



Ministry of Health, Kenya

**TRAINER'S MANUAL
FOR RAPE TRAUMA
COUNSELLORS IN KENYA**

October 2006



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DEFINITIONS

Child friendly

'Child friendly' refers to a counselling room with space and materials that can be used by children during the session, such as papers, pencils and toys.

Counselling

American Counseling Association:

Counseling is a collaborative effort between the counselor and client. Professional counselors help clients identify goals and potential solutions to problems which cause emotional turmoil; seek to improve communication and coping skills; strengthen self-esteem; and promote behaviour change and optimal mental health.

British American Counselling and Psychotherapy (BACP):

Counselling takes place when a counsellor sees a client in a private and confidential setting to explore a difficulty the client is having, distress they may be experiencing or perhaps their dissatisfaction with life, or loss of a sense of direction and purpose.

Personal therapy

'Personal therapy' refers to debriefing counsellors. 'Debriefing' refers to various stages of support in a traumatic or critical incident, including informal support on the job, defusing by discussing feelings shortly after a session and a formal debriefing hours or days later in a large group, with supervisors or peer support counsellors as leaders.

Round

'Round' is a method where participants in a group sit in a circle, without any table or object at the centre to distract their view of each other, and perform an activity in the training course.

Sexual encounter

'Sexual encounter' is sexual intercourse between people.

FOREWORD

The reproductive health services needed by sexual violence survivors are complex. Sexual violence results in unwanted pregnancy, HIV and other sexually transmitted infections, psychological trauma and physical injuries.

Comprehensive care includes counselling, treating and managing injuries, treating sexually transmitted infections, handling post-exposure prophylaxis, dealing with HIV care and preventing pregnancy. Unintended pregnancy increases adverse pregnancy outcomes and can result in unsafe abortions and complications. Additionally, emerging worldwide evidence shows sexual violence is contributing towards vulnerability to HIV.

Rape trauma syndrome and post-traumatic stress disorder often accompany sexual violence. Psychological care is needed to support clinical care. It includes counselling for crisis prevention and long-term support for the survivor and family. Counselling is necessary for testing for HIV, adhering to PEP and preventing pregnancy. Comprehensive care for sexual violence survivors includes both counselling and clinical management.

This manual aims to set standards for delivering counselling services to the survivors of sexual violence and build the capacity of those who provide counselling services to the survivors. It will go a long way in addressing issues around counselling survivors of sexual violence.



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INTRODUCTION

Rape trauma counselling is a key component in comprehensive post-rape care services. This course aims to help provide standard, effective and efficient rape trauma counselling and comprehensive post-rape care in health facilities in Kenya. This manual does not necessarily provide counsellors with skills for long-term trauma counselling. Although, if counsellors have the skills, they may provide long-term support, especially where rape trauma syndrome has developed into post-traumatic stress disorder.

This manual provides a program that equips trainers to prepare participants to reach out to rape trauma clients in a sensitive, compassionate and professional way. It is intended to provide structure and guidance to the trainers.

The manual is divided into three modules, which include practice and demonstration of counselling skills by the participants. It has a sample training agenda, course purpose and objectives, an overview of different topics and methods and assessment tools. This manual and handouts should provide quality training to rape trauma counsellors.

COURSE STRUCTURE

Module 1

Module 1 is a one-week, residential training. It is the first time participants and facilitators meet. This is a theoretical phase, although participants will prepare a referral directory at the start of this module, which will be reviewed at the end of the module. Participants will be assessed on their skills and participation in class. Participants will undertake a pre- and post-course evaluation (annex 12); the results will be given when they come for phase 3. (See annex 2 for the assessment details.)

Rounds

Each day should start and end with a round. The morning round will enable participants to share their expectations for the day and how they are feeling. Allow time in this session for housekeeping issues. This helps set the climate for the day.

Module 2

Module 2 is eight weeks of practicum, with participants working in their own institutions. Participants counsel survivors who visit the institution. An experienced rape trauma counsellor observes at least two of the participant's sessions. Participants are required to see at least five clients, one of whom should be a child. Each client is to be counselled for at least two sessions. Participants will keep a diary of each session. The participants are expected to write two case studies of the five clients seen. The case studies will be submitted to their facilitators one week before phase 3 and evaluated. This will enable the trainers to know which topics from module 1 need to be reviewed. The diary will be submitted the first day of phase 3.

Module 3

Module 3 is a one-week residential course for participants who have completed both modules 1 and 2. This module will cover new topics. Participants will share their experiences and learn from each other. Participants will be assessed before becoming certified to practise as rape trauma counsellors.

OBJECTIVES

Broad objective

By the end of this course participants should be able to counsel survivors of sexual violence.

Specific objectives

By the end of each module the participants should

Module 1

- Develop a common understanding of gender and sexuality issues and their interactions with sexual violence.
- Develop an awareness of personal values, gendered belief and attitudes and their influences on services for survivors.
- Develop knowledge and understanding of the medical and legal issues surrounding sexual violence.

- Develop skill in counselling sexual violence survivors for
 - o Preventing immediate crisis
 - o HIV pre-test and post-test for extreme trauma
 - o Adhering to HIV prevention antiretroviral drugs
 - o Preventing pregnancy
 - o Preventing an STI
 - o Preparing survivors to deal with the criminal justice system
 - o Ongoing support
 - o Referral, where possible

Module 2

- Provide the participants with an opportunity to further develop themselves in counselling.
- Develop the skills and awareness of participants in dealing with and reflecting on the complexity of issues emerging.
- Develop the capacity to support survivors through the health and justice systems.
- Maintain the necessary records following the national guidelines on the managing sexual violence and rape.

Module 3

- Provide participants with an opportunity to evaluate their practice.
- Establish their strengths, and areas of weakness.
- Explore the counselling opportunities available, as individuals and within the institution.
- Provide participants with the opportunity to
 - o Explore the challenges faced during the practicum.
 - o Review, reflect on and analyse experiences in phase 2.
 - o Drawing in-depth understanding of issues and challenges in providing care for survivors of sexual violence.
 - o Review and practise advanced counselling skills needed for rape trauma counselling.
 - o Deepen self-awareness on participant socialization and sexuality.

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- o Facilitate information exchange, sharing and learning from each other's experience.
- o Provide a supportive environment for supervision and counselling for the rape trauma counsellors.

Note: Evaluate the sessions at the end of the day and at the end of each unit.

COURSE PREPARATION

Participants

Each class should have not more than 12 participants.

Participant selection criteria

Participants must

- Be either health service providers already counselling, either as voluntary or diagnostic counselling and testing counsellors or as professional counsellors within an institution.
- Have practised as counsellors for at least one year and with half a year of HIV counselling.
- Have a will to provide trauma counselling full time or at least twice a week.
- Bring papers of any training they have done in counselling.
- State how much time they will dedicate to counselling after qualifying as rape trauma counsellors.

Participant names will be forwarded to the trainers, who will choose who will be interviewed. Participants must be from different regions, two per region if possible, so they can peer supervise each other during their counselling practice. An interview will ensure that the right people are selected for this course, to avoid enrolling participants who have no counselling experience or who are not involved in providing counselling services. The interviews will be conducted by the Provincial Reproductive Health Training and Supervision teams.

Note: A participant who is selected but does not meet the selection criteria will be turned away.

Trainers

At least two trained and practising rape trauma counsellors will facilitate the course. They should also be qualified to train trainers.

External speakers

The external speakers should be persons recognized in that field, but their number should be kept to a minimum. The arrangements need to be discussed with the resource person(s) in advance.

Venue

Modules 1 and 3 will be residential. All arrangements such as food and entertainment, should be finalized two weeks before the course starts.

Course evaluation

The trainer will need to evaluate the course using the following:

- Morning and evening rounds
- Participant activity and pre-tests and post-tests in modules 1 and 3
- Regular course evaluation

Timetable:

See annex 3 for the timetable.





MODULE 1





DAY 1

SESSION 1

INTRODUCTION AND CLIMATE SETTING

Time: 90 minutes

Objectives

Participants get to know each other, bond and contract as a group, and

1. Develop safety and comfort with each other.
2. State their expectations of the course.
3. Develop governance norms for the group.

Key content

- Introductions
- Group norms and expectations
- Course content
- Teaching methods

Participants negotiate start, break, lunch and end times and ground rules, creating a learning environment.

Activity 1: Introductions

Methods

Welcome the participants to the training. Participants introduce themselves by saying their name, where they come from and what they would like the rest of the class to know about them, such as what they like and don't like.

1. Each participant gives the introduction while seated in a circle.

or

2. Participants work with someone they do not know and introduce themselves. Then each participant introduces the partner to the rest of the group.

or

3. Participants pass around a Cellotape and state who gave it to them and to whom they are giving it. This will help everyone learn names and help the group bond.

KEY POINT

Learning names gives value to each group member. It is important to start with an activity that will help the group start bonding in the first session.

Activity 2: Group norms and expectations

Objective

1. Establish how the group will work together throughout the week.

Method

While seated in a round, participants state what they wish each person to observe. This will give each person the boundaries to work with one another.

LEARNING POINT

The facilitators should not impose ground rules on the participants but should encourage them to come up with their own norms. However, the facilitator may need to contribute, such as if participants come up with schedules that will not allow the trainers to finish the course on time.

Activity 3: Course content

Objective

1. Introduce the class to the content to be covered during the week and what the entire course entails.

Method

Participants share their expectations for the training and write all of them. The facilitator goes through the expectations and explains, in each case, any that may not be met and why. The trainers need to explain the details of the whole course. Then they must focus on the objectives for module 1.

List the 'course objectives' on a flipchart, so participants can see which expectations will be met. If there are any that the training cannot meet, the facilitator should explain that from the start. This will enable the group to have a clear picture of what they should get by the end of the training. The facilitator gives each participant a copy of the timetable.

Activity 4: Teaching methods

The facilitator highlights the different teaching methods that will be used.

UNIT 1: GENDER AND POWER RELATIONS

Time: 90 minutes:

Objectives

By the end of unit 1, participants should be able to

1. Describe gender, sex, sexuality and related terms.
2. Explain the interactions between gender, sex, sexuality and vulnerability to sexual violence and HIV.
3. Examine the influences of socialization on our sexual values and attitudes.

Key content

- Meaning of gender, sexuality, sex and related terms
- Interactions between gender, sex, sexuality and vulnerability to sexual violence and HIV
- Socialization influences on sexual violence and attitudes

Activity 1: Meaning of various terms

Method 1

The facilitator breaks the following words into two parts, such as *gender*, and writes each part on a separate, folded piece of paper: *gender, sex, sexuality, gender equality, stereotypes, gender equity, socialization, rape, sexual violence, sodomy, defilement*. Each participant picks one paper and finds out who has the remaining portion word. All participants whose letters join to form the same word or phrase should get into a group and discuss their understanding of it.

The small groups share these understandings with the whole group. The facilitator should encourage discussion among views and use the understanding to build definitions. Examples should be provided to highlight how these terms intersect. The facilitator should help

participants explore how they view their world with the new understanding.

Method 2

Small groups discuss different words. Then the words are discussed in the whole group.

LEARNING POINTS

This activity helps examine personal values, beliefs and attitudes towards sexual violence and the ways in which we condone, contribute, support and enhance sexual violence.

- The participants learn the distinctions between gender, sex and sexuality and how socialization influences values and beliefs.
- Participants begin to develop insight into what influences gender inequality and the institutions and systems that promote it.

CONTENT: GENDER AS A CONCEPT AND RELATED TERMS

Sex

'Sex' is a biological classification of females and males, defining physical differences between them.

Gender

'Gender' is a social construct that defines differentiated roles of men and women, boys and girls. Gender is also a social idea of femininity and masculinity, which is learned, rather than innate. It varies by culture, time and place. The construction of gender takes place in all social institutions, such as family, educational institutions, religious institutions and workplace. Various factors determine how gender is socially constructed in such institutions. The construction of gender could arise out of observation or remarks made or actions taken.

| Gender | Sex |
|--------------|----------------|
| Dynamic | Static |
| Geographical | Universal |
| Learned | Innate |
| Social | Biological |
| Construct | Classification |

Gender roles

'Gender roles' are defined as social expectations of what men and women should do in different environments, based on the cultural ideas of masculinity and femininity. Gender roles are culturally determined and are learned. They differ from one society to another.

Sex roles

'Sex roles' are from nature; they are genetically determined characteristics of male and female, such as pregnancy and childbirth.

| Gender roles | Sex roles |
|------------------------|---------------|
| Rearing | Pregnancy |
| Feeding | Breastfeeding |
| Mechanical engineering | Childbirth |
| Piloting | Impregnating |
| Household chores | |

Gender equity

'Gender equity' promotes equal opportunity and fair treatment for men and women personally, socially, culturally, politically and economically. It is based on fairness and justice.

Gender equality

'Gender equality' is where men and women are seen to be equal, such as women and men having equal access to education.

Gender sensitivity

'Gender sensitivity' is theoretical, when a person or program recognizes that gender roles are socially constructed and can be changed.

Gender responsiveness

'Gender responsiveness' is a when a person or a program practises gender sensitivity. Actions address gender unfairness and discrimination, promote equity for women and men and include their empowerment and advancement.

Activity 2: Gender, HIV and pregnancy

Time: 60 minutes

Method

In groups of three, the participants discuss their understanding of HIV transmission, progression, clinical signs, symptoms, vulnerability and practical HIV testing and test policy and sexual violence in Kenya. If participants seem unclear on HIV issues, the facilitator may give information and case studies as an assignment.

The participants discuss the relationship between gender and HIV infection. The following questions may be asked:

- Who are more vulnerable to HIV infection? Pregnancy?
- What, in your opinion, influences vulnerability to HIV infection? Pregnancy?
- What, in your opinion, are the intersections between gender and HIV? Gender and pregnancy?

Materials

Handout, case studies, Kanini, Ellen and Chebet (annex 4)

LEARNING POINT

Vulnerability and social influences are linked to gender and HIV and gender and pregnancy. Sexual violence and its effects are linked to a background of gender inequality, power relations and vulnerability.

CONTENT: GENDER, HIV AND PREGNANCY

GENDER AND SEXUALITY

Sexuality, like gender, is a social idea of a biological drive—sex. It is defined by with whom it is done, how it is done, why it is done, under what circumstances it is done and what is its outcome. Sexuality is influenced by an interplay of social, cultural and economic forces that determine power in a community and, therefore, the sexual choices of women and men.

INFECTION IN KENYA

Sexual intercourse between women and men is the main way HIV is transmitted in Kenya. Both women and men are infected almost equally, but with different infection peaks in different age groups. Among women, peak infection is at 15–25 years of age, with also higher chances of getting pregnant. Among men, peak infection is 30–40 years.

Biological considerations

- Women are more susceptible than men to infection because they have a large surface area exposed to seminal fluid and friction during intercourse.
- Both men and women are susceptible to HIV infection with anal penetration.

Activity 3: Social and cultural considerations, norms and expectations

Method

In small groups, participants discuss social and cultural norms and how they

- influence our sexuality
- determine risk and vulnerability to HIV and unwanted pregnancy

CONTENT: SOCIAL AND CULTURAL CONSIDERATIONS

In most Kenyan communities, gender norms define masculinity by virility, courage, knowledge and control. Femininity is supposed to be dependency, passiveness, shyness and unquestioning loyalty and obedience to men, especially husbands. These norms shape sexuality for women and men and often determine risk and vulnerability to HIV and unwanted pregnancy:

- *Knowledge of sex and HIV.* Men are expected to know about sex and often will not ask questions. Women, on the other hand, believe virginity means ignorance on sex issues and will not ask because doing so may be construed as being promiscuous. Thus, people rely on inaccurate information on HIV, which often perpetuates myths and increases transmission.
- *Motherhood vs. fatherhood.* Expectations for women and the social status attached to being a mother and breastfeeding often influences the decision (or lack of active decision) to bear a child, regardless of HIV status. When the man relinquishes responsibility and involvement in childbearing, maternal responsibility increases, even though the woman has limited choice and control.
- *Fidelity and multiple partners.* While fidelity is expected for women, multiple partners are expected and 'allowed' for men, making messages of partner fidelity for safer sex difficult to implement.
- *Control and power.* Within households and relationships control is generally held by men and expressed in sexual interactions. Gender norms are linked with risky behaviour for men and acceptance of men's risky behaviour from women.
- *Sexual domination.* Sexual domination makes violence against women acceptable and significantly increases their risk and vulnerability. 1) Physically abused women often report sexual coercion, increasing their risk to STI and HIV infection. 2) Fear of violence prevents discussing fidelity, condoms, using voluntary counselling and testing and is a barrier to seeking prevention. 3) The sexually abused are more likely to have unprotected sex, multiple partners and sex for money.
- *Ownership, access and control of services and resources.* The 'son' preference encourages male control of resources, property and women's low

education, time, labour and rights to choices. Looking after the sick and household chores constrain access to information and services.

- *Maternal health outcomes.* Gender and social and cultural factors negatively affect maternal health. If these disparities are not eradicated, negative health outcomes for women will persist.

