to work effectively with children, youth, and families to support healthy brain development; and how to improve services through cross-system collaboration and trauma-informed practice.[4]

Internationally there are some very good models that exist on the TIC approach. For example, the **Australian Childhood Foundation** has developed its own models of trauma informed care for out of home care children. Essentially it has integrated its commitment to effective practice with vulnerable children and their carers or families with an interpretation of the evidence base emanating from the neuroscience of child development, trauma, attachment and interpersonal neurobiology.[5]

The **Blueknot Foundation** is another model that uses a guide for health care practitioners which states that trauma-informed care and practice is a strengths-based framework grounded in an understanding of and responsiveness to the impact of trauma, that emphasises physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment.[6]

The **American Institute of Research (AIR)** has developed a framework for building Trauma-Informed organisations and systems that offers a process and curriculum for adopting organisational trauma-informed care. This requires a commitment to changing the practices, policies, and culture of an entire organisation.[7]

In the South Asian regional context, this area of child care is largely unaddressed and there is lack of research studies, evidence based data or intervention based on TIC that have been documented in the context and culture of the region. Most references to this comes in the context of trafficking, sexual abuse and child labour in which the issue of trauma of child victims is only raised in the passing and most often the solution referred to is counseling.

Further Readings

What is trauma: The TIP Guide, Available at http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf

Common Questions About Trauma, Available at www.camh.net/About_Addiction_Mental_Health/Mental_Health_Information/commonquestionsabouttrauma.html)

What is TIC and how to become trauma informed, Available at http://www.traumainformedcare project.org/

Becoming trauma informed school, Available at http://www.apmreports.org/story/2016/12/16/trauma-informed-school

Brain Story Certification, Available at http://www.albertafamilywellness.org/training

[3] https://www.childwelfare.gov/pubs/issue-briefs/trauma-informed/
[4] https://www.childwelfare.gov/pubs/braindevtrauma/
[5] As extracted from http://www.childhood.org.au/for-professionals/our-trauma-informed-principles
[6] http://www.blueknot.org.au/Workers-Practitioners/For-Health-Professionals/Resources-for-Health-Professionals/Trauma-Informed-Care
[7] http://www.air.org/sites/default/files/trauma-informed-care-instrument-one-pager-August-2016-rev.pdf

Chapter 2

Discussions and Proceedings at the Consultation

Welcome Address: Dr. Kiran Modi

Dr. Kiran Modi in her welcome address mentioned that bad behaviour is only a signal and not a symptom. As caregivers, we need to bring in trauma informed care into the system of child care intervention. Catering to social, mental and cognitive needs of the child in alternative care is important for a holistic development. Even though we have a shortage of mental health care providers, the existing ones are not trained in TIC. It is imperative that people involved with children at all levels are trained and well informed about the trauma informed aspect of care.

Emphasizing the need of training in TIC, Dr. Modi said that while dealing the children in difficult circumstances, one cannot expect children to operate on the same footing as children who have not faced such life adversities. Tender love and care (TLC) is important and interventions will have more impact if we keep in mind the dysregulation, hyper vigilance, post traumatic stress disorder (PSTD) that the child has developed in the course of facing vulnerabilities. It is important to look at a bad behaviour as a signal and not a symptom, a signal calling for help. This is what TIC is about.

Dr. Modi laid emphasis on the fact that research has shown consistently that children with histories of caregiver abuse and neglect have problems with concentration, anger, panic, depression, food intake, drugs, and sleep, higher levels of stress hormones and reduced or repressed immune systems. The relationship between documented brain changes and psychopathology is complex. For children in alternative care, it becomes even more complex as they face more vulnerabilities while living in the juvenile protection system of close case management and multiple placements, facing police and courts. Such compounding trauma can be reduced if the service providers have a TIC approach.

Dr. Modi mentioned about the National Plan of Action for Children which was launched recently in January this year by the Ministry of Women and Child Development, Government of India. In one

of its guiding principles the National Plan states that the 'mental, emotional, cognitive, social and cultural development of the child is to be addressed in totality'. It also has a strategy for creating a cadre of well-qualified and professionally trained mental health service providers and counselors. But the challenge we face is far bigger. Even as the overall mental health care system is weak in our country, the trauma informed lens for all children and particularly for children living in alternative care is largely unaddressed. India just has a total of 3,800 psychiatrists, 898 clinical psychologists, 850 psychiatric social workers and 1,500 psychiatric nurses nationwide, according to a reply by the Ministry of Health and Family Welfare in the Lok Sabha in December 2015. With time, the numbers may increase but will they all be trained in TIC? As the situation and vulnerability of children living in alternative care becomes more serious, it is important that all caregivers and service providers are well informed about the TIC approach and its benefits.

The Mental Health Care Bill, 2013, has been passed by the Rajya Sabha in August 2016. The new Bill aims to increase funding to centres of excellence in mental health. The NPAC talks about 'developing a "do no harm" policy and guidelines for all staff, caregivers, teachers and practitioners. Promoting children's mental health, well-being and growth is critical to protect them from long-term problems. Dr. Modi explained how at Udayan care efforts are made to rehabilitate and reintegrate children with the society. Advocacy efforts such as workshops, biennial conferences also help leverage the issue and bring like-minded professionals and organisations together.

Keynote Address: Dr. Monisha Nayar-Akhtar

Dr. Akhtar in her keynote address said that trauma is an event that overwhelms the existing defence system against anxiety and stress. The existing defences in people vary with age, temperament and situations and when people have fantasies, the ability to express often gets mitigated, affecting the impulse to act upon it. This leads to experience of physical helplessness and the inability to effectively respond to the crisis.