Economic factors: power relations, poverty and dependence

- *Sex as a market commodity.* With increased poverty, especially among single, unmarried, divorced or widowed women, immediate, practical needs, such as food and shelter, often surpass the long-term health implications of HIV.
- *Low economic leverage.* Little resource control within relationships reduces women's bargaining power and increases their fear of abandonment and destitution, reducing their choices of acceptable partner behaviour.
- *Migration patterns.* Migration and its results, where spouses live apart for long periods, have increased men's risk and vulnerability.
- *Access to information.* Economic status and education affect access to information, treatment behaviour and costs in time and transport.
- *Reproductive health choices and decision making.* The lower a woman's income, education, wage or lack of permanent employment the more it affects her reproductive health choices and decisions.

GENDER PERSPECTIVES AND VULNERABILITIES OF YOUTH AND ADOLESCENTS

- Gender relations among women and men have roots in adolescence. During this time young people face challenges of reconciling cultural and family gender norms and expectations with their own sexual feelings and desires.
- Socialization and roles and responsibilities at this time include matters of freedom of mobility, using time, making decisions within the home and assigning sexual privileges—sex as a necessity and expression of masculinity for young men; virginity, birth control, and passivity for young women.

CONCLUSION

Gender determines HIV risk, vulnerability, prevention, treatment access and quality, care burden, social stigma and support. The social and economic consequences of HIV and its interventions, such as voluntary counselling and testing, condoms, and mass communication strategies, need to be understood and addressed from a gender perspective.

SESSION 2

UNIT 2: SELF-AWARENESS AND PERSONAL DEVELOPMENT

Objectives

By the end of unit 2, participants should be able to

1. Demonstrate an awareness of their gender identities.
2. Describe how socialization and gendered experiences influence systems.
3. Question gender and other power inequalities and facilitate attitude change.
4. Reflect on values, attitudes and beliefs about sexual violence and examine how they influence preventing sexual violence and providing care services to survivors.

Key content

- awareness of the self as a gendered person and influence system
- socialization and gender experience
- understanding rape

Activity 1: Awareness of the self as a gendered person

Time: 45 minutes

Method 1

The participants, in small groups, share the story of their lives, focusing on experiences that created or reinforced the awareness they were either male or female and what effect these experiences had. Then, in the whole group each participant will say one important point from the discussion.

or

Method 2

In a round, participants share how they came to realize they were either male or female and how it influenced them. Participants may pass if they are not ready to share their views.

LEARNING POINTS

- All persons have had different experiences and undergone varied socialization, influencing how they view life and the world; it will be the same with clients.
- All persons and all social, legal, political and professional systems are developed and sustained by people with these different experiences, who also shape the systems. This is important to remember when supporting sexual violence survivors through the health care and legal systems.

Activity 2: Socialization and gendered experience

Time: 45 minutes

Method 1

The facilitator reads the 'World upside down' (annex 5) to the participants. They respond to it at the end.

or

Method 2

The participants reflect on the exercise they did on 'awareness of the self as a gendered person' (above). The facilitator asks them, either in whole or in gender groups, to answer

- What have been the influences of socialization on the world around me?
- Is there anything about this world that I described that I would like to see change? If so, what?
- In what ways could I be an agent of this change?

Materials

Handout 'World upside down' (annex 5)

LEARNING POINT

Socialization and gendered experiences shape the world in different ways and each person, including a client, is part of them. There are aspects of the world we live in each of us would like to see differently. We all have a responsibility, to our clients and ourselves, to shape our immediate worlds to facilitate empowering our clients and ourselves.

Activity 3: Question gender and other power inequalities

Time: 20 minutes

Method

The facilitator guides discussion on how gender inequality is manifested in different communities and its effects. The group can also suggest ways these inequalities can be addressed.

Activity 4: Establish participants' understanding of rape

Time: 45 minutes

Method 1

The facilitator marks out three definite areas in the room: *Agree*, *Disagree* and *Not sure*. Read out statements, such as the examples given below, one at a time. Participants decide individually and stand in 'Agree', 'Disagree' or 'Not sure'. After each statement, participants give their rationale for choosing their response.

- A man cannot be raped.
- She was raped because she asked for it.
- If she is carrying a condom, she is asking for sex.
- A woman cannot be raped by her husband.
- Women should report all rapes to the police.
- She asked to be raped; look at her short skirt.
- He was provoked into raping her.
- A man should not be raped.

Note: The facilitator needs to come up with statements that can be 'agreed', 'disagreed', or 'not sure'. Before the exercise begins, participants need to understand that there are no 'right' or 'wrong' responses; everyone is free to express an opinion without fear of being judged by the rest of the group.

or

Method 2

The facilitator reads out the following statements. After each statement discuss what the participants feel about it, whether or not it holds true for them.

- Women are raped by strangers in dark places outside the home.
- Rape of men is more shameful than that of women.
- There is no rape in marriage.
- Women say 'No' when they mean 'Yes'.

- Men rape because they are overcome by sexual urges.
- Men who rape are obviously not normal.

or

Method 3

These statements above can be discussed by looking at newspaper cuttings on sexual violence. The participants decide whether the statements are true or whether they justify why rape happens.

LEARNING POINTS

- These statements are myths, untrue and must be challenged.
- Each person has personal values shaped by socialization. These values, beliefs and attitudes contribute to sexual violence or disempower people from dealing with sexual violence.
- Each person's values must be respected. However, the counsellor must be ready to challenge, with high support, survivor values and attitudes that increase self-blame, guilt and reduce progress in recovery and attitudes held by colleagues and family that encourage and condone sexual violence and negatively influence survivor care.
- Counsellors should avoid imposing their values on their clients or passing judgement on them. They should provide an environment where the clients will not feel as if they are to blame for what happened.

SESSION 3

UNIT 3: SELF-AWARENESS AND PERSONAL DEVELOPMENT IN DEALING WITH SEXUAL VIOLENCE

Objectives

By the end of unit 3, the participant should be able to

1. Discuss the psychological and social effects of sexual violence on survivors, families and societies.
2. Question the social 'justifications' for sexual violence and know they are invalid.

Key content

- Sharing personal experiences of sexual violence
- Justifications for rape
- Establishing the effects of sexual violence

Activity 1: Personal experiences of sexual violence

Time: 75 minutes

Method

Within the round, the facilitator encourages participants to share their experiences with sexual violence—their own or of those close to them. Confidentiality should be stressed and facilitators help create an atmosphere of support. Anyone who desires can share personal experience with the group. This will prepare the participants to understand the different forms of sexual violence.

Note: If the facilitator thinks the group has not bonded enough to share these experiences, this exercise can be taken up the next day as session 1.

LEARNING POINTS

- Sexual violence is more common than is thought and happens to many people.
- Often survivors feel helpless, blame themselves and feel intense guilt. Often survivors do not tell anyone and suffer the trauma and prolonged effects silently.
- The effects of sexual violence, at whatever age, are negative, varied and long term. They are painful to relive and to share. Often they are buried in denial and survivors feel unable to discuss and deal with them.
- Clients will come with similar feelings. Therefore, support must be given in a non-judgemental way to enable them to deal with issues and begin to recover.

Note: In this session there could be participants who are survivors of sexual violence. The session should be conducted in a way they will feel appreciated and their experiences accommodated.

Activity 2: 'Justifications' for rape

Time: 30 minutes

Method 1

Participants form pairs, come up with justifications given for rape, and present to the rest of the class what they came up with.

or

Method 2

The whole group discusses the reasons given for rape and sexual violence. Allow participants to give their views on these reasons and discuss why none is valid.

The facilitator could lead a discussion how everyone participates in perpetuating rape by remaining silent.

Note: Sexual violence is a crime; it cannot be justified. Sexual violence takes away the worth of a person. This has to be clear and with consensus from participants for the session to continue.

LEARNING POINT

Each society has different values and people have differing opinions as to why rape happens.

REGARDLESS OF ANY REASON, SEXUAL VIOLENCE AND RAPE IS A CRIME AGAINST A PERSON AND THE STATE. IT CANNOT BE JUSTIFIED

CONTENT: FACTS ABOUT SEXUAL ASSAULT AND ABUSE

Do sexual assaults and abuses really happen? Myths and facts

Myth: *Women ask to be raped.*

Fact: Rape is violent and humiliating. It is often accomplished by the rapist using threats and life-endangering force, during which the victim fears injury or death. No one asks to experience the fear and trauma of rape.

Myth: *'Young attractive girls' get raped.*

Fact: Rapists do not choose victims on appearance or age. Any woman can be raped. The age range of victims is from 2 days old to 103 years old.

Myth: *Rapists are strangers.*

Fact: Sadly, children are usually assaulted by acquaintances, a family member or other caretaking adult. Children are usually coerced into sexual activity by their assailant and are manipulated into silence by the assailant's threats and promises, as well as their own feelings of guilt.

Myth: *Sexual violence is an impulsive act, done for sexual gratification.*

Fact: Most rapes are planned in advance, either by the rapist stalking a victim or waiting for a safe opportunity and finding a victim. Sexual gratification is not the motive for rape; it is an act of anger, aggression, and control, with sex used as a weapon.

These myths

- Increase the trauma experienced by the survivor.
- Encourage prejudice about the legal liability of both the victim and the accused.
- Slow down or prevent the recovery of the survivor.
- Discourage survivors from reporting the incident as a crime.
- Help lawyers assist the offender escape conviction or reduce the sentence.
- Hamper society understand the causes of sexual violence and its effect on survivors.
- Denies survivors the support and assistance they need to heal from sexual violation.

Activity 3: Establish sexual violence effects

Time: 15 minutes

Method 1

The whole group offers short suggestions on the possible effects of rape and sexual violence, keeping in mind the discussions just taken place. Categorize these effects into psychological and physiological. Write them on a flipchart and hang it in the room. They will be revisited and further categorized.

or

Method 2

Small groups discuss and list the effects of rape and sexual violence. Then discuss the effects within the whole group.

LEARNING POINT

The effects of rape and sexual violence manifest differently from one survivor to the next. The counsellor needs to be able to identify the effects experienced by their clients to know how to support and refer their clients appropriately.

CONTENT: SEXUAL VIOLENCE EFFECTS

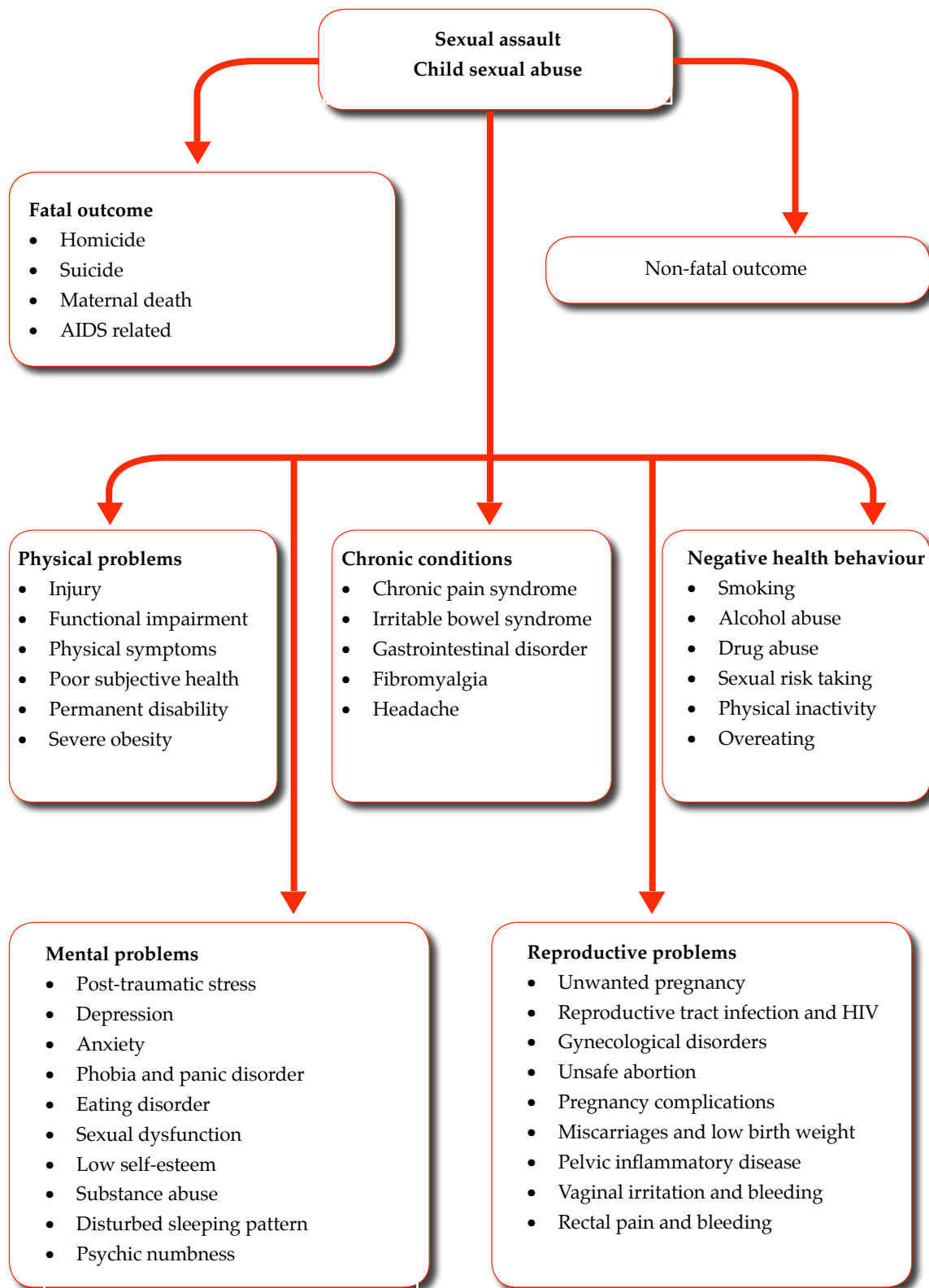


Figure 1. Sexual violence effects

UNIT 4: SELF-AWARENESS AND PERSONAL DEVELOPMENT WITH RAPE TRAUMA SYNDROME

Objectives

By the end of unit 4, the participant should be able to

1. Identify varied reactions to crisis and stress.
2. Identify self-reaction during crisis.
3. Elaborate ways of handling clients with different reactions after being assaulted.

Key content

- Exploring and understanding rape trauma syndrome
- Exploring the classifications of rape trauma syndrome
- Reaction and crises management

Activity: Explore and understand rape trauma

Time: 60 minutes

Method

Participants reflect on personal experiences. Each participant should select an event they remember as traumatic and share it with the group, including what the initial reaction was and current feeling. The facilitator needs to set an environment of support and safety, allowing each participant to share. At the end, the facilitator should start a discussion on the lessons learned. Reactions to immediate, short- and long-term trauma should be discussed.

Activity: Self-reaction to crisis

Method

The facilitator provides participants with role plays. Participants play a role in the traumatic scene and describe how they would react and how they feel about the situation.

With the active participation, the facilitator uses flipcharts to enhance classifying reactions into physical, emotional, psychological, social and behavioural. Traumatic experience effects should be highlighted.

LEARNING POINTS

- Counsellors must understand the effects and reactions from trauma to be able to support clients with varied symptoms.
- Different people react differently to similar situations. To help them, counsellors need to handle each client as unique and respect the client's reactions.
- Trauma manifests itself with diverse short- and long-term effects. Survivors will experience high trauma when they visit the health facility. The counsellor should support them appropriately, especially when decisions are required.

CONTENT: RAPE TRAUMA SYNDROME

Very often after a rape, people will say things to the survivor, such as 'It's over now, you must get on with the rest of your life.' Or they will not understand why, six months after the rape, the survivor is still suffering. Rape begins with the physical act, during which the victim concentrates on surviving. After the assault, the struggle to comprehend what has happened begins. Its meaning floods over the survivor, who must find a way to return to life, body and self. Rape is as much a destruction of 'self' as a physical invasion. The battle between 'mind rape' and the will to find self again is called survival.

Rape trauma syndrome

'Rape trauma syndrome' is the medical term for the response survivors have to rape. It is similar to traumatic stress disorder. People who are defiled and people who get sodomized also experience this syndrome.