She elaborated upon the common sources of trauma, which could be accidental injury, severe illness, catastrophes and disasters, physical and sexual abuse or witnessing conflict or war. For children living in alternative care, it is critical to look at preventing re-traumatisation as most of them have already experienced trauma and which has had significant impact on them.

Dr. Akhtar explained the consequences of trauma on individuals. Feelings of not being able to avoid and helplessness is common as the cognitively frontal part of the brain which deals with the solutions generation gets impacted. There is often the surrender pattern of giving up or it could lead to depression signs such as numbing. In situations of long term continuation of emergency regimes, the survival instinct gets oriented and often cognitive constriction or phobia, aggression and behavioural symptoms can be seen.

In all the above situations, it is very important to avoid the pain which in different settings, comes in different ways. Sensitivity training is very crucial for people working with the distressed. For example,

if a child starts yelling, shouting or acting out at any episode there must be some trigger to that reaction and that trigger can be anything which makes the distressed child recall the traumatic experience, often leading to re-traumatisation. Children need help and assistance in developing social skills and **ego resiliency** where the child with traumatic past needs to take responsibility and adapt to life task at their own pace. Often children go through a sense of shame and loose the ability to trust others. Caregivers cannot expect trust from the children just because they are loving them or caring and providing for them.

Signs of Trauma in Children

- Disruption of sleeping and eating
- Anxiety and fearfulness
- Fearful conviction that the trauma will reoccur
- Hyper-vigilance and physiological over-reactivity
- Regression to the behaviour of a younger child
- Complaints of aches and pains with no medical explanation
- Use of magical thinking to explain cause of trauma usually resulting in self blame for trauma's occurrence
- Loss of concentration and attention
- Acute awareness of parent's reaction to trauma and/or distress with efforts to protect from further worry
- Accident-proneness and reckless behaviour
- Vulnerability to anniversary reactions when calendar year reminders recall the trauma

Trauma and its vicissitudes can be developmental, behavioural, cognitive, social or emotional. The process of developing trauma includes the recognition that danger cannot be avoided. There is a surrender pattern or depression, affective blocking (numbing) and continuation of 'emergency regimes'. This also could include cognitive constriction or rigidity of the mind, phobia, black hole or dead to the world and the use of aggression as a defense. Children develop behaviours to avoid pain, PTSD symptoms (thoughts, places, people and situations), constriction of developmentally appropriate activities may therefore occur, when avoidance fails to protect and emotional numbing develops and in more severe cases, it could lead to dissociation. Trauma-related behaviours that develop in response to modeling and leading to maladaptive behaviours and coping strategies include examples such as physical and sexual abuse. The risk to substance abuse, self-injury and suicidal behaviours also increases.

Dr. Akhtar then dwelt into the concept of **ego resiliency** which is the ability to overcome challenges to adaptation or development. Resilient children are those who worked and played well, held high expectations. It is not a static characteristic since developmental changes will influence resilience.

The features that constitute resilience will vary according to the risk mechanism and not according to an intrinsic feature of the individual. It also resides in the social context. Ego-resiliency means the ability to be happy and have purpose and direction, the capacity for productive work, emotional security, self-acceptance, self-knowledge and good reality testing and interpersonal adequacy and the capacity for warm and caring relationships.

An ego resilient child has

- Social competence
- Problem solving skills
- Autonomy
- Sense of purpose and future

Factors that promote ego resiliency are connection with others, self-disclosure of trauma to loved ones, spirituality, identifying as a survivor as opposed to a victim, helping others and finding positive meaning in the trauma. According to the American Psychological Association, this can be done through the following:

- Maintain positive relationships with close family members, friends and others
- Avoid seeing crises or stressful events as unbearable problems
- Accept circumstances that cannot be changed
- Develop realistic goals and move towards them
- To look for opportunities for self-discovery after loss
- To develop self-confidence
- To keep a long-term perspective
- To maintain a hopeful outlook
- To take care of one's mind and body
- Both mental and physical exercise
- Take decisive actions in adverse situations

In **classrooms**, helping children develop:

- High expectations of themselves
- Meaning for life
- Goal setting and personal agency
- Inter-personal problem solving skills

In **communities**, the characteristics which play a huge role in fostering resilience are:

- Availability of social organisations
- Consistent expression of social norms
- Opportunities for children and youth to participate in activities of communities

The **family space** can help children by the following:

- Caring and supportive
  - Assigned chores
  - Caring for brothers and sisters
- Contribution of part-time work
- Family routines and celebrations
- Maintenance of common values regarding money and leisure
- Religion

In the **context of alternative care for children,** the following helps:

- Attachment between youth peers and care providers
  - Reactive/disorganised attachment
  - Stronger connections to peers
- Care provider's factors
  - Personal trauma

Across **cultures**, the following factors help:

- Access to material resources
- Access to supportive relationships
- Development of desirable personal identity

- Experiences of power and control
- Adherence to cultural traditions
- Experiences of social justice
- Experiences of a sense of cohesion with others

Address by Guest of Honour

Shri Oma Nand, Director (Hospitals), Ministry of Health and Family Welfare, Government of India, in his address appreciated the organisers for the event and highlighted the importance of the approach of TIC while working with vulnerable children. He stated that everyone experiences some form of mental disorder or the other once in life time, and that the WHO Study has shown that depressive disorder in Indian population is at 4.7 per cent. He also highlighted the acute shortage of mental health professionals in the country and mentioned that the National Mental Health Programme of 1982 (NMHP) has not made much progress in supplementing requirement. There are about 21 hospitals and institutions that so far have become the centres of excellence. He also shared that the District Mental Health Programme is being implemented in 339 districts where the focus is on quality mental health intervention, early diagnosis and care for all. He said that sensitisation and convergence of stakeholders are necessary to provide quality services and to address the issue of shortage of quality professionals. In his opinion, the NMHP requires improvisation. There is also a need of consultation with various stakeholders as integration of mental health into the general health of the nation is important.