Physical symptoms of rape trauma syndrome

- Shock, in which the survivor feels cold, faint, confused and disoriented, trembles, nauseous and sometimes vomits
- Resulting pregnancy
- Gynaecological problems include irregular, heavier and painful periods, vaginal discharge, bladder infections and sexually transmitted diseases
- Bleeding and infection from tears or cuts in the vagina or rectum
- A soreness of the body, bruising, grazes and cuts
- Nausea and vomiting
- Throat irritation and soreness from forced oral sex
- Tension headaches
- Pain in the lower back and in the stomach
- Sleep disturbances, including difficulty sleeping or feeling exhausted and needing more sleep than usual
- Eating disorders, including not eating, eating less or eating more than usual

Behavioural symptoms of rape trauma syndrome

- Crying more than usual
- Difficulty concentrating
- Restless, agitated and unable to relax or feeling listless and unmotivated
- Not wanting to socialize or see anybody or socializing more than usual, to fill up every minute of the day
- Not wanting to be alone
- Stuttering and stammering more than usual
- Avoiding anything that reminds victim of the rape
- More easily frightened or startled than usual
- Very alert and watchful
- Easily upset by small things
- Problems with family, friends, lovers and spouses from irritability, withdrawal and dependence
- Fear of sex, loss of interest in sex or loss of sexual pleasure
- Change in lifestyle
- Increased substance abuse

- Increased washing or bathing
- Denial, behaving as if the rape did not occur, trying to live life as it was before the rape

Psychological symptoms of rape trauma syndrome

- Increased fear and anxiety
- Self-blame and guilt
- Helplessness, no longer feeling in control of life
- Humiliation and shame
- Lowered self-esteem, feeling dirty
- Anger
- Feeling alone and that no one understands
- Losing hope for the future
- Emotional numbness
- Confusion
- Memory loss
- Constantly thinking about the rape
- Having flashbacks to the rape, feeling it is happening again
- Nightmares
- Depression
- Developing suicidal ideas

Managing rape crisis

- Refer survivor for counselling
- Refer for medical management

There are many influences on how each sexual violence survivor copes with the experience and how long the symptoms may be present. These include

- Support systems, such as referral to health care provider and counsellor, family support and spiritual support
- The relationship with the offender
- The violence used
- Social and cultural influences

- Previous experience with stress
- Ability to cope with stress
- Attitude of those immediately contacted after the assault

How the counsellor can offer support

The counsellor can offer the survivor support by

- Creating a supporting environment in which to share the experience
- Exploring and addressing client concerns
- Addressing client fears about health care, family and social consequences
- Addressing the fears and concerns of the guardian or parent for a child survivor

Survivors will not respond in the same ways. While most survivors experience these symptoms, some may experience only a few and others none at all. We must be careful not to judge by the symptoms whether someone has been raped. Because most survivors are afraid to tell anyone, it is important to treat everyone who says they have been raped as if they were.

Almost all rape survivors suffer severe and long emotional trauma because

- The rape is sudden.
- It is perceived as life threatening.
- Its apparent purpose is to violate the survivor's physical integrity and render the survivor helpless.
- The survivor is forced to participate in the crime.
- The survivor cannot prevent the assault or control the assailant, normal coping strategies failed, and the survivor becomes a victim of someone else's rage and aggression.

The trauma is usually compounded by the myths, prejudice and stigma associated with rape. Survivors who have internalized these myths fight feelings of guilt and shame. The burden can be overwhelming, especially when other people reinforce the myths and prejudices. All legal, medical and police procedures must not cause further trauma to survivors, who must be given all possible support to overcome and survive the ordeal.

DAY 2

SESSION 1

UNIT 5: OVERVIEW OF COUNSELLING AND SKILLS

Objectives

By the end of unit 5, participants should be able to

1. Discuss their understanding of the goals, principles and values of counselling.
2. Highlight expected issues clients will be dealing with after sexual violence that require counselling support.
3. Analyse the role of the counsellor in helping clients deal with the concerns and issues they face.
4. Demonstrate knowledge on the skills, techniques and approaches when counselling sexual violence survivors and their partners and families.

Key content

- Counselling, its principles and goals
- Expected counselling issues for sexual violence survivors
- Techniques and approaches to counsel sexual violence survivors

Activity 1: Review counselling, its principles and goals

Note: This is a group of experienced and practising counsellors and, therefore, this should be a revision session.

Time: 20 minutes

Method 1

The whole group offers short suggestions on what counselling is and what it entails. Discuss counselling principles, values and expected outcomes. Write these on flipcharts and display them for the rest of the course.

or

Method 2

Participants, in groups, define counselling and list the counselling skills they know. The skills will be reviewed later.

CONTENT: COUNSELLING

Counselling

'Counselling' is a structured conversation between people that assists one participant to work through particular problems or conflicts, explore feelings and find ways to resolve or cope with them. Counsellors encourage people to recognize and develop their coping capacity, so they can deal more effectively with problems.

While the term 'counselling' may be unfamiliar to some, the behaviour is probably common in all cultures. Counselling not only helps people with their immediate problems, it can help them to recognize and draw upon their own resources for future problems.

Goal

Counselling helps create new perspectives and change. It may help people feel differently about a situation or change their behaviour, such as practising safer sex; or change something in their environment, such as setting up a support group.

Counselling aims to help people

- Understand their situation more clearly.
- Identify options for improving the situation.
- Make choices that fit their values, feelings and needs.
- Make their own decisions and act on them.
- Cope better with a problem.
- Develop life skills, such as being able to talk about sex with a partner.
- Provide support for others while preserving their own strength.

Principles and values

Counsellors uphold the values of integrity, impartiality and respect. They also uphold the principles of autonomy, beneficence, justice, avoidance of harm, and fidelity to specific situations. They have a responsibility to the clients, to themselves, their colleagues, the profession, members of other caring professions, the community and the law.

Activity 2: Expected counselling issues for sexual violence survivors

Time: 40 minutes

Method

Participants, in groups of three, read short case studies that highlight different scenarios of sexual violence and discuss the possible issues and concerns the survivor may have.

Concerns may include

- fears of the personal effects of sexual violence, including health consequences
- feelings the survivor may have, such as shame, stigma, blame, guilt and fear of being alone, talking to people and walking about
- relationships with immediate family, including partner, siblings and parents
- societal concerns, such as stigma, social sanctions and discrimination

Note: If this activity takes longer, participants may be asked to use these questions as an assignment and discuss them groups. This session may be deferred to Day 3, Session 3.

Material

Real cases (annex 6)

Using these cases, the trainers can list some of the skills and techniques to be used in counselling. These will be discussed in detail later.

LEARNING POINTS

- Each client will present diverse issues and concerns. The counsellor needs to acknowledge these different fears while supporting the client in dealing with immediate concerns.
- The counsellor needs to support the client in dealing with fears and NOT provide advice on how to deal with them. This includes
 - Supporting the client to make informed decisions. Acknowledge that with trauma the client does not always have to develop a plan, especially in initial counselling sessions, but can be guided through a plan when they begin to address their immediate fears.
 - Enabling the client to cope better with the issues arising through exploration with minimum challenge.
 - Helping the client develop coping skills.
 - Providing support to the client while preserving own strength.
 - Referring the client appropriately.

UNIT 6: COUNSELLING ISSUES

Objectives

By the end of unit 6, the participant should be able to

1. Highlight expected client and counsellor issues arising after sexual violence.
2. Discuss the issues the clients and counsellor that would require counselling support after sexual violence.

Key content

- Transference
- Disclosure
- Self-disclosure
- Confidentiality
- Shared confidentiality
- Giving information
- Informed consent
- Ongoing support counselling

Activity 1: Understanding transference**Time: 20 minutes****Method**

The whole group discusses how to handle transference and counter-transference by answering the following questions:

- If the client reminds you of someone you know, how might this affect your counselling?
- What might happen if the client looks like your mother, daughter, or ex-partner?

Transference can happen from counsellor to client and from client to counsellor. The more traumatic the experience, the greater the likelihood of transference, such as a woman raped after an evening out reminds the counsellor of the last time she herself went out.

Brainstorm in the group how to handle transference and counter-transference.

LEARNING POINT

Transference and counter-transference can easily happen in counselling. It can seriously affect the counselling. Counsellors need to be aware of their own transference and to be able to put it aside. The counsellor also needs to be aware of possible transference from the client and to challenge it if necessary.

CONTENT: TRANSFERENCE AND COUNTER-TRANSFERENCE

A transference reaction means shifting feelings, thoughts and wishes from one person to another—usually to the analyst. Some people refer to transference as a 'projection'; you project your own feelings, emotions or motivations onto another person without realizing the reactions are yours, rather than other person's.

Counter-transference may refer to a situation in which the counsellor's feelings within the therapeutic relationship may or may not be directed towards the client.

This suggests that transference and counter-transference are two-way; the client's transference may affect the counsellor and the counsellor's counter-transference may affect the client. Transference invariably shapes the analyst's counter-transference; and the analyst's counter-transference partly shapes the patient's transference.

The client may evoke transference from the counsellor's past relationships and situations, bringing up unresolved feelings. The client may project behaviour and feelings not accessed during the counselling session onto the counsellor. The counsellor may not recognize these feelings, which the client unconsciously carries. In some instances this transference is replayed in supervision, where the supervisor may identify it. The client's feelings and behaviour are unconscious and projected from one individual to another until they are identified and can be dealt with. Counter-transference refers to negative and positive feelings towards the client from unresolved areas in the counsellor's life.

Activity 2: Disclosure

Time: 30 minutes

Method

All the participants share their understanding of disclosure. The group discusses each example and how to inform the client about disclosing the assault and HIV test results.

Use the following examples:

- a married woman who has been raped
- a child who was raped by the parent
- a man who is about to marry a woman and he is gang raped

LEARNING POINT

Disclosing a rape or sexual assault can be quite challenging, especially when the client is not ready to tell anyone about it, be it parents, spouse or friend. Survivors need to undergo an HIV test, for which disclosure is important, especially when the client has a sexual partner and safe sex has to be practised while the client is on PEP. The counsellor needs to help the survivor realize and understand what disclosure is all about and why it is important to find a way to disclose the assault to someone they choose and who can give them support. The counsellor will need to work with the client on how to go about disclosure but should accept the client's pace and not coerce the client into doing anything uncomfortable or that the client is unready to do.

CONTENT: DISCLOSURE

- The relationship between a counsellor and the client is a contract.
- This contract, written or oral, means the information disclosed by the client to the counsellor is confidential.
- There are exceptions to this contract and every counsellor sometimes walks the fine line between exceptions and information misuse.
- The responsibility for disclosure should always remain with the client.
- The client has the right to know the contract boundaries.
- High trust between individuals sustains a high disclosure; low trust results in low disclosure.
- Counselling begins with disclosure and is characterized by trust, self-doubt, and even shame by some survivors.
- In a safe environment, clients feel comfortable with each counselling session, relax their defences and begin to share more personal details of what happened.
- The counsellor should help clients gain control of their emotions and reactions, to make connections from past abuse to present symptoms.

Activity 3: Self-disclosure

Self-disclosure

'Self-disclosure' is when the counsellors reveal something personal about themselves to the clients.

Time: 10 minutes

Method

The facilitator explains what self-disclosure is and asks the group to brainstorm on what the benefits and disadvantages might be.

LEARNING POINTS

Benefits

- Self-disclosure might help clients develop a new perspective towards their problems.
- Self-disclosure might reduce a sense of isolation and bring a sense of universality.

Disadvantages

- Self-disclosure might take attention from the client to the counsellor.
- The counsellor might assume that because both have experienced the same thing, they both respond the same way.
- The client might want more information than the counsellor is willing to give.

Note: The client is not bound by confidentiality to the counsellor.

CONTENT: SELF-DISCLOSURE

- Self-disclosure is a challenging skill.
- Self-disclosure is where helpers constructively share some of their own experiences, behaviour and feelings with clients.
- Self-disclosure happens when the counsellor communicates personal characteristics to the client with every look, movement, emotional response, sound and word.
- Self-disclosure can make clients see helpers as less well adjusted or can frighten clients.
- Instead of helping, self-disclosure might place another burden on clients.
- In some instances, self-disclosure can be appreciated by clients.

Benefits

- By disclosing something about yourself, you may help free clients to talk about themselves.
- Appropriate self-disclosure may prevent the counsellor from appearing to be too interested.
- Self-disclosure may contribute to the counsellor being perceived as a real human being, rather than hiding behind a phoney or defensive façade.
- By the counsellor sharing experiences, clients may get a different perception of their problems and how to deal with them.
- Self-disclosure helps clients know that others have undergone the same crisis, so they are not alone.

Dangers

- Clients usually have enough problems without having to carry the counsellor's burden too.
- Clients may ask themselves, 'Why is the counsellor telling me this?' and attribute negative reasons for disclosure.
- Vulnerable clients tend to perceive their helpers as strong people and may become anxious about evidence to the contrary.
- Inappropriate disclosure may shift the focus of the session from the client to the counsellor.

- Some helpers may, either intentionally or unintentionally use self-disclosure to manipulate clients to meet their own needs for approval, intimacy and sex (Jones 2000).

Activity 4: Confidentiality

Time: 10 minutes

Method

The whole group brainstorms to define confidentiality.

One definition: Confidentiality is the agreement of the counsellor not to share anything that is said or done in the counselling room with anyone else without the express permission of the client.

LEARNING POINT

Confidentiality is challenged in many different settings. Counsellors need to be continuously aware of it.

CONTENT: CONFIDENTIALITY

- Confidentiality is the agreement by the counsellor not to share anything said or done in the counselling room with anyone else without the express permission of the client.
- Confidentiality enables the client to feel safe in the counselling session.
- Confidentiality protects the client after the counselling session.
- Confidentiality promotes trust between the client and the counsellor.
- Confidentiality can be broken in some circumstances, when there is a danger to self or others.
- Counsellors need to be very careful if they break confidentiality, because it can destroy the reputation of all counselling.

Activity 5: Shared confidentiality**Time: 20 minutes****Method**

The whole group discusses what 'shared confidentiality' means. Then participant pairs explain to each other how they would explain shared confidentiality to a client.

LEARNING POINT

Although counsellors are required by the counselling code of ethics to maintain confidentiality of all client issues, it becomes hard to do this with rape and sexual violence because survivor post-rape care uses diverse services and referrals, hence the need for shared confidentiality. The counsellor must tell this to the client, so the client understands what shared confidentiality is and why it is important. The counsellor must seek to assure the client the material will be disclosed only to people who will assist and facilitate effective treatment.

CONTENT: SHARED CONFIDENTIALITY

- Shared confidentiality is confidentiality shared with others.
- These others might include family members, loved ones, caregivers and trusted friends.
- This shared confidentiality is at the discretion of the person tested.
- Although HIV test results should be kept confidential, other professionals, such as counsellors and health and social service workers, might need to be aware of the person's HIV status or the incident to provide appropriate care.

Activity 6: Giving information

Time: 10 minutes

Method

Using case studies, participants practise how to give information and not advice.

Identify examples of giving advice rather than information, such as 'You need to dress well' and 'You will have to go for an HIV test'.

LEARNING POINT

Counsellors should not give clients advice on what to do or not do because it will impose on clients the counsellor's way to handle issues. Counsellors should give clients all the information they need and let them make informed decisions.

Activity 7: Informed consent

Time: 30 minutes

Method

The group discusses what informed consent is and why it is important for rape. The group practises how to get informed consent from the clients and how to explain shared confidentiality.

CONTENT: INFORMED CONSENT

Rape is a crime against the state and is punishable by law.

- The client should give consent for the tests, so the counsellor is not considered to have forced the client to undertake the tests.
- The counsellor needs to empower the client appropriately for any future course of action.

- The counsellor should give the client all the information needed and let the client make an informed choice on the next course of action.
- By giving advice to the client the counsellor will be encouraging the client to depend on him or her and, should anything go wrong, the client will blame the counsellor and not being benefit from the counsellor's support.
- Advice directs the client; information allows the client choice.

Activity 8: Ongoing support counselling

Time: 10 minutes

Method

The facilitator gives a lecture on assuring clients they will be given ongoing counselling whenever they have issues they want to share with the counsellor. Counsellors need to offer ongoing counselling, even to clients who turn HIV positive at baseline, and refer clients to any other place or person, such as a comprehensive care centre, post-test club or home-based care, where they can be given support.

Note: Refer to the rape trauma counselling protocol on ongoing counselling.

LEARNING POINT

Trauma counselling cannot be offered within a day or one session. The counsellor should establish a supportive relationship with the client to offer support as the client works through issues. However, both the client and the counsellor need to understand the boundaries of a supportive relationship.

CONTENT: ONGOING COUNSELLING

Ongoing counselling should be given to all clients whether they are on PEP or not. Issues to be addressed include

Exploration

- How have the client and client's family been coping?
- What are the client's fears and concerns?
- Were the sexual violence, HIV and pregnancy test results disclosed?

Reducing risk

- Sexual exposure since the sexual violence
- Risk reduction strategies the client adopted

Drug adherence

- Client feelings about the drugs taken
- PEP side effects
- Importance of adherence
- Need for an HIV test at the end of 28 days

The counsellor also needs to consider referring the client for further clinical care and management when necessary.

SESSION 2

UNIT 7: COUNSELLING THEORIES

Objectives

By the end of unit 7, the participant should be able to

1. Name counselling theories.
2. Discuss different counselling theories.
3. Demonstrate application of counselling theories in trauma counselling.

Activity: Counselling theories

Time: 10 minutes

Method

Participants state the different counselling theories they know:

- Psychoanalytic theory
- Behavioural theory
- Cognitive theories
- Humanistic theories
- Person-centred therapy

The trainer should tell participants that the theories covered in the training will be

- Psychoanalytic theory
- Behavioural theory
- Cognitive theories
- Humanistic theories

PSYCHOANALYTIC THEORY

To introduce psychoanalytic theory, do the following exercises.

Activity 1: How were your feelings expressed and treated when you were a child?