To a **question** on what is being done in the field of education to create awareness regarding mental health, Shri Oma Nand replied that 339 districts have been covered under the Information, Education and Communication (IEC) Programme and funds for school and college students have been disbursed. He also informed about the process of sharing of information through e-mail between the central and state governments.

Address by Chief Guest

Dr. Manju Mehta, former President Indian Association of Clinical Psychology, in her address congratulated Dr. Modi for the success of the event. She said that the Delhi State Legal Services Authority (DLSA) has counselors but no one knows about TIC. She agreed that trauma needs to be addressed and incidents that happen in childhood have their implications on adulthood. In her opinion, trauma not only causes mental problems but also physical implications such as body aches, fibromyalgia, psychosis, hysteria, etc.

She said that children are not able to share such experiences with anyone which becomes a burden on the child's fragile and developing mind. Trauma has no boundaries, but its risk can be minimised with counselling and sensitisation of both parents and the child.

To a **question** by Ms. Isabel Sahni on whether fibromyalgia is the manifestation of child abuse only, Dr. Mehta replied in the negative. To another **question** on whether developmentally the first push for a

child is repression and whether the mind forgets but the body keeps, she said that children can be helped in developing age appropriate skills. It is important to remember that in adolescence the symptoms become aggressive and the treatment of metallisation is about the ability to understand one's self, be self-reflective and have a function of cognitive theory, but for children, it is like living with false self.

To another **question** of whether children in alternative care be allowed to be interviewed as it could lead to re-traumatisation, Dr. Kiran Modi replied that at Udayan Care such interviews are discouraged.

To a **question** to Dr. Monisha on how to go about in situations where children living in group housing (like Udayan Care) talk to one another on having boyfriend or girlfriend and such other matters, Dr. Akhtar said that the ability to understand oneself and others and the ability to understand someone's situation standing in that person's shoes is important. In group behaviour, at the stage of latency (6, 7, 8 years of age), groups become important while in adolescence independence becomes prevalent. Talking about love, intimacy, girlfriend or boyfriend is a taboo in our society. Problem occurs when a child in latency period comes into contact of these things through the groups in home (the elder ones). The solution is to have free and open discussion about intimacy, attraction, love, sexuality and related topics so that the children do not have to hide or discuss secretly about such topics. As compared to children living with family of origin, children in alternative care do not have elders or elder siblings to discuss topics related to love and choosing a right life partner. It is, therefore, important to overcome our inhibitions, and also to conduct sensitisation and life skills training related to these topics.

Aneesha Wadha, mentor mother and trustee at Udayan Care asked about 'consistency in care'- if the same people in the child's life are not always there, what is the importance of consistency in a child's development. Dr. Modi, while adding to this, said that consistency in terms of placement is very important. Dr. Akhtar said that consistency in a child's life is very important as it results in better outcome for child. While consistency has to be in all the aspects of life, it should be especially ensured in regard to the people around the child like the care staff, mentors, peers, volunteers, social workers and others. Any sudden departure of a close person can re-traumatise the child. Dr. Akhtar shared an anecdote that while she was leaving from New York to Delhi, a girl in her second trimester started getting worried about her leaving. She told the girl about the details of her visit and also informed through email that she had landed in Delhi safely. The crux is linking behaviour with experience, which allows problem solving and self-reflection for the child. The anxiety doesn't go away but it becomes less.

Panel Presentation

The session was moderated by Dr. Akhtar and consisted of Dr. Rajesh Sagar, Dr. Naveen Grover, Dr. Jitendra Nagpal and Dr. Deepak Gupta.

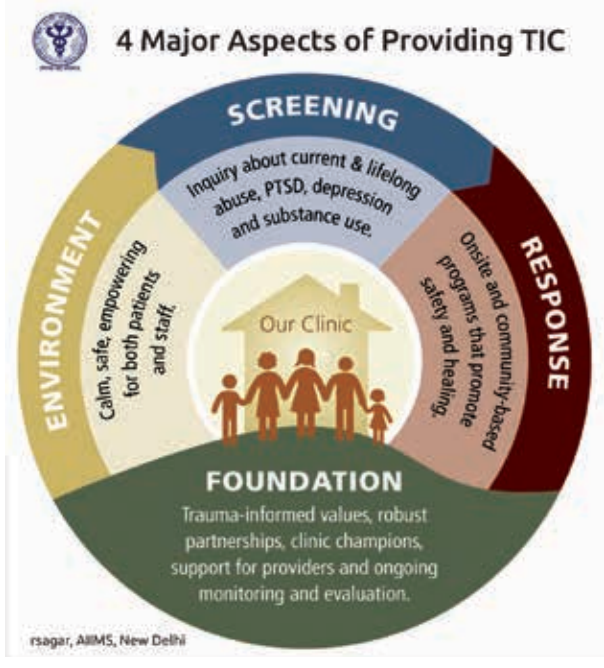
Dr. Rajesh Sagar, Professor of Psychiatry, AIIMS, Delhi

Dr. Sagar began with an acknowledgement that TIC in the context of child protection has hardly been discussed earlier in India.

He mentioned that trauma from the perspective of a child means that the child is feeling helpless and there is a fundamental change in the way he/she views himself/herself and the world.

He emphasised that abuses experienced by children can be of many types like physical, emotional and sexual, and the prevalence of trauma is highlighted in the high rates of trauma exposure and Post Traumatic Stress Disorder (PTSD). According to him, everyone and even the professionals blame the child for his/her behaviour or aggression. But in reality, there is a need to see the whole pathway from where all this is coming from, as some source of problematic behaviour is lying deep in the child's mind and the past. He also stated the following:

- Adverse Childhood Experience Study – Impact of trauma is not only psychological but also physical like heart disease, diabetes, immunity diseases, etc.
- Trauma has implications in adulthood – People with complaints of multiple pain, of which no reason can be traced, have been found to have experiences of adverse childhood and trauma.
- Ignorance about trauma and lack of sensitivity in the people who are a part of the juvenile justice system can result in re-traumatisation of the children.
- Whether or not a given event evokes a trauma response, particularly with children, greatly depends on the response of caregivers.
- Each service provider that a child/adolescent comes into contact with after a trauma event can either hinder or harm or help stimulate healing.
- There is a need for education and sensitisation of people with whom the child comes in contact with while in the juvenile justice system.
- Core principles of TIC – Awareness, safety, trustworthiness, voice and choice, collaboration and empowerment.
- Relationship building is a very crucial aspect of TIC.
- There is a need to have a mental health care plan and training of staff.



To a **question** on how we can address the problem of having caregivers from vulnerable backgrounds and how can people who themselves have witnessed and experienced trauma help the children, Dr. Sagar responded by saying that identification of problem and response should

go hand-in-hand. There is a Trauma focused Cognitive Behavioural Therapy (CBT) whereby the response and intervention are not very complex things – the complex therapies are one aspect of it – talking, understanding, empathising and sensitisation are in itself intervention. TIC is an approach to service delivery that is grounded in awareness and understanding and is responsive to the impact of trauma. It emphasises the need to create an environment that ensures safety, choice, control, and empowerment for the survivors.

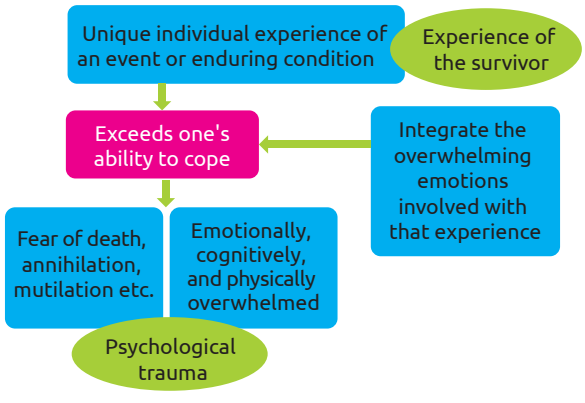
Dr. Deepak Gupta, Child and Adolescent Psychiatrist, Delhi

Dr. Gupta elaborated the technical aspects of psychological trauma and its impact on the brain, and highlighted the importance of sensitivity trainings. He said that children, when frightened and traumatised, are almost always on edge, and the slightest of cues sends them hurtling back inside their protective shells. When a traumatic event creates psychological trauma, it exceeds the person's ability to cope with it and the coping mechanism has negative repercussions.

He specified that the amygdala, which is the hippocampus, and the ventromedial prefrontal cortex play a role in re-traumatisation wherein the hippocampus, the prefrontal cortex, and the amygdala complete the neural circuitry of stress. The hippocampus facilitates appropriate responses to environmental stimuli, so the amygdala does not go into stress mode – prefrontal cortex regulates emotional responses by controlling the functions of the amygdala.

The hippocampus – responsible for memory functions – trauma leads to reduction of the hippocampal volume. This mechanism triggers extreme stress in situations even remotely related to past traumatic experiences. The prefrontal cortex regulates emotional responses triggered by amygdale, as it regulates fear. Trauma increases activity in amygdala – processes emotions and fear responses. Children with a history of trauma contacting a stimuli, remotely related to the experience, results in hyperactivity in the amygdala, extreme stress, panic, anxiety and fear.

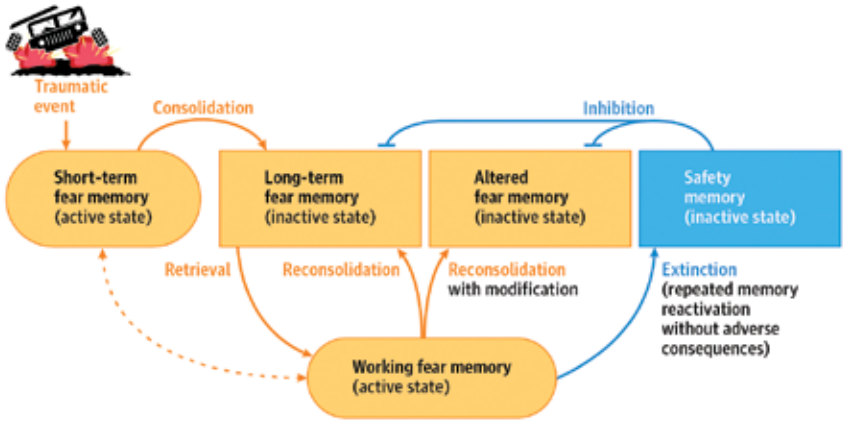
When a traumatic event or situation creates psychological trauma?



Before children reach the therapists, the care givers have to intervene, and there has to be the management of fear conditioning and approaches to regulate crisis. He also covered the following aspects:

- Eye movement desensitisation and reprocessing (EDMR)
- Intervention at various levels
- Amygdala-specific circuits that are involved in fear conditioning

The post-traumatic memory reconsolidation can be shown as below:



Dr. Gupta concluded by stating that research has shown that psychological interventions can help prevent long term chronic psychological consequences. Psychotherapy is designed to reverse the lasting impact of fear conditioning (e.g. prolonged exposure therapy and cognitive behaviour therapy). There is an exposure to the conditioned stimulus in a safe environment without the expected adverse outcome.