Time: 30 minutes

Method

In pairs, with 5 minutes, participants answer, 'How were your feelings expressed and treated when you were growing up?' Participants give brief answers, such as anger, grief, fear and love.

Then, remembering confidentiality, each participant will share their own experiences, not those of the other person in the pair. The facilitator asks

what each participant learned, if each had similar experiences, if each expressed their emotions in the same way as those they were brought up with.

LEARNING POINT

We may or may not express our emotions and feelings similarly. However, we can be influenced by experience, such as a person who was raped as a child may become a child abuser. Each of us will have had different experiences growing up; we should not assume we are all the same.

Activity 2: Introduction to psychoanalytic theory

Time: 20 minutes

Method

The facilitator gives a short lecture using the information below.

LEARNING POINT

Psychoanalytic theory believes that we are formed by our first 12 years of life. Most of this formative experience will not be remembered, but it will be in our subconscious.

CONTENT: PSYCHOANALYTIC COUNSELLING APPROACHES

Key figure: Sigmund Freud

Key concept: human nature

The Freudian view of human nature is deterministic. Our behaviour is determined by three main factors: irrational forces, unconscious motivations, and biological and instinctual drives. The drive is by psychic energy, which is sexual.

There are two main instinctual drives. One is the life instinct, 'eros', which is for survival and encompasses nurturing and creativity. The second is the death instinct, 'thanatos', which accounts for aggressive drives, sometimes manifested as an unconscious wish to die or to hurt people.

Structure of personality

Freud thought there were three subsystems of psychic energy in the mind:

Id

'Id' is biological, present at birth; it is the pleasure-seeking, illogical and unconscious.

Ego

'Ego' is psychological; it is the seat of intelligence and is in touch with reality (the reality principle); it is the executive and mediates the other two energies.

Superego

'Superego' is judicial; it comprises the moral code, strives for perfection and seeks the ideal, rather than the real.

Anxiety

'Anxiety' is when the ego is unable to balance the psychic energy between the id and the superego. One of three anxiety states arises:

- Reality anxiety
- Neurotic anxiety
- Moral anxiety

Ego-defence mechanism

When the anxiety state is excessive, a person sets up an 'ego-defence mechanism' to cope with the situation at hand. This is mostly unconscious; the aim is to either deny or distort reality. Examples include repression, reaction formation, projection, displacement, rationalization, sublimation, regression and introjection.

The unconscious

Freud argued that our behaviour is largely a result of unconscious

motivation. His analogy of unconsciousness is the iceberg. Evidence of the unconscious appears in slips of the tongue, dreams and wishes.

Psychosexual stages of development

- *Oral stage* lasts from birth to one year. Erogenous zone is the mouth; suckling satisfies need for food and pleasure.
- *Anal stage* lasts from about 18 months to 3 or 4 years. The focus of pleasure is the anus; holding it in and letting it go are greatly enjoyed.
- *Phallic stage* lasts from age 3 or 4 to 5, 6 or 7 years. The focus of pleasure is the genitalia; masturbation is common.
- *Latent stage* lasts from age 5, 6 or 7 years to puberty, somewhere around 12 years. During this stage, Freud believed that the sexual impulse was suppressed in the service of learning.
- *Genital stage* begins at puberty and represents the resurgence of the sex drive in adolescence; it focuses more on pleasure in sexual intercourse.

Therapeutic techniques

Freud's therapy has been more influential than any other and more influential than any part of his theory. Here are some of the major points:

- **Relaxed atmosphere.** The client must feel free to express anything. The therapy is in a unique social situation, one in which you do not have to be afraid of social judgement or ostracism. In Freudian therapy, the therapist practically disappears. Add in the physically relaxing couch, dim lights, soundproof walls, and the stage is set.
- **Free association.** The client may talk about anything at all. The theory is that with relaxation, unconscious conflicts will inevitably drift to the fore. One can see a similarity between Freudian therapy and dreaming; but, in therapy, the therapist is trained to recognize clues to problems and their solutions the client would overlook.
- **Resistance.** One of these clues is 'resistance'. When a client tries to change the topic, draws a complete blank, falls asleep, comes in late, or skips an appointment altogether, the therapist sees these as signs of resistance, which suggest a client is nearing something in their free association they unconsciously find threatening.
- **Dream analysis.** In sleep, we are somewhat less resistant to our unconscious and allow a few things to come to awareness as symbols.

These are wishes from the id and provide the therapist and client more clues. Many forms of therapy use client dreams, but Freudian interpretation is distinct in the tendency to find sexual meanings.

- **Para praxes.** 'Para praxis' is a slip of the tongue, often called a Freudian slip. Freud thought these slips were clues to unconscious conflicts. Freud was also interested in the jokes his clients told. Freud thought almost everything meant something almost all the time—dialling a wrong number, making a wrong turn, misspelling a word, were serious objects of study for Freud. However, in response to a student who asked what his cigar might be a symbol for, Freud noted that 'Sometimes a cigar is just a cigar'. (Or is it?)

Transference

'Transference' occurs when a client projects feelings towards the therapist that more legitimately belong with certain important others. Freud felt that transference was necessary in therapy, to bring to the surface repressed emotions that long plagued the client.

Catharsis

'Catharsis' is the sudden and dramatic outpouring of emotion that occurs when the trauma is resurrected. The box of tissues on the end table is not there for decoration.

Insight

'Insight' is being aware of the emotion source, the original traumatic event. The major portion of the therapy is completed when the client experiences catharsis and insight. Freud said that the goal of therapy is 'to make the unconscious—conscious'.

BEHAVIOURAL THEORY

To introduce the behavioural theory, do the following exercise.

Activity 1: How do you change behaviour?

Time: 30 minutes

Method

The facilitator divides the participants into two groups and gives each group a question:

- If you want to change the behaviour of your child, what might you do?
- If you want to give up smoking, what might you do?

The groups discuss the questions for 10 minutes. Then the whole group discusses the strategies.

LEARNING POINT

Different behavioural changes need different strategies. Certain ideas fit in with behavioural theories, such as punishment and disapproval, called aversion therapy; praising and rewarding, called reinforcement; reducing stress, called relaxation; and establishing a plan, called self-management.

Activity 2: Behavioural theories

Time: 30 minutes

Method

The facilitator gives a short lecture on basic assumptions in behavioural therapy.

LEARNING POINT

Behaviour is difficult to change and doing so may take a long time. We have to *want* to change before we will do it. What helps change is support, aiming for achievable goals, being ready to change and seeing the benefits.

CONTENT: BEHAVIOURAL COUNSELLING**Behavioural counselling**

Key figures: Albert Bandura, B.F. Skinner, Arnold Lazarus, Joseph Wolpe, Hans Eysenck, Edward Thorndike, J.B. Watson

Basic assumptions

- We are born as 'blank slates'. Everything we are as individuals, we have learned from other people or from our own experiences.
- The behaviour in the here-and-now is important; the past is insignificant.

Key concepts**Classical conditioning**

'Classical conditioning' was formulated by Ivan Pavlov, based on experiments with animals. In his famous experiment, Pavlov paired presenting food with the sound of a bell. After a series of such presentations, eventually the bell alone elicited salivation. The essential feature is that an unconditioned stimulus (food), leads automatically to an unconditioned response (salivation), when presented repeatedly with a conditioned stimulus (bell), causing a conditioned response (salivation). Soon after Pavlov's experiments, a series of experiments was conducted in humans to abolish or produce maladaptive behaviour. The most infamous case was that of little Albert, who was subjected to repeated presentations of a white rat paired with a loud noise. After a while the infant reacted with fear to the white rat. This fearful response was generalized to other similar stimuli, such as a fur coat. On the basis of this experiment, it was concluded that phobias are conditioned emotional responses. Psychologist John Watson's conviction of the power of the learning theory was so great he claimed that, through conditioning, he could make an infant into a thief, a lawyer or a doctor.

Operant conditioning

'Operant' refers to voluntary behavioural responses, different from involuntary or reflex behaviour. Edward Thorndike (1911) studied animals

using a wooden box with a door that could be opened by pulling a loop. When a cat was placed within the box it generally made a number of ineffectual movements, but eventually it accidentally pulled the loop and escaped. Gradually, the animal decreased the length of time it took to pull the loop and escape. Instrumental or 'operant conditioning' states that behaviour is largely determined by its consequences. Behaviour is reinforced continuously, scheduled or intermittently.

The difference between classical and operant conditioning is that in classical conditioning the stimulus is applied before the behaviour. In operant conditioning stimuli is applied after the behaviour—to reward or punish.

Systematic desensitization

'Systematic desensitization' was developed by Joseph Wolpe (1958), who proposed a hypothesis of neurosis using Pavlovian learning principles; behaviour was under direct stimulus control. Wolpe attempted to incorporate learning principles in treating neurotic disorders.

He advocated the pairing relaxation, which is antagonistic to anxiety, with contact with conditioned stimuli. The client is trained to relax and relaxation is paired with imagined contact with the feared object or situation. The assumption is that relaxation reciprocally inhibits the anxiety, weakening the association between the stimuli and anxiety. It also involves gradual exposure of the person with the phobia or other anxiety-provoking situation to whatever arouses the anxiety; it is sometimes referred as the exposure principle.

Techniques

Some of the techniques used in behavioural theory include behavioural analysis, self-monitoring and self-regulation, aversion therapy, covert sensitization, satiation and systematic desensitization.

COGNITIVE BEHAVIOURAL THEORY

Activity: Cognitive theories

Time: 30 minutes

Method

Give a short lecture using the information below and the handout.

- We are all rational beings.
- We also have beliefs that influence our lives.
- Cognitive behavioural therapy helps a client change by focusing on the client's thoughts and beliefs.

Example

Belief: My mother told me not to wear that dress.

Result: I wore it, I was raped and I deserved it.

Change to

Belief: My mother told me not to wear that dress.

Result: I wore it, I was raped, and no one deserves to be raped no matter what they were wearing. I don't deserve it.

CONTENT: COGNITIVE BEHAVIOURAL COUNSELLING

Key figures: Aaron Beck (1921) and Albert Ellis (1913)

KEY POINTS

- All human beings are rational and can reason.
- No two people will respond to an event in the same way.
- Emotions and behaviour are determined by thinking.
- Emotional disorders result from negative and unrealistic or maladaptive thinking and altering this maladaptive thinking can reduce emotional disturbance.

- Clients may be only partially aware of maladaptive thinking.
- Childhood experiences may be the origin of maladaptive thinking patterns, but their thinking, 'here and now', is more significant.
- Counsellors will help the client understand how their thinking influences their emotional responses and their behaviour through logical discussions that challenge negative and unrealistic thinking by examining the evidence for and against such thinking.
- The counsellor and the client collaborate to achieve the goal.

Benefit of trauma counselling

It allows for a wider interpretation and considers childhood influence.

HUMANISTIC THEORY

This is the most fundamental theory in trauma counselling. To introduce it, do the following exercise.

Activity 1: Humanistic theory in practice

Time: 20 minutes

Method

In pairs, participants sit silently facing each other as in a counselling session. For a few minutes participants just look at their partners and assume the other person is the client. They study each other well, as if they have never seen each other before, as if they have big difficulties or problems. They imagine the problems. They imagine what the clients might be like and how the counsellor might help them.

After a few minutes the facilitator reads out statements about humanistic theories.

- Your client is a good person.
- The client has the capacity to solve all personal problems.
- The client will always work towards being the best person possible.

Participants take a few minutes to consider these statements in relation to the partner.

The whole group discusses the exercise: Did anyone feel a change in attitude towards the partner? How did it feel to believe in those assumptions?

LEARNING POINT

Believing these theories can make a significant difference in how one sees someone. It is easy to make assumptions about people, which may not always be positive. When people realize they are able to solve their own problems, they can get relief.

Activity 2: Humanistic counselling theories

Time: 30 minutes

Method

Mini-lecture. The facilitator writes the following on newsprint:
Assumptions of humanistic counselling theories:

- Human beings are basically good.
- Human beings have the capacity to solve their problems.
- Human beings always strive towards self-fulfilment.

According to Carl Rogers, the essential qualities of a counsellor are

- *Acceptance* or unconditional positive regard
- *Genuineness*
- *Empathy*, not sympathy

These qualities help clients feel valued for themselves. Clients treated in a genuine, non-judgemental and understanding manner will be able to understand themselves, liberate their resources, and manage their lives more effectively.

Participants write down the different skills they use. Participants write an example of a sentence they use. The assignment will be reviewed the next day.

LEARNING POINT

Everyone has different values. Counsellor attitude towards clients affects how they counsel. Counsellors may feel clients are difficult because they know little about them. Counsellors should learn as much as they can by talking to people from the clients' culture and acknowledge their own prejudices. If counsellors truly believe their clients are good and can solve their own problems, counsellors will be less likely to give advice or tell clients what they should do. Sometimes it can be hard to believe clients are good, if their lifestyles are different from the counsellors'.

CONTENT: HUMANISTIC APPROACHES

Key figure: Carl Rogers (1902–1987)

Basic philosophy and assumptions

Human beings are basically good. Humans have a natural self-actualizing tendency. Within therapy, the client experiences feelings that were denied or distorted and becomes self-aware, then self-actualizing. The client's potential is maximized and the client moves towards growth—awareness, spontaneity, trust in self and inner directedness.

Key concepts

Clients have the potential to gain insight in their issues and can resolve them. The therapist is not an expert and does not direct or interpret issues for the client. Mental health is viewed as a congruence of the ideal and the real self, and maladjustment is a discrepancy between the two. Focus is on the here-and-now and on experiencing and expressing feelings.

Therapeutic relationship

The relationship is the therapy. Important qualities for the therapist are genuineness, accurate empathy, non-possessive warmth and caring, and the ability to communicate these attitudes to the client. The client is able to transfer their learning to other relationships.

Techniques

Few techniques are used, as stress is on the therapist's attitude. The therapist uses self as an instrument. Basic techniques are empathy, genuineness and unconditional positive regard shown through active listening, reflection of feelings and being available for the client. No diagnostic testing, interpretation, history taking, probing or questioning are done or are minimal.

Benefits and limitations for trauma

- Using humanistic counselling theories enables the client to be the expert and to make decisions. Humanistic counselling empowers the client.
- In trauma counselling, although focused on the client, the counsellor leads the session to ensure all issues are covered, so it is not totally humanistic.
- Sometimes, it may be hard to believe clients are good and are striving towards self-fulfilment, if their lifestyle appears destructive.
- As with psychoanalytic theory, humanistic therapy may take a long time to achieve change.

DAY 3

SESSION 1

UNIT 8: CLINICAL EVALUATION AND MANAGING SEXUAL VIOLENCE SURVIVORS

Objective

By the end of unit 8, the participants should be able to

1. Describe clinical evaluation and managing sexual violence survivors and relevant medical and legal issues.
2. Link clinical care and counselling.

Key content

- Managing the physiological effects of sexual violence
- Points to remember during counselling
- Links between clinical care and counselling

Activity 1: Managing the physiological effects of sexual violence

Time: 60 minutes

Method

Refer to the chart on sexual violence effects, made in unit 3. The whole group reviews sexual violence effects, including STIs, HIV, hepatitis B, pregnancy, and internal and external injuries.

A clinician should lecture on

- Treating injuries
- Forensic examination, sample collection and analysis
- Documentation and examination protocols
- Emergency contraceptives
- Preventing and managing STI
- Preventing HIV
- Preventing hepatitis B

This session needs to be detailed enough for counsellors to know what information to provide clients, but it does not need to cover extensive clinical details.

Materials

Handout, given at the end of the session, *National guidelines on medical management of rape/sexual violence*.

Note: A clinician should facilitate this session.

Activity 2: Information the counsellor must remember to provide to the client

Time: 30 minutes

Method

The clinician or the facilitator discusses with participants the most important clinical information the client should have.

KEY POINTS

Counsellors must give clients certain information:

- Forensic examination and documentation is primary evidence in court and should be done for all survivors.
- Survivors should have a copy of their PRC 1 form.
- Emergency contraceptives reduce chances of conception by 75–89%, depending on the regimen.
- Post-exposure prophylaxis (PEP) should be taken within 72 hours.
- Emergency contraceptives should be taken within 120 hours.
- PEP does not prevent HIV, but it reduces chance of infection by 80%.
- The client must be told how PEP works, its side effects and doses.
- PEP should be given only to HIV-negative people.
- STI prophylaxis is not an emergency, but it should be given on the first visit to the clinic.

Activity 3: Links between clinical care and counselling

Time: 30 minutes

Method

Participants discuss the links between clinical care and counselling services. This can be done in groups or the whole group.

LEARNING POINTS

In addition to psychological trauma, counselling is required for issues directly related to clinical care:

- The necessity for examination and documentation that are often painful and embarrassing
- Concerns and options for pregnancy that may be not addressed by clinicians
- HIV testing
- Adhering to PEP because the PEP side effects and those of rape trauma syndrome interact

CONTENT: HIV PRE-TEST AND POST-TEST COUNSELLING

HIV pre-test and post-test counselling is necessary because HIV testing is a prerequisite for PEP.