- The approaches to regulate circuits are deep brain stimulation, vagal nerve stimulation, and repetitive transcranial magnetic stimulation and transcranial direct current stimulation.
- Pharmacological agents that may help to block the reconsolidation of traumatic memories and psychotherapy which help that way is EMDR (Eye Movement Desensitisation and Reprocessing)

Dr. Naveen Grover, Clinical Psychologist, IHBAS, Delhi

Dr. Grover started by laying importance of empathy and caring attitude towards patients/ clients. He said that we have to become a friend not a person of authority to be able to get into the shell of the child and render help.

According to him the principles of working with children are the same as working with adults. He narrated the case of a 17-year-old girl who had come to him for help on relationships and later they realised that she was a victim of incest abuse. She asked him a number of questions relating to his personal life such as whether he was married or not and whether he had kids or not. Usually in such cases, he said, the psychologist gets on to become defensive and it is not always true that just because he is a clinical psychologist, he or she may also be empathetic. Just because the person has a degree, it does not mean that the person is automatically trustworthy. They are trained in this but not on TIC approaches as such.

Although we should not hide anything from a doctor, when a person experiences trauma, he or she may not want to reveal a lot and we have to allow that space. The concept is that the doctor can help only if he is told everything about the person but it does not work like this all the time. In the case of the 17-year-old girl, she was trying to get into a relationship with the authority figure, the clinical psychologist in this case, by asking questions and finding out about the person. So in the case of caregivers working in alternative care and CCIs, it is important to remember that when the child asks questions or does not trust the adult, or pokes the caregiver, this behaviour could be seen as a positive trait of the child in trying to establish relationship, as the past experiences have taught them not to

trust anyone easily. Often as adults, we need to ask ourselves why we need respect from children. Power and respect often go hand-in-hand. At the end of the day, we are all doing our job and it is a job that we as adults have chosen for ourselves. So one should not seek gratitude and respect for the work he/she does.

In terms of the conflict between activism and term of life, at times when children are abused, the perpetrator also lives in the same environment. In terms of alternative care, abuse can happen in the children's homes also and the perpetrator is often present in the system itself. Often the question arises in regard to the need to confront the abuser or not. Dr. Grover said that it is important to remember that the abuser is still present in that environment of conflict. In the activism mode, the way is to say that the abuser has to be caught, punished, exposed and there should be no fear in doing so. But the system does not support often and the process becomes more traumatic for the child. He said that as professionals, the quality of life of the child must be our priority. There should be a balance because at the end of the day the issue concerns not the abuser but the child survivor. For an activist it is important to prove the other person wrong but for a professional, it is about quality of life of victim.

He said that many times the caregivers themselves are traumatised and their capacity to take care and heal is compromised. While one school of thought supports the view that the people who have experienced trauma in their developmental stage and have inculcated it into their personalities are not capable of offering psychological support, the other school of thought says that those who have experienced trauma themselves are the best persons to deal with it.

He further explained that irrespective of whether one has gone through trauma or not, the person can help if he/she receives proper and adequate training on how to care and what is TIC. Also, it is a myth that same gender works better because it is the understanding and sensitivity of the caregiver and professional that is the key rather than the gender.

In alternative care, the stress is more on mentor parents to develop relationships with children but it can lead to many concerns as there is pressure of attachment. Giving full attention is difficult and often children can make their caregivers feel demeaning due to the stress in relationships.

Dr. Akhtar reacted by saying that it is about transparency in relationship as we all have feelings but may not be aware of them all the time. It is important to maintain a balance between relationship building and moving away. In the mind we are at all times grappling with three concepts called the Id (self), ego and superego. The superego should not be too harsh and not too weak, because then the person will punish self for every little mistake. There should a balanced ego in caregivers. Modulating the Id is important, otherwise the person is out of control. A balance leads to creativity, motivation and productivity. In trauma the ego gets impaired and defenses develop, and it is in such situations that group work can help, where allowing the group ego to function in a constructive way. In alternative care settings, when you have caregivers who have experienced trauma, their capacity is already compromised and then they have additional responsibility of other children. Thus all group works in alternative care settings are important and if there is a good leader, a structure can be created in a systems approach. Ego has to come to a compromise.

He also added that all relationships are asymmetrical – patient and therapist, parent and child, teacher and student, but they have the same world. We have to live by the fact that relationships are asymmetrical but it does not mean that there is no respect in the relationship and power should not come in. For traumatised child this creates a different narrative and we need to take account of that.

Dr. Jitendra Nagpal, Program Director, Expressions India and Sr. Consultant Psychiatrist, Moolchand Medcity, Delhi

Dr. Nagpal said that as professionals we have been taught to diagnose the 'problem' but what about the 'person' in question. Diagnosis comes second – knowing the person is important and must be given first preference. He said that the 21st century classroom is an Inclusion Paradigm for:

- Building an **inclusive society**
- Nurturing **holistic** development
- Creating **welcoming communities**
- Effectively combating **discriminatory attitudes**
- Achieving **education & wellbeing**

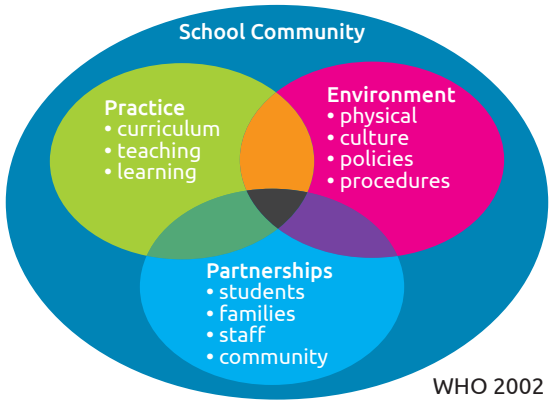
While citing the extent of physical, sexual and emotional abuse that child beggars face; he emphasised that the focus must always be more on preventive intervention than therapeutic intervention.

Enhancing Psychosocial Climate of a School

The following measures will enhance psychosocial climate in a school:

- Provide friendly, rewarding and supportive atmosphere
- Support cooperation and active learning
- Forbid physical punishment and violence
- Non-tolerance of bullying, harassment and discrimination
- Development of creative activities
- Enhance family - school partnership
- Promote equal opportunities and participation for all children.

Health and Safety Promoting Schools Framework



WHO 2002

With the Protection of Children from Sexual Offences Act, 2012 (POCSO) coming into force, the schools would be required to play a positive role. As far as question of victims being from the school is concerned, they have to be able to identify children:

- Who may be victims of sexual abuse either inside or outside the school
- Who may have the propensity to commit such offences

Apart from mandatory reporting, the schools would have to be prepared to handle such situations sensitively while ensuring that the victim is not revictimised and his/her identity is protected. As preventive measures, schools would be required to:

- Teach small children about good touch and bad touch
- Encourage children to speak up about such issues

- Provide appropriate sex education to children
- Also warn them of the dangers of getting involved in such offences
- Interact with parents through parent-teacher meeting etc., to provide them relevant information

He also highlighted the following issues:

- Need for educating the parents about the JJ Act, POCSO Act and child rights
- Bullying at school – a child being abused at home bullies others at schools
- Drug abuse among children and teens due to easy availability of hard drugs now a days
- Ignorance, prejudice and discrimination
- Need to encourage school based intervention like teachers as counsellors
- Persons With Disability Act – no clear guidelines for the mental illness clause

Dr. Kiran Modi highlighted the issue of Udayan Ghar children being discriminated and bullied because they are from a 'Ghar' or child care institution. In view of re-traumatisation by peers and teachers, there is a need to educate teachers, students and parents on the issue. The following measures are important in this regard.

- Inclusive classrooms – Focus on not just admitting children from economically weaker section (EWS) or disabled children but proper emphasis on retaining them in the schools – creating an environment that does not compel them to dropout – by removing the handicaps
- Inclusiveness – all types of teachers with all types of children in all types of schools
- Child psychology principles must be included in curriculum for teachers
- Focus on empowerment, not victimization – need for developing coping skills in children

To a question on how to tackle the issue of gay relations among children living in groups in CCIs, Dr. Nagpal replied that an event in the childhood is not necessarily a trauma. It becomes a trauma when the past starts interfering with the future. The need of the child to be loved and his/her affection can be the reason for displaying sexual behaviour.

Dr. Deepak added that there has to be an emphasis on preparedness and equipping children and youth with life skill trainings.