- Pre-test counselling includes a sexual risk assessment for possible HIV infection before the sexual violence incident.
 - o This should be offered to the patient by a trained rape trauma counsellor.
 - o The counsellor refers the client to the laboratory for an HIV test.
- Post-test counselling includes delivering the results.
 - o The counsellor collects the results from the lab on behalf of the survivor.

CONTENT: PEP ADHERENCE COUNSELLING

The counsellor provides information on HIV post-exposure prophylaxis (PEP), the drugs and how they work. PEP efficacy is discussed. Possible sero-conversion is stressed and discussed with the survivor or guardian, including implications, even with PEP.

SESSION 2

UNIT 9: COUNSELLING SKILLS

Objectives

By the end of unit 9, the participants should be able to

1. Identify key skills required in counselling rape trauma survivors.
2. Demonstrate the skills.

Key content

- Establishing counselling skills
- Practising counselling skills

Activity 1: Establishing counselling skills

Time: 45 minutes

Method 1

Each participant writes on the flipchart counselling skills they know. The group goes through the list to establish whether all skills have been listed and whether they are counselling skills.

or

Method 2

The group briefly discusses and classifies counselling skills into two categories: support and challenging as per the following list. Discuss how these skills are applied, their merits, demerits, effectiveness in different situations and potential challenges.

| Supporting skills | Challenging skills |
|-------------------------------|--------------------|
| Paraphrasing | Questioning |
| Active listening | Self disclosure |
| Empathy | Confrontation |
| Physical attending | Immediacy |
| Structuring* | Advanced empathy |
| Reflection of feelings | Genuineness |
| Unconditional positive regard | Focusing |
| Summarizing* | Summarizing |
| Minimal prompts | Working silence |
| Working silence* | Structuring |

* can be both supporting and challenging

Using the identified skills, the facilitators choose which to concentrate on. The exercises develop skills. Each exercise should conclude with a group discussion, highlighting lessons learned and how it felt to apply the skill. The exercises may take time through to session 3. The facilitators will need to factor them in, depending on participant needs.

LEARNING POINTS

- Many skills are available and each counsellor needs to know which can be best applied to support clients.
- Support and attending skills are very important when counselling survivors and challenge skills should be avoided. (These are covered in depth in module 3.)

Activity 2: Active listening skills

Time: 15 minutes

Method

Ask participants to pair with the person next to them. Each person should talk for 3 minutes about anything, such as something recently done, experienced, enjoyed or interested in. The other person listens actively for 2 minutes, then stops listening actively for 1 minute. The facilitator signals the end of 2 minutes. Participants swap roles.

The whole group discusses

- How they recognized that they were being listened to
- How it felt to be listened to and not to be listened to
- How you showed you listened or did not listen

Showed listening

The person leaned forward, sat close, kept eye contact, nodded, smiled, stayed still, asked questions and stayed quiet.

Showed not listening

The person fidgeted, looked around the room, sat back, did not look at the speaker, stopped asking questions and looked bored.

LEARNING POINT

It feels great to be listened to and humiliating not to be listened to. Clients, just like counsellors, can tell from body language when they are being listened to and when not. This will influence the counselling session and support given to the client. Active listening is a key attending skill.

CONTENT: ACTIVE LISTENING

Active listening involves not just receiving sound, but, as much as possible, understanding its meaning. It uses receiver and sender skills to show you have understood (Jones 2000). It is listening to the words and content.

PURPOSE

- Active listening is essential for establishing rapport.
- Active listening improves the counsellor's understanding of the client.
- Active listening expresses compassion, which will help the client open up.
- Active listening establishes trust and can bridge differences between client and counsellor.

For counselling to flow, the counsellor must listen actively.

Activity 3: Mirroring

Time: 15 minutes

Method

The group offers brief suggestions on what mirroring entails.

LEARNING POINTS

Mirroring shows you have really listened carefully to all that the client is saying. Mirroring includes body language and words. It can feel embarrassing to have your body language repeated to you when you may not have been aware of it. It needs to be done sensitively.

Activity 4: Reflecting feelings

Time: 15 minutes

Method

The group offers brief suggestions on what reflecting feelings entails.

LEARNING POINT

Counsellors need to pick up the different feelings expressed by the clients. Clients may not say how they feel; counsellors need to pick out non-verbal cues. This makes clients realize you want to help them.

CONTENT: REFLECTING FEELINGS

Reflecting feelings may be viewed as feeling the flow of emotions with others and communicating it back to them. It offers expressive emotional companionship.

Purpose

- Reflecting feeling allows clients to listen more deeply to their own feelings.
- Reflecting feeling helps clients realize what they are really feeling.
- Reflecting feeling helps clients take responsibility for their feelings.

Reflecting feelings is a way counsellors can communicate empathy and help clients feel understood. Counsellors must be careful to pick up the actual feeling.

Activity 5: Vocabulary of feelings

Time: 15 minutes

Method

Read stories from newspaper cuttings on sexual violence to the participants. Ask each participant to write on visualization cards to describe their feelings, when the story was being read and at the end of the story. Stick the cards on the wall or a flipchart. Discuss the different descriptions for the same story and highlight the different words used for similar things, such as some people will use 'cross' when they are furious, others will use 'furious' for something minor.

LEARNING POINTS

Counsellors must have a range of language skills. Understanding contextual terms and nuances can be significant in counselling. Many people may feel inhibited using direct words on sexual violence from cultural limitations on what can be expressed and by whom. Counsellors must be sensitive in getting clients to avoid embarrassment in expressing themselves and talking about their experiences.

Activity 6: Summarizing

Time: 15 minutes

Method

Divide participants into two groups. For each group, ask one participant to be the facilitator and one to be the moderator. Each facilitator should sit and observe. Ask the participants to pick an issue (not necessarily related to counselling) and discuss it within their group for 7 minutes. The facilitators should summarize the discussions, 1 minute each, without repeating each other. The facilitators should provide feedback to the group on the exercise highlights, any significant issues left out in the summary and why they were significant. Facilitator attending skills should be mentioned.

The whole group briefly discusses what they learned from the exercise.

LEARNING POINTS

Summaries are brief statements bringing together the key points from a counselling session or a part of a counselling session. Summarizing can be done at any point during the counselling session.

- Summaries ensure that counsellors and clients understand each other correctly and can move the session forward.
- Summaries allow counsellors to reiterate issues picked up during the session that they did not have an opportunity to address when the client was giving the story.
- A summary can complement listening and attending skills, giving the client confidence that the counsellor has followed their explanations.

CONTENT: SUMMARIZING

Summarizing brings fragments into a whole. Statements were scattered in the session. The counsellor assembles them in a short form to find the client's main points.

Purpose

- Summarizing allows counsellors to monitor their listening and understanding.
- Summarizing allows clients to fill in details or add those overlooked.
- Summarizing helps focus attention on problematic areas.
- Summarizing helps clients select or order their issues.

A summary helps the client feel listened to and enhances the relationship. It is a reliable counselling tool. The summary must not change the client's meaning or exclude the main issues because the client may then close up.

Activity 7: Silence

Time: 20 minutes

Method

Divide participants into groups of three to act as client, counsellor and observer. The counselling session should last 12 minutes. Before the session, and to the side, instruct all participants who have been assigned the client role to fall silent after about 3 minutes of counselling and remain silent. After about 8 minutes, the facilitator will signal and the 'client' can resume talking. The observer provides feedback to the group.

The whole group discusses

- The feelings the counsellors had when their clients went silent.
- How the counsellors initially reacted to the silence.
- What the counsellor was thinking when the client was silent.
- How the counsellors conducted themselves through the silence.
- What the counsellors did to break the silence and why they chose that particular time to break the silence.

Discuss the necessity for silence and explore ways counsellors can deal with client silence in a supportive way.

LEARNING POINTS

- Observing silence is a necessary skill when dealing with trauma clients. Clients may not be ready to talk and this needs to be respected by counsellors.
- Silence requires attending skills, so clients know the counsellor empathizes and is not afraid of their silence.
- Counsellors should use silence as a skill to allow clients to think and enhance therapy.
- Counsellors need to know when and how to break a silence without making the client feel guilty for not communicating.

Note: The rest of session 2 should be spent practising support skills that challenged participants in this exercise. Silence and different attending skills require practice. The facilitators can pick out the skills. Each exercise

needs to be concluded with a group discussion, highlighting lessons learned and how it felt to apply the skill. The exercises below may take time into the next session and the facilitators should factor this in, depending on participant needs identified from the preceding exercises.

CONTENT: WORKING SILENCE

Working silence is communication with no words, but counsellor demeanour indicates that the counsellor is still with the client (Egan 1998).

Purpose

- Working silence allows clients to reflect and collect their thoughts.
- Working silence allows clients to communicate a strong feeling or emotion to themselves and the counsellor.
- Working silence allows the counsellor to reflect on the session and possible ways forward.

Counsellors must become comfortable with silence to allow clients deal with emotions or recollect thoughts. Counsellors must not fill the silence with questions or finish the client statements because it may be regarded as intrusive.

Activity 8: Practising counselling skills for rape trauma clients

Time: 45 minutes

Method 1

The facilitator reads to the class case studies or newspaper articles on sexual violence incidents. The facilitator asks participants to answer the following questions, assuming the survivor in each case is in the counselling room:

- What questions might you ask the client or person accompanying the client and why?
- What information would you offer the client and why?
- What skills would you use to explore client issues?
- What do you think may challenge you, as a counsellor, in this case?

The facilitator should allow participants to debate among themselves and provide only minimal guidance, preferably through prompts.

LEARNING POINTS

When supporting clients, the counsellor needs to be aware of the different scenarios and the reason they chose to follow up certain issues. This avoids curiosity questioning and allows support to the client.

or

Method 2

Participants use the following scenarios for role playing different counselling sessions. The participants form groups of three or four, depending on each role play. Participants should choose their roles. Each play should have an observer, a counsellor and a client. Participants employ the various counselling skills discussed. Role plays may include, but are not restricted to

- An adult (female or male) either alone or accompanied by the police
- An adult (female or male) accompanied by their partner, significant other or family member
- A child under 5 years, assaulted by a relative with whom they live
- A mentally retarded client brought in by a family member
- A commercial sex worker
- A teenager accompanied by the parent

After 10 minutes of role playing, the facilitator asks each group to discuss

- Which skills did the counsellor use?
- How were these skills used? Were they appropriate?
- What issues did the client present? How did the counsellor address them?
- What issues did the partner, significant other or family member present? How did the counsellor address them?
- Did the client feel helped by the counsellor?
- Were there any difficulties in applying certain skills?
- What could have been done differently? How?

Note: Each participant should provide feedback from their own point of view, identifying what was useful and good about the session and what could be improved, before discussing it with other group members.

Each group should present their discussions and answers to the whole group. The facilitators should pick key concerns and skills for further practice.

LEARNING POINT

Different clients will come into the counselling room with different trauma. Counsellors need to know how and when to apply different counselling skills for each case. Clients require flexibility in the skills used. Some are accompanied and feel threatened by the company; some cannot communicate effectively, such as people who cannot speak either Kiswahili or English well or who are deaf, dumb, or retarded.

SESSION 3

UNIT 10: SELF-AWARENESS AND PERSONAL DEVELOPMENT AROUND SEXUAL VIOLENCE

Objectives

By the end of unit 10, the participants should be able to

1. Reflect further on issues from participants' lives and sexual violence and begin to deal with them.
2. Practise counselling and personal therapy for participants, while exploring sexual violence concerns.

Key content

- Dealing with shared experiences on sexual violence
- Counselling and debriefing participants

Activity 1: Dealing with shared experiences on sexual violence

Time: 60 minutes

Method

Within the round, re-emphasizing support and confidentiality, participants volunteer their experiences of sexual violence, experiences of those close to them or those they have witnessed, including what was shared previously. Participants share their feelings about these experiences—at the time of the event, in retrospect and what they feel about sharing the experiences. At the end of sharing, participants highlight the lessons learned. Facilitators choose lessons and issues from the sharing to illustrate the need for participants to explore and address their issues around sexual violence and the concerns sexual violence survivors present.

Note: Some participants may be sexual violence survivors. Much support and bonding is required. Participants should feel their experience is important and that they can make use of it as a counsellor.

LEARNING POINTS

- Counsellors begin to explore and deal with their own issues around sexual violence to help clients deal with theirs and avoid transference with clients.
- Sexual violence is extremely traumatic to deal with and talk about. Clients may be unable to express themselves or to confide in the counsellor. This may sometimes leave the counsellor feeling they did not help the client. However, some clients may need time to be able to discuss their experiences.
- Clients may express feelings that differ with time and circumstance. The counsellor needs to address them because they reflect client issues.

Activity 2: Debriefing exercise

Time: 60 minutes

Method

Participants in groups of three take turns so each participant acts as counsellor, client or observer, providing support counselling to each other. Each participant should get at least 10 minutes of counselling. Each group should make a counselling contract; the issues should be real. The observer should take notes and provide feedback to the group at the end of each session.

The whole group should address participant feelings at the time; observations of the counselling, highlighting what the participant observers, counsellors and clients learned; and what counselling skills were used. These should be written on a flipchart.

LEARNING POINT

This exercise allows for debriefing. Participants in a smaller group may feel safer and able to discuss issues they are unable to discuss in the larger group. It sets the stage for discussing counselling skills.

DAY 4

SESSION 1

UNIT 11: RAPE TRAUMA COUNSELLING PROTOCOL

Objectives

By the end of unit 11, participants should be able to

1. Demonstrate familiarity with the counselling protocol.
2. Discuss the approaches when counselling different clients.

Key content

- General protocol
- Other protocols

Activity 1: General protocol

Time: 45 minutes

Method

The facilitator discusses the protocol contents. Participants must understand the protocol is just a guide; they should conduct each session according to client needs (annex 7).

Activity 2: Other protocols

Time: 60 minutes

Method

The facilitator discusses different client scenarios, such as not all clients will be unaccompanied and not all on PEP will stay HIV negative. In groups, participants discuss how they would handle the following clients:

- A client accompanied by a parent, guardian or friend
- A child brought to the centre by a school teacher or stranger
- A client who turns HIV positive at baseline
- A client who comes for counselling several days, months, or years after the assault

Counsellors need to think about their own issues before attending a client and prepare the client for the test results.

LEARNING POINT

Since traumatic reactions cannot be generalized for all clients, and not all clients will come alone after being assaulted, participants should know which protocol to use.

Activity 3: Accompanied clients

Time: 30 minutes

Method

The whole class offers short suggestions on how they would handle clients accompanied by parents, guardians, relatives and friends to the session. The clients may be underage, traumatized, mentally retarded, or want to have that particular person in the counselling session.

In groups, participants practise how they would handle accompanied clients. This can also be done as an assignment.

LEARNING POINT

Clients may wish that another person, besides the counsellor, attends the session. While some clients are accompanied to the counselling centre, it does not imply they want that person to attend the session too. From the start, the counsellor must establish what the client wants and, in cases where the third party has to attend the session, the counsellor will need to find a way to establish a relationship with the survivor with the other party present.

SESSION 2

UNIT 12: HIV COUNSELLING

Objectives

By the end of unit 12, the participants should be able to

1. Provide information and skills on counselling for HIV in rape cases.
2. Establish the purpose of trauma counselling.
3. Practise counselling skills for effective and efficient services to sexual violence survivors.

Key content

- HIV and rape
- HIV test preparation
- Practising counselling skills

Activity 1: HIV and rape

Time: 30 minutes

Method

The facilitator guides participants in establishing the relationship between HIV and rape, including the risk of transmitting HIV.

In groups, participants discuss

- Factors that increase risk of HIV infection in rape and sexual violence
- The importance of an HIV baseline test
- Preventing HIV with PEP
- PEP action
- PEP side effects

LEARNING POINT

Tears and force during rape infect the victim with HIV. However, not all survivors will sero-convert. The counsellor must know the facts and explain them to clients. The counsellor must discuss PEP with each client and how it works.

CONTENT: RAPE AND HIV: KENYAN SOCIAL AND MEDICAL PERSPECTIVES

- 7% of Kenyan adults are infected with HIV.
- Over half the women in their 30s have experienced violence after age 15.
- About 1.1 million adults, aged 15-49, are HIV infected.
- Nearly two-thirds of the infected are women.
- A preliminary analysis of studies sponsored by UNAIDS and its partners shows in western Kenya, nearly one girl in four (1:3 or 1/4), aged 15-19, already lives with HIV, compared with one boy in 25 (1:24 or 1/25).
- Rape and forced sex carries a higher HIV risk because condoms are rarely used and forced intercourse can damage the delicate vaginal lining, making it easier for the virus or other microbes to enter the girl's body.
- In Kenya, 24% of women, ages 15-24, are infected compared with 4% of men in the same age group. Sexual coercion is one main reason for these high numbers (KDHS 2003).
- More than 2800 rapes were reported to police in 2004—almost 500 more than the previous year.
- The Kenya Ministry of Planning in 2003, revealed that at least half of all Kenyan women had experienced violence after age 15, with close family members among the perpetrators.
- The Gender Violence Recovery Centre, Nairobi, treats up to 15 rape and domestic violence survivors every day.
- In 2004, the Kenya media most frequently reported 12-15-year-olds were survivors of sexual abuse.

- From media reporting in Kenya, 2004–2005, girls of any age, 0–18 years, may be vulnerable to sexual abuse.
- A 2001 population survey to explore the prevalence and patterns of sexual coercion among married and unmarried males and females, aged 10–24, in Nyeri, Kenya showed that
 - 21% of females and 11% of males had experienced coerced sex.
 - Most of the perpetrators were intimate partners, including boyfriends, girlfriends and husbands.
 - 5% of sexually experienced females reported having been physically forced into sex and 3% reported having been raped.
 - Only 23% of young women and 22% of young men who had been coerced told anyone about the experience.

Activity 2: HIV test preparation

Time: 30 minutes

Method

The groups discuss what to consider when preparing a sexual violence survivor for an HIV test. Participants need to understand the survivor is still traumatized and counsellors need to be sensitive, when introducing the client to an HIV test because

- The client may have never had an HIV test before.
- The client is still processing the whole ordeal.
- Clients fear the results, from past exposures and the stigma attached to HIV and rape.
- The client may not have disclosed the assault to the partner or family.
- The client may not really understand what an HIV test result means.

KEY POINT

The counsellor should know how to introduce an HIV test to the survivor, so the survivor will see the importance of having the test and give consent. Since the test will need to be done in the laboratory, so it can be documented, the counsellor needs to discuss shared confidentiality and the survivor giving consent for the test by signing the back of the lab request form.

LEARNING POINT

The test is needs to be conducted on the first day or within 3 days, so the client, depending on the baseline HIV test results, can be given PEP, which continues for 28 days.

UNIT 13: ADVANCED COUNSELLING SKILLS

Objectives

By the end of unit 13, participants should be able to

1. Discuss advanced counselling skills.
2. Demonstrate the advanced skills that need to be applied cautiously while dealing with traumatized clients.

Method

Participants discuss skills classified as advanced, such as a challenging skill.

Activity 1: Introduction to focusing

Time: 15 minutes

Method

The facilitator explains that enabling clients to focus allows them to understand their issues at greater depth and to move from the general to the specific.

Examples

Client: I feel scared all the time.

Counsellor: What is it that scares you?

Client: I had a terrible weekend.

Counsellor: What happened this weekend?

Client: My life is in a mess.

Counsellor: What messed up your life?

CONTENT: FOCUSING

Focusing means redirecting clients when they drift away from the issue, asking them to order exactly what they want to tackle at that time.

Purpose

- Focusing helps the client be clear and it brings out priority issues.
- Focusing provides direction to the session.
- Focusing facilitates effective use of time.

Clients may come in with jumbled issues. It is possible to spend a lot of time 'going in circles' or 'beating about the bush'. An effective counsellor needs focusing skill to redirect clients and help them set priorities.

Focusing helps clients move from the past to the present, from others to self, from facts to feelings and from general to specific.

Activity 2: Questioning

Time: 10 minutes

Method

The facilitator explains questioning is a skill to help counsellors and clients explore and understand the issues discussed more fully.

KEY POINT

Questioning, probing and prompting have the same objective—to help clients name, notice, explore, clarify or further define issues. There are many types of questions. Open-ended questions are commonly used in counselling.

- *Open-ended question.* An open-ended question gives clients considerable choice in how to respond and aims to lead the discussion, often using 'how', 'what', and 'when'.
- *Closed-ended question.* A closed-ended question restricts choice and leads to a single-word or yes or no answer.
- *Leading question.* A leading question makes assumptions and leads to yes or no answers.
- *'Why' question.* A why question often sounds interrogative and tends to put people on the defensive.
- *Checking question.* A checking question verifies your understanding of client statements and checks whether the client understands what you have said.

Note: Questions should not simply satisfy the counsellor's curiosity.

Activity 3: Using questions

Time: 10 minutes

Method

The participants form pairs. For 3 to 4 minutes they

- Talk to each other asking only 'leading questions', such as 'So it made you feel bad?'
- Compile a list of open questions that encourage a client to go on talking, such as 'Could you say some more about that?'

Then the pairs write questions a counsellor might ask a client who was raped.

Activity 4: Experiencing 'why' questions

Time: 15 minutes

Method

The participants form pairs, A and B.

A asks B a 'why' question about something he wears or did, such as 'Why did you go to his house?' B replies. A continues asking the same question for a minute and B replies, each time giving a different answer. The participants switch roles. Discuss feelings and reasons behind 'why' questions and whether they were helpful.

LEARNING POINT

Questions are important in counselling. They can be helpful or not. Be aware of how the questions are asked. Do not ask simply out of curiosity. 'Why' questions can be heard as criticism.

CONTENT: QUESTIONING

Questioning is the skill of encouraging, prompting and helping clients explore their concerns, when they do not do it spontaneously. It is a verbal tactic to help clients to talk more about themselves, their concerns and their feelings (Egan 1998).

Purpose

- Questioning allows counselling to clarify information.
- Questioning identifies the client's real issue.
- Questioning helps break down problems into components.
- Questioning allows the counsellor to lead the client into deeper exploration of self.

Questioning is a useful skill, but it must not be over used. It can turn the session into an interrogation. The counsellor should always use open-ended questions.

Activity 5: Challenging

Time: 10 minutes

Method

The facilitator gives a mini-lecture introducing challenging skills and asks for examples.

Challenging skills help a client examine belief or behaviour that seems to be self-defeating or harmful. In trauma counselling, challenging skill can be used when the client's story is not consistent. The counsellor will need to challenge the story to get the right information from the client.

It can be useful to challenge

- Mixed messages, such as discrepancies between vocal and body messages, words and actions and past and present statements
- Clients focusing on other people, not themselves
- When there seems to be a lack of reality
- When the client is not acknowledging choice

Example

Counsellor to client:

- 'You say you are fine, yet your tone of voice is sad.'
- 'You say you fear HIV, yet you are not willing to adhere to or use PEP.'

The whole group discusses the benefits and disadvantages of challenging.

LEARNING POINT

By challenging, the counsellor can understand the client better. It might appear the counsellor does not believe the client and seems judgmental; therefore, challenging needs to be done very carefully.

CONTENT: CHALLENGING SKILLS

SELF-DISCLOSURE

'Self- disclosure' is when a counsellor shares something personal for the benefit of the client to manifest solidarity in the human struggle with human difficulties

Purpose

Self-disclosure is as a form of modelling.

- Self-disclosure helps clients know they are not alone and gives them the confidence to tackle the issue.
- Self-disclosure expresses genuineness to clients, enhancing the counselling relationship.

Counsellors who are authentic, understanding and respectful add much to their approachability when disclosing something personal. The disclosure must be appropriate and beneficial to the client.

CONFRONTATION

'Confrontation' means challenging clients to develop a new perspective and to change internal and external behaviour, even when they are reluctant and resistant to do so (Egan 1998).

Purpose

- Confrontation helps the counsellor make the case for the client to live more effectively.
- Confrontation helps the client understand what it means not to change and look at the consequences of not changing maladaptive behaviour.
- Confrontation leads to effective counselling and conclusion.

For counselling to be effective there must be a conclusion. Behaviour change is a goal. Confrontation is valuable, when necessary, to achieve this goal.

IMMEDIACY

'Immediacy' is direct mutual talk. It is the counsellor's ability to discuss the counsellor's relationship with the client in the here and now (Egan 1998). There are three immediacies:

- Immediacy that focuses on the overall relationship, 'How are you and I doing?'
- Immediacy that focuses on a particular event in a session, 'What is going on between us right now?'
- Immediacy that focuses on self-involving statements.

Purpose

- Immediacy gives direction to a directionless session.
- Immediacy helps release tension between counsellor and client.
- Immediacy is useful when a diversity of issues become distracting and get in the way.

Immediacy helps ensure counter-dependency does not block the helping relationship. Immediacy should be used sparingly, only when absolutely necessary. It is an essential skill for every counsellor because counselling relationships sometimes lose direction and can easily degenerate to other relationships, such as a client becoming dependent on the counsellor.

Activity 6: The assignment given yesterday evening

Time: 60 minutes

Method 1

In groups of three, participants share the examples they wrote.

or

Method 2

In groups of three the participants take up roles of a counsellor, client and observer and ask each other the written questions. Then they discuss how they felt as clients.

LEARNING POINT

Participants need to have an idea how the various skills can be used and know how to apply a skill in trauma counselling.

DAY 5

SESSION 1

UNIT 14: SELF-AWARENESS AND PERSONAL DEVELOPMENT WHEN DEALING WITH CHILDHOOD AND THE PAST

Objective

By the end of unit 14, participants should be able to

1. Establish a relationship between their past experiences and their present ones.

Method

This exercise starts with individual work, then goes into pairs; it is followed by group discussion.

Showing an example, the facilitator asks the participants to each take a sheet of A4 paper and draw a large 'S' that covers the whole sheet. The beginning of the 'S', at the bottom, represents birth; the end, at the top, represents the 12th birthday. Participants spend 5 minutes marking all the events they can remember during that time in their lives. Then participants, in pairs, share their findings. Each participant gets 7 minutes. During sharing they should answer the following questions:

- What happened at that time?
- What is it that makes you remember it?
- What did it mean for you at the time? What does it mean now?
- Where were the adults in these occurrences? How did that affect you?
- How do you think this influenced you?

The whole group discusses what they felt about the exercise and why. In the discussions consider the following questions:

- Was it easy to remember? Why?
- Did you learn anything about yourself?
- How do you think our childhood influences our present?

LEARNING POINT

The present is influenced by events in the past. Often, the most painful occurrences are easiest to remember. Just the same way, clients require support to process sexual violence, especially when they often do not understand what has happened to them. Counsellor childhood experiences have the potential to influence counselling sessions. Counsellors should be aware of them when counselling adults and children.

SESSION 2**UNIT 15: CHILD COUNSELLING****Objectives**

By the end of unit 15, participants should be able to

1. Define 'children' and provide guidance for counsellors on how to deal with children.
2. State the phases of child sexual abuse.
3. Draw distinctions between child and adult counselling.
4. Describe the skills, techniques and approaches to counsel children alone or accompanied by parents or guardians.

Note: 'Children' are those about 12 or fewer years of age.

Key content

- Understanding
- Phases of child sexual abuse
- Differences between child and adult counselling
- Type of skill required when counselling children

Activity 1: Understanding

Time: 15 minutes

Method

The facilitator asks participants to remember, when they were 5–12 years, two adults in their life; one was someone they liked and one was someone they did not like. Participants list the qualities each had and reasons why they liked or did not like them. The whole group discusses these qualities, how they influenced the relationship with that person and how they influenced participant lives. Participants tell what they feel about the same people today.

The facilitator asks participants to think of someone they talked to or confided in when they were young. Participants discuss the reasons for confiding in that person and what the person told them.

LEARNING POINT

Understand how people in different circumstances relate to adults.
Understand how to build relationships with child clients.

Activity 2: Phases of child sexual abuse

Time: 20 minutes

Method

The trainers should explain the different phases of child sexual abuse and their signs.

LEARNING POINT

Most children are violated by people they know.

CONTENT: PHASES OF CHILD SEXUAL ABUSE

Child sexual abuse over an extended time typically involves five phases:

- 1) The **engagement phase** is usually subtle and non-violent. The child is usually enticed and coerced by gifts, preferential treatment, money or affection by the perpetrator.
- 2) The **secrecy phase** is usually a continuation of the physical contact and mental coercion begun in the first phase. A perpetrator will also test a child's ability to keep 'little secrets' before demanding secrecy for sexual contact or conduct. The child is made to feel guilty and ashamed, and is reminded of their participation to help seal the silence.
- 3) The **coercion phase** is characterized by increased pressure on the child to keep the abuse secret. At this stage, advanced sexual contact and threats of violence are often made. The perpetrator may also tell lies to a child, alleging that telling about the abuse can only lead to negative consequences.
- 4) The **disclosure phase** is when the child either tells someone about the abuse or the abuse is discovered. Many years may elapse between the third and fourth phases.
- 5) The **validation phase** affirms the child's feelings about the abuse. During this phase, it is vital that the child is believed and the responsibility for the assault be placed firmly and solely on the assailant. Rape is never the victim's fault. Also, every effort must be made to protect the child from further abuse and retaliation for telling.

Recovery from sexual violence

The sexual assault of a child by a stranger may be an isolated incident. With stranger assaults, the child survivor may not have to deal with trust and safety within the family. A child's recovery from assault by a stranger can be more rapid than an attack by a caretaker or a relative. The speed and success of the child survivor's recovery depends largely upon the degree to which four factors played a role in the assault.

1) Degree of intimacy and acquaintance between the survivor and the assailant

Contrary to popular myth, rapists are generally not strangers lurking in the bushes. Most child sexual assaults involve perpetrators known to the survivor, such as a caregiver or a family acquaintance. Most incest involves a father and a daughter. The entire family is often dysfunctional in incest cases.

Assault by a relative or caretaker involves more trauma to the child survivor because the child's trust has been betrayed and the sense of safety within the family is disrupted. The child may also feel betrayed by other family members, such as the mother and siblings, who they feel could or should have intervened, but chose not to.

2) The time over which the abuse occurs

Long-term, repeated abuse, characteristic of incest, is more traumatic to the child survivor than a single assault, characteristic of stranger assault, because long-term abuse may involve extreme psychological pressure, causing confusion and guilt in the child. A child is more likely to report a one-time event to parents or other caregivers, who may help the child understand what happened.

3) The relative intrusiveness of the abuse

Generally incest involves abusive contact progressing from lesser, though still traumatic contact, such as sexual talk, showing pornography, and unwanted affection or contact, to more intrusive and penetrative abuse. The more intrusive the contact, such as penetration, oral sex and genital fondling, the more traumatic it can be for child survivors.

4) The way the child was engaged in 'sexual' activity

Although physical violence will exacerbate the assault trauma for the child, a child survivor who was tricked into sexual activity may have more difficulty recovering from the assault. As with adult survivors who were not physically harmed, others may not believe an emotionally overpowered child survivor as readily and may feel the child could have done something to stop or prevent the abuse.

Activity 3: Differences between child and adult counselling

Time: 40 minutes

Method

The facilitator divides participants into groups of four and provides them with the case study 'Grace was raped last night'. The groups read the study and answer the questions at the end.

The groups present their answers to the whole group. The whole group discusses the responses. The facilitators should highlight

- Counselling issues for guardians and parents
- Skills needed to counsel and why to use them
- Differences between child and adult counselling

Materials

Case study 'Grace was raped last night' (annex 8)

LEARNING POINTS

Different skills need to be applied when counselling children than when counselling adults because the traumatic effects differ. Children will not always communicate directly and require patience and understanding. Counsellors need to learn body language and use it. Trust has to be built between the counsellor and the child for the child to open up.

Counsellors need to know their own limitations, especially when counselling a child, because it can invoke high emotions. Where necessary, counsellors should refer child clients to where they can get more psychological support.

CONTENT: COUNSELLING CHILDREN

- The basic principles of counselling children are the same as for adults.
- Counselling may be provided to children individually or as part of family counselling.
- Counselling a child requires establishing a relationship between the child and the counsellor, called 'joining'. The methods depend on the age of the child.
- Counselling children requires skill in talking and listening to them.
- Many tools can be used to help communicate with children, including drawing, telling stories, play and drama.

Principles of counselling children

Counselling aims to help people cope better with situations they face. Counsellors help children cope with their emotions and feelings and help them make positive decisions. Doing this involves

- Establishing a relationship with the child
- Helping the child tell the story
- Listening carefully
- Providing correct information
- Helping the child make informed decisions
- Helping the child recognize and build on strengths
- Helping the child develop a positive attitude towards life

It does not involve

- Making decisions for the child
- Judging, interrogating, blaming, preaching, lecturing or arguing
- Making promises that cannot be kept
- Imposing beliefs on a child

Types of counselling for children

- 'One-to-one counselling' may be individually provided to children and young people.
- 'Group counselling' may also be provided to a child as part of family counselling.

Counselling skills required in child counselling

If adults wish to counsel a child, they first need to establish a relationship with the child, called 'joining'. The methods depend on the age of the child and are very different from methods used with adults. For example, for a child under five years, the counsellor may get on the floor to play a game the child likes. Talking with and listening to children and young people requires special skills and approaches and may use telling stories, drawing, drama and games.

Other issues

Adults counselling children and young people need to be aware of their own feelings towards issues that might come up. They should be aware of their own beliefs on culture, tradition, religion and gender. They should avoid imposing these on the child. They also must know the rules regarding confidentiality. These should be made clear to the child in a way appropriate for their age. In many cases, counselling may reveal issues that require action. The counsellor may need to act on behalf of the child on some issues, a form of *local advocacy*.

Activity 4: Type of skill required

Time: 30 minutes

Method

The whole group offers short suggestions on the skills to be used with child survivors. Then in groups, participants discuss and share their feelings on the case studies and what they would do as counsellors.

Note: Refer to the protocols (annex 7).