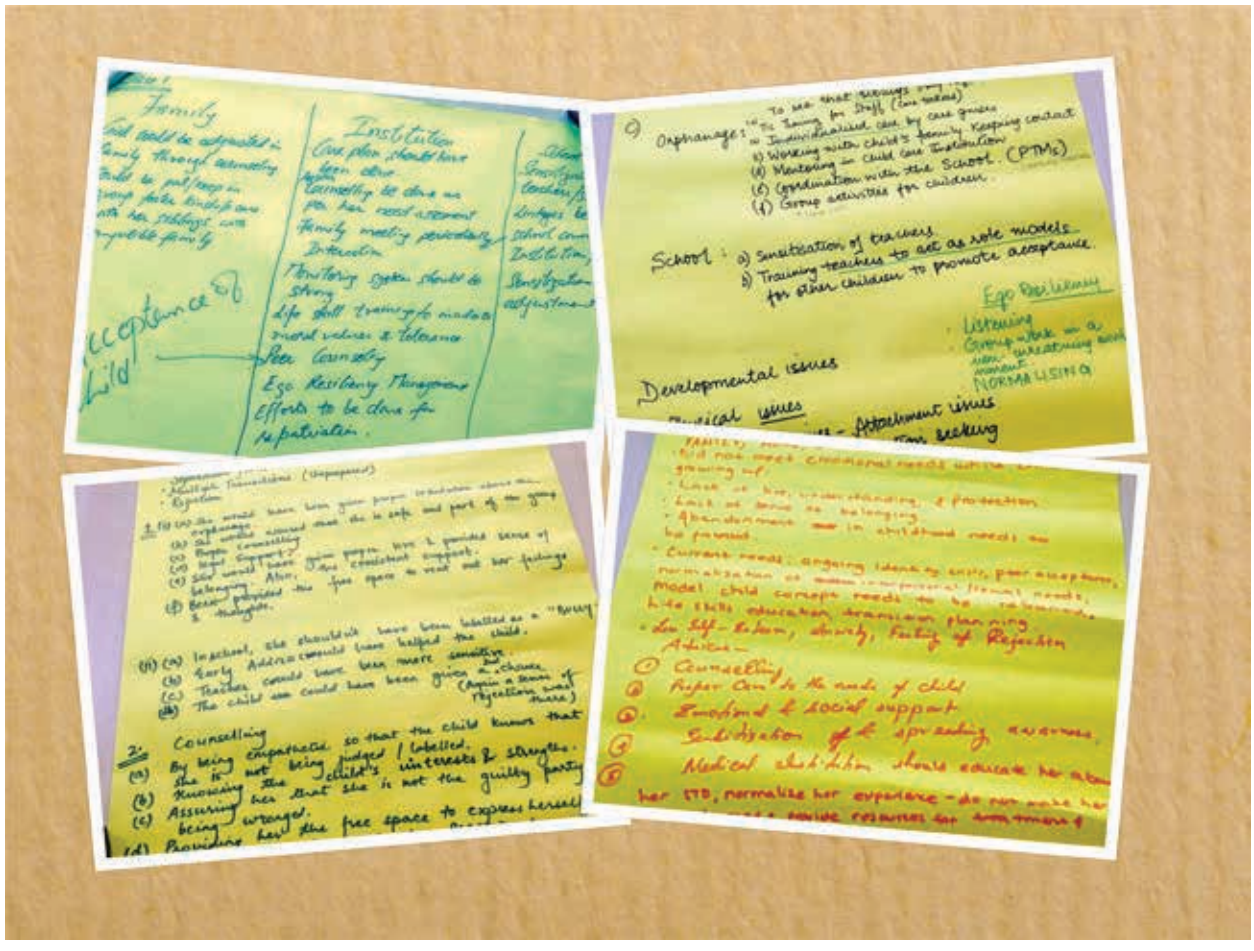
Post Lunch Group Work

Dr. Akhtar and social workers from Udayan Care facilitated group work where participants applied the knowledge gained on TIC in the pre-lunch sessions to some hypothetical case examples. The participants formed seven groups and every group was given three cases to solve using the TIC concepts and approaches.

The three hypothetical case examples reflecting issues related to school, police and hospitals are given in Annexure. After group discussions, all the groups presented their findings on the following parameters:

- The institutions involved and what do you think will be the outcome for the child.
- Could the problem have been averted?
- What advice and training would you give to the different agencies that are handling the case?
- What developmental issues would you need to consider for each child? What are their psychological concerns?
- How can each institution be instructed on how to handle the problems being presented by each child?
- How does the presentation of a child affect the way others treat them?
- Is there a way we can build ego-resiliency?

A glimpse of some of the group presentations after the group work:



The consultation ended with a formal **vote of thanks** to all contributors, supporters, resource persons and participants by Shri Arun Talwar, COO at Udayan Care.

Recommendations

The following key points emerged from the deliberations:

- Keeping in view the benefits of a TIC approach to child care, it is absolutely necessary to incorporate it in the practice of care for all children in alternative care in India.
- There is need to undertake research on the development of children in care so that their mental health is ensured despite their exposure to severe adversity.
- The laws and policies on child protection and alternative care should be influenced and informed by a TIC approach with a view to identifying ways of developing resilience in children, adolescents and youth.
- Caregivers and everyone involved with child and youth care should be trained in TIC so that they can normalise the experience and not pathologise it. A special cadre of TIC experts and professionals is urgently needed in India to ensure that the risk and vulnerability of children to re-traumatisation is minimised.
- There is a need for more deliberations in TIC and issues in context of all children falling under the umbrella of care and protection.
- There is need to sensitise parents, families and schools on rights of children and TIC.
- There is a need for periodic screening of youth and adolescents for their mental health needs with the help of objective tools of assessment (e.g., for depression, substance disorder etc.) in all child care settings. Also, there should be assessment of their trauma history, current triggers, warning signs, calming strategies and environmental support with close monitoring of progress and report, if symptom persists for longer, to make appropriate referral.
- There should be Information, Education & Communication material prepared on TIC for children in alternative care.
- Community Outreach and Partnership Building on TIC are required

Participants' Feedback

"Extremely educative"

– Karabi M.G. Majumdar
Independent Child Right Consultant

"The workshop is very timely and addressed a very important issue. The sessions were very thought-provoking, though few topics were too technical."

– Priti Mahara
Advocacy Advisor, SOS Children's Village International

"The whole consultation was very informative and comprehensive. As a child counsellor working with the children in difficult situation, I come across such children on frequent basis. I will incorporate the learning in my work, which I feel will help me deal with traumatised children more effectively."

– Sanjukta Sarkar
Counsellor, SATHI

"I am so heartened and hopeful about the outcome of the event. Trauma is an ambit of overwhelming work, and often has a huge paucity of numbers and resources compared to the need in the city. I wish there was the opportunity for more conversations of such kind."

– Chaitali Sinha
Psychologist, HAQ

"This subject is one that needs firm foundations and connections between the theories of trauma informed care and the on-the-ground practices. This consultation was a forward-thinking step towards this goal."

– Ian Anand Forber Pratt
National Programme Director, Children's Emergency Relief International