LEARNING POINT

Most counselling skills can be used, with sensitivity. The counsellor needs to be patient and understanding when handling children.

CONTENT: EFFECTIVE COUNSELLING FOR AN ABUSED CHILD

Table 1. Effective counselling for an abused child

| DO'S | DON'TS |
|---|---|
| Believe the child | Do not ask accusing questions |
| Create a rapport with the child | Do not be overly informal |
| Show a measure of trust | Do not be judgemental |
| Let the child relate to you as a fellow human being | Do not be impersonal, but do keep a professional distance |
| Show some accessibility and reliability | Do not miss appointments, read or talk on the phone when the child is talking to you |
| Assure the child reasonable confidentiality | Do not give information about the child unless professionally required |
| Be realistic and explain what is likely to happen | Do not assure the child about matters that you cannot control |
| Exhibit professionalism | Do not be too personal with the child and do not create dependency by personalizing the relationship |
| Ensure privacy is obtained so the child can talk in confidence | Do not interview in an open space, likely to have interruptions |
| Agree at the onset the time it will take | Do not appear to be in a hurry |
| Keep proper physical space | Do not take personal liberties, such as hugs and pecks, especially if you are of the opposite sex |
| Be sensitive to any reactions from the child | Do not react negatively to any negative reaction of the child |
| Empathize | Do not sympathize |
| Maintain a lifeline with the child by assuring the child can always come back | Do not feel frustrated that the child does not open up |
| Be in control of your emotions | Do not break down |
| Be patient: let the child go at their own pace, listen carefully and patiently and with understanding | Do not pressure the child to speak nor rush the child |
| Be wise, warm and sensitive | Do not keep interrupting |
| Evaluate your own thoughts and behaviour | Do not project or transpose personal experience |
| Accept the child as she or he is | Do not be judgemental |
| Be impartial and objective | Do not mislead |
| Be knowledgeable | Do not be ignorant on how to relate with others; lack of understanding of child behaviour will not help |
| Create a relaxed atmosphere | Do not go to a room from which the child wants to leave as soon as possible |

| DO'S | DON'TS |
|--|--|
| Show commitment | Do not offer assistance if you cannot be committed |
| Be real and know where your competence or assistance is no longer useful. This may be <ul style="list-style-type: none"> • with a case of insanity • when you have a personal clash • when you are closely related or are friends • when you are not making any headway • when the issue needs legal assistance, not counselling • when you are attracted to the client • if the person is suicidal | Do not make referral without the child's or guardian's consent |

Adapted from Odhiambo and Maganya, *Making Schools a Safe Horizon for Girls* (2004)

CONTENT: SEXUAL ASSAULT AND COUNSELLING CHILDREN

Although assailants abuse children for many of the same reasons they assault adults, the needs of the child survivor may often be different from those of the adult survivor.

With children or adolescent survivors, the counsellors should

- Assure survivors they are not to blame for the assault.
- Tell survivors they believe them.
- Tell survivors they are safe now and they did the right thing by telling.
- Assure survivors they did not deserve the assault and abuse, for example, by being out after curfew or going somewhere without permission.
- Address survivors' concerns and feelings of confusion, shame, fear, betrayal, and guilt.
- Communicate with the children in a way they can understand.
- Not force children to talk about their experiences when they are not ready.

Sexual assault and abuse of children can take varying forms. It can be perpetrated by individuals acquainted with the child, may occur over a short or a long time and may be accompanied by various physical violence.

Child survivors and parents

Child survivors will often be very concerned about their parents. They are extremely sensitive to their parents' emotions and may internalize some of the stress and anger the parent experiences. Especially in incest, children may be concerned about breaking up the family.

Assure child survivors that, whatever happens, they are not to blame. Do not promise, however, that their parents do not blame them for the assault. Although it may be difficult to accept, parents may blame children.

Child sexual violence victims are greatly affected by fear, confusion and stress and are overwhelmed by all that happens. Being the centre of a controversy can be a burdensome challenge, bringing unwanted attention, scrutiny and focus. As a result, some child victims may say they lied about an assault, in an attempt to stop the controversy or, in many cases, to protect the perpetrator from being prosecuted. Changing a position or story does not necessarily mean that a child was not a sexual violence victim.

The law requires all cases of child abuse, in any form, to be reported to the authorities. Unfortunately, the system often does not work on behalf of the victim. There is no guarantee that the child will be protected after reporting the incident to the proper authorities.

Parents may need a resolution, action or result pertaining to the sexual victimization of their child. As with any survivor of sexual violence, counsellors must focus on the needs and interests of the survivor first. For many child victims the legal system, for example, may only traumatize and victimize them more.

UNIT 16: SEXUAL VIOLENCE AND LEGISLATION

Objectives

By the end of unit 16, the participants should be able to

1. Discuss legislation on sexual violence.
2. Discuss interpretations and applications of legislation and requirements on sexual violence.
3. Discuss the information to give to clients to prepare them to deal with the criminal justice system.

Note: A legal resource person should do this session.

Key content

- Defining sexual violence, what the law says
- Roles and responsibilities of counsellors towards sexual violence survivors
- Practising counselling skills

Activity 1: Legislation defining sexual violence

Note: This session's method depends on the resource person. If possible, arrange to have a lawyer present this session to answer any questions that emerge in the discussions. Issues that need to be covered include

- The various definitions of diverse sexual violations in legal documents
- Gaps within the legal framework and current interpretations of legislation on sexual violence
- The implications of the gaps and legislation for caring for and rehabilitating the survivor and justice for the survivor, the system and society

Time: 90 minutes

Method

The facilitator picks a word or phrase, such as 'sexual violence' or 'rape'. The facilitator guides a discussion on how these words are understood and from the understandings gets additional legal words and discusses them. By the end of the session, all the legal words used should have been brought up and discussed. The legal definitions and contexts should be clarified, and the penalties for the offences stated. It is fundamental that the social and normal English interpretations of these words are discussed and differentiated from the legal meanings.

Participants form groups to

- Discuss litigation procedures for reporting, investigating, preserving evidence and prosecuting.
- Discuss the gaps in legislation and the implications or consequences these gaps have on care, rehabilitation and justice for survivors.

The whole group discusses the group work. The facilitator should clarify litigation processes in Kenya and highlight challenges, constraints and potential solutions. Implications of gaps in legislation should be discussed, with participants providing potential solutions they could use to support survivors or change the system.

LEARNING POINTS

The local meanings and understandings of sexual violence often vary from those in legislation. Health workers need to be aware of these differences and support survivors in their search for justice.

Legal gaps exist, so attaining justice for survivors may be difficult or virtually impossible. Counsellors need to prepare clients for these challenges. Counsellors need to understand how litigation works and to inform clients, including what to expect at police stations, what forms they will have to fill out, what are client rights and obligations. Counsellors need know certain sexual offences are not clearly stated or are excluded from the law, such as male rape and marital rape. Nevertheless, each survivor is entitled to receive comprehensive and quality post-rape care.

CONTENT: DEFINITION OF SEXUAL VIOLENCE

'Sexual violence' is 'any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic women's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim, in any setting including but not limited to home and work' (WHO 2002).

Sexual violence includes sexual contact by one person to another against their will. It may include forced penetration of the vagina or anus with a penis or other object; touching the perineum; oral sex by placing the mouth or tongue on a person's vagina, penis or anus; rubbing a penis, hand or other object against another person's perineum; and performing such acts with an animal. However, the law defines all these activities differently.

Key words***Carnal knowledge***

'Carnal knowledge' within legal discussions is a penile–vaginal penetration. While the anus and mouth are orifices that could also be penetrated by a penis, when these other orifices are mentioned, 'against the order of nature' is added in the law.

Against the order of nature

The law presumes sexual behaviour should be between adults of the opposite sex. Natural acts include only a penis and a vagina. Therefore when sexual activity, including penetration, is outside this assumption, it is regarded as unnatural and described as 'against the order of nature'. Consent is not considered.

Penetration

'Penetration' is the partial or complete insertion of the genital organs of a person into the genital organs of another person.

CONTENT: SEXUAL VIOLENCE TYPES

The following is quoted from The Sexual Offences Act, 2006

Section 3(1) rape

A person commits rape if

- a. He or she intentionally and unlawfully commits an act which causes penetration with his or her genital organs,
- b. The other person does not consent to the penetration, or
- c. The consent is obtained by force or by means of threats or intimidation of any kind.

Section 4 attempted rape

Any person who attempts to unlawfully and intentionally commit an act which causes penetration with his or her genital organs is guilty of attempted rape.

Section 5(1) sexual assault

Any person who unlawfully

- a. Penetrates the genital organs of another person with
 - i. Any part of the body of another or that person; or
 - ii. An object manipulated by another or that person except where such penetration is carried out for proper and professional hygienic or medical purposes;
- b. Manipulates any part of his or her body or the body of another person so as to cause penetration of the genital organ by any part of the other person's body, is guilty of an offence termed sexual assault.

Section 6 compelled or induced indecent acts

Any person, who intentionally and unlawfully compels, induces or causes another person to engage in an indecent act with

- a. The person compelling, inducing or causing the other person to engage in the act;
- b. A third person;
- c. That other person himself or herself; or

- d. An object, including any part of the body of an animal, in circumstances where that other person
 - i. Would otherwise not have committed or allowed the indecent act; or
 - ii. Is incapable in the law of appreciating the nature of an indecent act, is guilty of an offence.

Section 8(1) defilement

A person who commits an act which causes penetration with a child is guilty of an offence called defilement.

Section 8(2)

A person who commits an offence of defilement with a child aged 11 years or less shall upon conviction be sentenced to imprisonment for life.

Section 8(3)

A person who defiles a child between the age of 12 and 15 years is liable, upon conviction, to imprisonment for not less than 20 years.

Section 8(4)

A person who defiles a child between the age of 16 and 18 years is liable upon conviction to imprisonment for not less than 20 years.

Section 9(1) attempted defilement

A person who attempts to commit an act which would cause penetration with a child is guilty of an offence termed attempted defilement.

Section 12 promotion of sexual offences with a child

A person who

- a. Manufactures or distributes any article that promotes or is intended to promote a sexual offence with a child; or
- b. Who supplies or displays to a child any article which is intended to be used in the performance of a sexual act with the intention of encouraging or enabling that child to perform such sexual act is guilty of an offence.

Section 20(1) incest by male persons

Any person who commits an indecent act or an act which causes penetration with a female person who is to his knowledge his daughter, granddaughter, sister, mother, niece, aunt or grandmother is guilty of an offence termed incest.

Provided that, if it is alleged in the information or charge and proved that the female person is under the age of 18 years . . . it shall be immaterial that the act which causes penetration or the indecent act was obtained with the consent of the female person.

Section 21 incest by female persons

The provisions of section 20 shall apply *mutatis mutandis* with respect to any female person who commits an indecent act or an act which causes penetration with a male person who is to her knowledge her son, father, grandson, grandfather, brother, nephew or uncle.

Section 22 (1) test of relationship

In cases of the offence of incest, brother and sister includes half brother, half sister and adoptive brother and adoptive sister and a father includes a half father and an uncle of the first degree and a mother includes a half mother and an aunt of the first degree whether through lawful wedlock or not.

Section 22(2) in this Act

- a. 'uncle' means the brother of a person's parent and 'aunt' has a corresponding meaning;
- b. 'nephew' means the child of a person's brother or sister and 'niece' has a corresponding meaning;
- c. 'half brother' means a brother who shares only one parent with another;
- d. 'half-sister' means a sister who shares only one parent with another;
and
- e. 'adoptive brother' means brother who is related to another through adoption and 'adoptive sister' has a corresponding meaning.

Section 23(1) sexual harassment

Any person, who being in a position of authority, or holding a public office, who persistently makes any sexual advances or requests which he or she knows, or has reasonable grounds to know, are unwelcome, is guilty of the offence of sexual harassment.

Other types of sexual offences include

- Gang rape
- Indecent act with child or adult
- Child trafficking
- Child sex tourism
- Child prostitution
- Child pornography
- Exploitation of prostitution
- Trafficking for sexual exploitation
- Prostitution of persons with mental disabilities
- Sexual offences relating to position of authority and persons in position of trust
- Sexual relationships that predate position of authority or trust
- Deliberately transmitting HIV or any life-threatening sexually transmitted disease.
- Administering a substance with intent
- Cultural and religious offences
- Not disclosing conviction for sexual offences

CONTENT: SEXUAL OFFENCES ACT 2006—QUESTIONS, CONCERNS AND NOTES**No marital rape**

The clause on marital rape was deleted from the Sexual Offences Act, as the MPs argued that there was no way non-consensual intercourse could occur between loving spouses. The Act now states, 'This section shall not apply in respect to persons who are lawfully married to each other' [non-application to lawfully married persons]

Other concerns

1) Definition of 'indecent act' [Section 2, p. 29] reads

'any contact between the genital organs of a person, his or her breasts and buttocks with that of another person

'with that of' suggests contact limited to contact specifically between these body parts, that is, buttock to breast, buttock to genital, genital to breast, and does not include contact with a hand to buttock.

2) 'Penetration' had, in previous drafts, included oral penetration.

However, the definition [Section 2, p. 30] now reads

'insertion of the genital organs of a person into the genital organs of another person'

This definition, when cross-referenced with definition of 'sexual assault' [Section 5(1)(b)] creates a situation in which it appears that forced cunnilingus, an individual forced to perform oral sex on a woman, is criminalized but forced fellatio, an individual forced to perform oral sex on a man, is not.

3) Section 8 deals with 'defilement' defined as 'an act which causes penetration with a child' [8(1)]. This section stratifies offences, and thus sentences, by age, so an adult, aged 18 years and older, is liable to convictions of differing severity.

Age stratifications are as follows:

8(2) 11 years or fewer

8(3) 12–15 years

8(4) 16–18 years

'Attempted defilement' [Section 9(1)] and the *'offence of committing an indecent act'* [Section 11(1)] are not age stratified and both carry sentences of 10 years.

Questions

- What might this mean for an 18 year-old male who has sex with his 17-year-old girlfriend, and what if his girlfriend were 15?
- How may this section be applied to an 18-year-old girl who engages in non-penetrative sex acts with her 17-year-old boyfriend?

- With the median age of sexual debut at 17 years among Kenyan youth (KDHS 2003), how might this section affect youth programs and the perception of accessible services?

4) Section 12(b) reads

[a person who] *'supplies or displays to a child any article which is intended to be used in the performance of a sexual act with the intention of encouraging or enabling that child to perform such sexual act . . . is liable upon conviction to imprisonment for a term not less than five years'*

It is unclear exactly what 'article' is being described. One interpretation might be sex toys, such as dildos. Could this section also be applied to condoms? If so, how would this affect policy, such as the Adolescent Reproductive Health and Development Policy (2003) that advocates promoting and distributing condoms among youth?

Would sexually explicit, sex-positive IEC/BCC (information, education and communication / behaviour change and communication) materials for youth in Sections 12(a), 16(1)(a), 16(2)(a) and 16(3) be problematic?

- 5) Sections 20(1) and 21 deal with incest by male and female persons, but do not recognize same-gender incest; for instance, the offence of a male person defiling his daughter is recognized, but not a male person defiling his son.
- 6) Note Section 24(5); it now applies to abuse in the VCT room, although the time limit for which this is applicable, the statute of limitation, is not explicit.
- 7) For sexual minorities, the Act neither adds nor detracts from the existing legal situation. For example, the Act leaves Sections 162, 163 and 165 of the Penal Code intact, meaning that consensual sex between people of the same gender remains a crime. However, could Section 43(1) and 43(3) of the Sexual Offences Act be used to criminalize transgendered and intersex people?

Activity 2: Responsibilities of counsellors towards sexual violence survivors

Time: 30 minutes

Method

Participants discuss the following questions as a whole group in smaller groups:

- What is my role as a counsellor in supporting sexual violence survivors?
- What is my role in preparing the client for the criminal justice system?
- What information would I be required to give a client in any session?
- What is my responsibility in supporting the client in dealings with the justice system? With regard to providing information and confidentiality?

CONTENT: THE RAPE TRAUMA COUNSELLOR'S RESPONSIBILITY

1) Inform the client on health and legal services and their purpose.

- Establish that a PRC 1 was filled in.
- Establish that the client was given the 3-page original PRC 1 form.
- Ask whether the client was aware if the doctor filled out any other forms.

Discuss the examination, documentation and the purpose:

- Establishes crime and provides evidence
- Necessary for police investigation
- Necessary for court and litigation

Discuss the P3, ensuring the client knows the duplicate PRC 1 will be attached to the P3 form. The client must keep the PRC 1 in its original form.

Note: If the client is being abused within the homestead, discuss the fact that the PRC 1 form may get 'lost'.

Discuss disclosing the rape and whom the client can rely on for support.

2) Inform the client on preventive therapy

Note: PEP and emergency contraceptives should only be discussed with clients who come to the clinic within 72 hours, unless the client asks about them.