Annexure 1

Program Schedule

Time	Session Theme	Resource Person
09:30 Registration		
Setting the Context & Release of Journal		
10:00	Welcome and Introduction	Dr. Kiran Modi, Managing Trustee, Udayan Care
10:10	Keynote address	Dr. Monisha Nayar-Akhtar, Psychotherapist & Psychoanalyst, USA
10:55	Address by Chief Guest	TBC
11:15	Release of the 7th issue of Institutionalised Children: Explorations and Beyond', (ICEB). (March 2017 issue)	
11:30 Tea Break		
Panel Presentation		
12:00	Moderator	Dr. Monisha Nayar-Akhtar, Psychotherapist & Psychoanalyst, USA
12:10	TIC and its application in the context of JJ System	Dr. Rajesh Sagar, Professor of Psychiatry, AIIMS, Delhi
12:30	Trauma & its impact on brain development: A Longitudinal perspective	Dr. Deepak Gupta, Child & Adolescent Psychiatrist, Delhi
12:50	TIC and its application in the context of schools	Dr. Jitendra Nagpal, Program Director, Expressions India & Sr. Consultant Psychiatrist, Moolchand Medcity, Delhi
01:10	Experiences from the Hospital settings	Dr. Naveen Grover, Clinical Psychologist, IHBAS, Delhi
01:30	Open Floor	
02:00 Lunch		
Group Work		
03:00	Facilitator	Dr. Monisha Nayar-Akhtar & Expressions India team
03:10	Group work	
03:50	Presentation by CWC/JJBs and discussion	
04:00	Presentation by CCIs and discussion	
04:10	Presentation by school teachers and discussion	
04:20	Presentation by hospital staff and discussion	
04:30	Open floor and responses	
04:50	Summing up & way forward	Dr. Kiran Modi, Managing Trustee, Udayan Care
05:00	Vote of thanks	Mr. Arun Talwar, COO, Udayan Care
05:00 Tea Break		

Annexure 2

Case Studies for Group Work

Case 1: Shari

Shari, a seven year old came to the orphanage when she was five. Her mother was deceased having died of uterine cancer when Shari was three years old and her father, unable to take care of Shari and her two older brothers, had sent them away to their grandmother's home in the village. Though he continued to work, his contact with them lessened over the two years and Shari has not heard from her father since she came to the orphanage.

Shari's grandmother found it difficult to take care of Shari and her brothers in addition to the others grandchildren (many of them in their teenage years) who stayed with her off and on. Ultimately, due to neglect and evidence of abuse (physical and sexual) Shari and her brothers were removed and sent to different homes. Since Shari's admission to this orphanage she has had no contact with her brothers.

Shari was a likeable little girl who initially got along well with the caretakers and other children in the orphanage. However, gradually, she became more aggressive and started fighting with other children, including the older kids. At school, she acquired the reputation as a bully and the teachers complained about her disruptive behaviour. The other children began to shun her and Shari became more and more isolated and grew increasingly angry. Finally, a fight between Shari and another younger girl broke out during recess. This resulted in the younger girl getting severely injured, needing medical attention. In desperation the school principal contacted the orphanage and demanded that Shari be removed. Shari remained stubbornly silent and defiant about everything.

What do you think could have been done differently to make Shari's adjustment smoother in the school and in the orphanage? How would you counsel Shari?

Case 2: Raju

Raju, a 14-year-old boy of North Indian descent, came to the orphanage when he was 12 years old. According to the social workers and initial intake, Raju had lived in a number of different orphanages from the time he was seven years old. His mother had abandoned him when his father died, as she was unable to take care of Raju who was the youngest of five children. The older children were able to go to different homes where they worked to pay for their keep and continued to attend school. Raju, however, had always been difficult as a young child. He was extremely active, prone to temper and easily distracted.

Though the social workers attempted to get information on his early care in the different orphanages, it remained largely unavailable and sketchy. Raju however did speak of several experiences of being sexually abused by staff, and being threatened if he spoke of this to anyone. For the most part however, this issue remained largely unexplored.

Shortly after his admission, Raju was referred for counseling. There were complaints of his disruptive behaviour, his foul language and his fondling of younger boys. The teachers were also concerned about Raju's overly sexualised behaviour. The counselor explained to Raju the problems associated with such behaviour and Raju appeared to grasp the seriousness of his conduct. His behaviour improved and Raju began to do better in school.

When Raju turned fourteen, he became friends with a young 12-year-old boy, also an orphan, from another orphanage. The two developed a special relationship and Raju would often pester his caretakers and social workers to see his friend and spend time with him. It was when Raju was fifteen years old, that the school authorities became aware of that Raju and his young friend were often seen in the bathroom together. Furthermore, there were reports of things missing from the desks of other children and the teachers became increasingly suspicious of Raju and his behaviour. Eventually the authorities were contacted and a series of interrogatory interviews ensued.

What advice would you give to the police officers? How will you help the school and other children in the school? Most importantly, what would you recommend to Raju and his young friend?

Case 3: Maya

Maya is 17 years old. She has lived in an orphanage all her life. Her mother died when she was an infant and her father quickly remarried. He passed away a year later when he was killed in a tragic car accident. The stepmother who had a child of her own refused to take care of Maya and sent her away to a relative's place who lived nearby. As Maya was an extremely dependent child, the relatives soon grew tired of her. Maya was sent away to an orphanage nearby. Since then, she has been a model child, good in school, friendly with her peers and accommodating in every sense of the word.

When Maya turned 16, she got involved with a group of girls (all orphans from the same home) who were more adventurous and appeared to have relationships with several young men. Maya was soon drawn into this circle. Her good looks and soft demeanor drew the attention of young men in this circle and it was not long before Maya had a boyfriend of her own. She met the young man secretly and told no one of her escapades.

A few months into this relationship Maya developed serious gynaecological problems and psychological symptoms. The counsellor affiliated with the home noticed the change in her behaviour and met with her on several occasions. It soon became clear that Maya had a STD and needed immediate attention. She was taken to a nearby hospital and treated for her symptoms. But things did not return to normal for Maya. Now labelled as being promiscuous, other girls in the home avoided her and her former group of friends abandoned her as well. She became increasingly depressed, and this was further complicated when she learned that she would soon have to leave the home. Maya's depression however continued to get worse, and one day she was found cutting her wrist in the bathroom. Maya could not tell anyone what was bothering her; and though everyone was concerned, there seemed to be no way of helping her.

Given situation in which Maya has been going through, what would you do? Could she have been helped earlier? How do we avert potential problems?

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