HIV, STIs and pregnancy

- Establish client's understanding of transmitting HIV and STI and pregnancy

Discuss preventing HIV

- Risk of HIV infection
- PEP 80% effective
- PEP initiation within 72 hours and client HIV negative
- Dose and duration of PEP
- Side effects common and mild, rarely severe
- Immediate HIV test implications

Discuss preventing STIs

- Preventing combination of STIs
- Client must know screening may be required

Discuss preventing pregnancy

- Dosage, side effects and effectiveness of emergency contraceptives
- Discuss options of pregnancy termination or child adoption

3) Inform the client on legal issues

Reporting and litigation

- Discuss whether client intends to report and the rationale
- Encourage reporting to the police, knowing it provides legal support, if the client might wish to report later. However, remember clients have their rights and can make informed decisions.

Discuss the reporting procedure

- Record in Occurrence Book
- Sign a written statement. Clients should sign only after they are completely satisfied that what is written represents them.
- Client may need writing support, especially if not very literate.
- Discuss client reporting concerns and issues.

- Refer clients appropriately, some to the officer, others to legal support groups

The client should expect:

- Cross-examination on many occasions by different people
- An identification parade, but can demand anonymity
- Their story to be challenged and disbelieved in the court
- The case to take some time, with many court visits

The rights and responsibilities of the client

- To be accompanied by an officer of chosen gender to the health facility
- To tell nothing but the truth.

Explore client concerns and issues regarding reporting. Refer the client appropriately, for instance, to legal support groups.

Activity 3: Practising counselling skills

Time: 90 minutes

Method

Participants in groups of three role play a counselling session using different scenarios:

- A teenager comes alone for counselling
- A perpetrator comes for counselling
- A perpetrator is accompanied by the police or the survivor's family
- A client sero-converts while on PEP or immediately after completing the dose
- A 3-year-old girl defiled by a 13 year-old boy are brought in together for counselling by their parents
- A difficult client who does not display any emotion or is mentally challenged

The whole class and the facilitator observe and give feedback during the last 30 minutes. Facilitators should support feedback sessions to enhance skill building.

LEARNING POINT

Trainers will use this session to assess counsellor skills. The whole class gives feedback to each other.

SESSION 3

UNIT 17: COUNSELLING PERPETRATORS

Objective

By the end of unit 17, the participants should be able to

1. Discuss managing sexual violence perpetrators as clients.

Key content

- Establishing attitude of participants towards perpetrators
- Counselling a sexual offender

Activity 1: Establishing attitude of participants towards perpetrators

Time: 20 minutes

Method 1

Participants offer brief descriptions on how they view sexual violence perpetrators.

or

Method 2

The facilitator writes '□□□□□' on a flipchart and asks participants to write anything that comes to mind about 'rapist' on the chart.

LEARNING POINT

Counsellor attitudes and perceptions are important. They can influence counselling positively or negatively.

Activity 2: How to counsel a perpetrator

Time: 45 minutes

Method

Participant pairs role play counselling scenarios:

- The perpetrator comes to the counselling centre
- The perpetrator is brought by the police, school teacher or relative
- The perpetrator accompanies the survivor

LEARNING POINTS

- Counsellors need to work through personal past experiences by seeking therapy.
- Counsellors must be aware of their attitudes, fears and thoughts regarding sexual violence.
- Counsellors need to be aware of their theoretical framework and offer core conditions, unconditional positive regard, empathy and genuineness to all clients.
- The perpetrator has a right to any service, before being condemned by the counsellor.

CONTENT: COUNSELLING A PERPETRATOR

Counsellors need to understand their own fears about how they would counsel a perpetrator. Each client has a right to quality counselling and access to preventive therapy, depending on when they come to the centre, usually after the assault. When the client is accompanied by police or a relative, the counsellor will need to let all of them know that everything discussed between the counsellor and client will be confidential. The counsellor is not under any obligation to disclose HIV or STI test results to

the police or any other person who brings the perpetrator to the counselling centre. Counsellors must realize this can be quite challenging, especially with maintaining confidentiality and with handling transference and how the client tells the counsellor the reason why they raped. The counsellor will have to provide this client with unconditional positive regard (UPR).

UNIT 18: STRESS MANAGEMENT

Objectives

By the end of unit 18, the participants should be able to

1. Define stress
2. Establish stress causes
3. Discuss different reactions to stress
4. Discuss skills, techniques and strategies for managing stress by counsellors and clients
5. Highlight challenges anticipated in module 2

Activity 1: Defining stress

Time: 10 minutes

Method

Participants offer suggestions to define stress and the facilitator gives them the correct definition.

LEARNING POINT

Stress is an emotional response to new or difficult situations. It is healthy and necessary. How people react to stress varies greatly. Some will find certain situations much more stressful than others. How people respond to stress also varies greatly.

Activity 2: Identifying the causes of stress

Time: 30 minutes

Method

In two groups, participants discuss stress.

- Group 1: The issues that can make one experience stress in counselling.
- Group 2: Reactions to stress, classified into behavioural, physical and emotional.

Activity 3: Common reactions to stress

Time: 45 minutes

Method

In three groups, participants discuss and list how people react to stress. Each group is given a category: behavioural, physical or emotional. Each group will share their findings with the whole group, where everyone will also give their suggestions.

Activity 4: How to manage stress

Time: 30 minutes

Method

The whole group discusses some ways they coped with stressful situations. The facilitator then guides them through the content on managing stress

LEARNING POINT

Each person experiences stressful times, but how stress is dealt with affects the person's life. This applies to counsellors too; they need to attend supervision sessions.

CONTENT: MANAGING STRESS**Stress**

‘Stress’ is a body response to either too much pressure or too little pressure.

**Causes**

Causes can be as diverse as the dynamics that surround daily life. They can be traumatic events, chronic difficulties or conflicts. Sources of stress for the counsellor can be

- Feelings of inadequacy
- Clients failing to open up during the session or keeping silent
- Transference
- A client sero-converting after PEP
- The counsellor controlling the session agenda rather than the client,
- Weak support systems for the client
- Self blame
- Dissatisfaction with the social systems

Reactions to stress*Physical reactions*

- Tiredness
- Palpitations
- Pain and tightness in the chest
- Indigestion
- Breathlessness
- Nausea
- Rapid weight gain or loss
- Headaches
- Sweating
- Trembling
- Vomiting

Emotional reactions

- Amnesia
- Mood swings
- Anger
- Guilty
- Drained
- Helplessness
- Hopelessness
- Loss of confidence
- Lack of self esteem
- Withdrawal
- Self-blame
- Nervousness
- Depression
- Hallucinations
- Fear

Behavioural reactions

- Accident prone
- Poor work
- Increased irritability
- Increased consumption of alcohol and drugs
- Overeating or undereating
- Impaired speech
- Change in sleeping pattern
- Physically careless
- Change in lifestyle
- Forgetfulness

Chronic effects of stress

- Psychosomatic illness
- High blood pressure
- Depression
- Low self-esteem and loss of confidence

- Poor performance at work
- Accidents
- Marital breakdown and strained relationships

Skills, techniques and strategies for managing stress

- Change the situation
 - Add resources
 - Subtract from the task
 - Avoid the situation
- Accept the unsolvable or unchangeable
- Change the way we think
 - Stop negative self-talk
 - Start positive self-talk
 - Expect and allow for imperfections
 - Make allowances
- Know stress triggers
- Relaxation, such as taking holidays
- Physical exercise
- Manage time better

Activity 5: Challenges anticipated in module 2

Time: 20 minutes

Method

In groups and then in the whole group participants share anticipated challenges. Participants exchange challenges between groups. Different groups suggest possible ways to overcome the challenges.

WAY FORWARD AND EVALUATION

Key content

- Social mapping, a referral system
- How to write case studies
- Documentation
- Examination and evaluation
- Trainee follow-up

Activity 1: Social mapping

Time: 20 minutes

Method

From the assignment at the start of the course, the class should compile a list of agencies in their districts involved in providing post-rape care, to help them refer clients.

Activity 2: How to write case studies

Time: 30 minutes

Method

Since the participants will need to see five clients in the next eight weeks and write full case studies on three of them, one being a child, the facilitator will need to brief the class on the case study format. The facilitator will give each participant a guideline handout.

CONTENT: ETHICAL PRINCIPLES IN WRITING CASE STUDIES

Writing case studies has certain ethical principles:

1) Respect for the uniqueness of the person

No two people are alike; each case study should include individual client issues.

2) Confidentiality

- All client names should be changed to disguise the client's identity and should be written in the case preamble.
- Appropriate, respectful names and terms should be assigned; avoid 'rape victim' for a client who has been raped.
- Facility and agency names may or may not be disguised. If they are disguised, this should be stated in the preamble.

3) Respect for the dignity of persons

- The names selected should be culturally congruent and avoid any taint of ridicule.
- Clients are to be referred to by their disguised full name throughout the case reporting, unless some exception is introduced.
- The same disguised, names should be retained for all the subsequent sessions and case study write-ups.

4) Veracity

- Counsellors need to present a truthful account and accurate data.
- Very sensitive material that has no bearing on the case should be omitted.

Activity 3: Documentation

Method

The facilitator gives a short lecture on the necessary documentation and keeping it.

Participants need to know how to fill out and keep the following records:

- Client data forms
- PRC 1 and PRC 2 forms
- Counsellor self-assessment forms, so counsellors can evaluate themselves
- P3 form, a police form

PRC 1 form

PRC 1 is an examination documentation form to be filled out for sexual violence and rape survivors. It is used for clinical notes to guide filling in the P3 form. It is to be filled in triplicate:

- The white copy should be given to the survivor.
- The yellow copy is attached to the P3 form and given to the police, in case the survivor reported the incident to the police.
- The green copy is the hospital copy.

PRC 2 form

The PRC 2 form is used for managing survivors on PEP at the comprehensive care centre. It is to be filled in duplicate:

- The white copy should be given to the survivor after completing PEP.
- The green copy is the hospital copy.

LEARNING POINT

The counsellor should know what are the various records kept at the hospital, police or counselling room. Then they can prepare their clients for the examination and documentation and ensure that proper records are kept for each survivor, since this is a legal issue.

Activity 4: Examination and evaluation

Time: 30 minutes

Method

Participants take a written exam to test their knowledge. Then they will evaluate the entire module.

Note: Details of the marks are given in annex 2.

Activity 5: Trainee follow-up

Method

Participants prepare an action plan to be used during observed practice.

Note: The trainer needs to visit the participants in the field one week after the end of module 1 to observe their practice.

Successful participants will be given a congratulatory letter for completing module 1.



MODULE 2





MODULE 2 (8 WEEKS)

Module 2 is practical; the participants must see at least five clients, at least one a child, and write case studies of three of them. The case studies will contain details covered in client sessions:

- The counsellor will have at least five sessions with each client.
- Each session should be recorded, step by step, in a diary.
- The name of the client should be disguised for confidentiality.
- The real name of the institution should be given.
- The counsellor uses only real cases or studies to accurately reflect the complexity and variability of real practice.

Conclusion

At the end of one month the participants have the completed case studies delivered to the facilitator, either personally or through the mail, for evaluation. The participants should be reminded to come with their diary during module 3. Each participant is expected to see at least five clients before proceeding with module 3 and being certified as a rape trauma counsellor.

CONTENT: FRAMEWORK FOR A CASE STUDY

Identification

- All clients names should be changed to disguise their identity .
- The client's, gender, age group or life stage should be stated.
- Counsellor's first impressions of client's physical appearance

Antecedents

- How the client came to see or contact the counsellor, for example, self-referred
- Site, such as agency, private practice, hospital or clinic
- Pre-contact information, such as what the counsellor knew about the client and implications

Problem and contract

- Summary of the client's problem
- Counsellor initial assessment, problem duration, precipitating factors or why client came to the counsellor, current conflicts or issues
- Contract includes session frequency, length and number and initial plan

Focus on content

- Client account of problem
 - o Relationships, including significant people, family and friends
 - o Identity, including self-concept, feeling and attitude about self
- Additional related or explanatory elements might include client's past or early experiences; strengths and resources; beliefs and values; hopes, fears and fantasies and possible implications of cultural, economic, social political systems.
- Define problem
 - o The client's view of the present scenario
 - o What scenario the client would prefer, what the client would like to happen, how the client would like things to be
- Assess and reformulate, how the counsellor accounts for and explains the problem
 - o Patterns, strands, themes, connections
 - o Importance of exploring patterns, strands, themes, connections, hunches and new perspectives
 - o Other important elements to explore
 - o Any silent hypotheses, blind spots, underlying issues or past problems
- Counselling plan
 - o The focus for future work, its possibilities and agenda
 - o The criteria for change, theoretical frameworks and assumptions
 - o Review and formulate plan

Focus on process

- Strategies and interventions
 - o Strategies and interventions used

- o Goal
- o The effect on the client
- o Alternative options
- Relationship
 - o Describe what happened between the counsellor and the client, reframe the relationship, try a metaphor

What happened within the client, such as transference

- o What happened within the counsellor, such as counter-transference
- o Changes within the developing relationship
- o Evaluation of the 'working alliance'
- Evaluation
 - o Review process
 - o Alternative tasks, strategies and ways of implementing counselling plan

Note: Participants should use the observed practice checklist (annex 9).





MODULE 3





INTRODUCTION

The same trainers in module 1 should participate in module 3 because

- They will give feedback to participants on the case studies submitted during module 2.
- The bond created during module 1 needs to be maintained.
- They will maintain continuity.

However, external experts could be invited to cover certain topics.

DAY 1

SESSION 1

INTRODUCTION AND CLIMATE SETTING

Objectives

To enable participants to

1. Remember and bond with each other.
2. Express expectations.
3. Understand the session objectives.
4. Create norms to facilitate bonding and free learning.

Time: 90 minutes

Key content

- Introduction and remembering names
- Getting participant expectations
- Establishing group norms
- Disseminating course objectives

Notes to remember

- An atmosphere should be created for the participants to share their expectations for module 3.

- Give ample time for each participant to share expectations because some may stem from challenges in the field on issues not covered in module 1.

Activity 1: Introduction and remembering names

The facilitators welcome the participants back. Participants remind each other of their names and where they are from. This can be done with various interactive exercises, such as the following:

Method 1

Fall off the cliff game

Participants line up between two borders, either floor lines or ropes, and assume they are standing on a cliff. They are told to arrange themselves according to alphabetical name order. To do so, they must manoeuvre around each other without falling off the cliff (going outside the straight lines). This should be done in silence, so participants do not remind each other of their names. Afterwards, participants say their names to see whether everyone got in the right place.

Method 2

Get to know me!

In groups of three from three different regions or institutions, so no group has participants from the same place, participants move around the class and introduce themselves. Participants then introduce themselves and say something that none in the group their small groups knows about them. When back in the main group, each participant introduces someone in their small group.

Activity 2: Getting participant expectations

Participants express their expectations for this module, through paired discussion, a panel presentation, in a round, or participants write down expectations on a flipchart or visualization cards. While participants discuss their expectations, the facilitator writes them on a flipchart.

The suggestions should remain up throughout the course to ensure the expectations are met.

Activity 3: Establishing group norms

The participants come up with standards to govern the one-week training. The trainer should not impose any norm on the group but should ensure that confidentiality, punctuality and respect are in the ground rules.

Activity 4: Disseminating the course objectives

The facilitators will disseminate the course objectives, to prepare participants for the rest of the course, and harmonize the objectives with participant expectations. The facilitator can address expectations that could be overlooked because they are not outlined in the course.

UNIT 1: CONCERNS FROM MODULES 1 AND 2

Objectives

By end of unit 1, the participant should be able to

1. Use the protocols well.
2. Review medical and legal issues regarding health care services to sexual violence survivors, including counselling.

Key content

- Re-evaluate module 1
- Review the protocol
- Review medical and legal issues on counselling and other health care

Activity 1: Re-evaluate module 1

Time: 45 minutes

The facilitator may use either of the following methods:

Method 1

In groups of three, participants, if possible each from a different site, list topics covered in module 1 and discuss the definitions and their interpretation. Each group presents their definitions and interpretations. The whole group discusses some of the difficult issues.

Method 2

Participants tell the facilitator the terms they remember and define them. All participants get a chance to speak and ask questions.

SESSION 2

Activity 2: Review the protocol

Time: 45 minutes

Method 1

In small groups, participants list different counselling scenarios that they have had in their practice and discuss how they applied the protocols. Participants should discuss challenges in applying the protocol in one case. The facilitator should make sure the groups discuss different clients and challenges.

or

Method 2

The participants share how they handled a case and how they might handle the following scenarios:

- A child, younger than 8 years and HIV positive at baseline, is brought to the health facility by the parent
- A client sero-converts despite PEP
- An adult who had never considered going for an HIV test is HIV positive at baseline
- A client who is mentally retarded, deaf or dumb comes for counselling unaccompanied
- A 14-year-old is HIV positive at baseline
- A 8-year-old boy is sodomized by a close relative

During feedback, facilitators need to cover all issues participants raise.

LEARNING POINTS

- Counsellors must understand that clients and their counselling needs vary. Counsellors must know the protocols and use them with all cases. However, counsellors must be flexible when the protocol structure may not be useful.
- Counsellors must cover protocols addressing client issues and concerns; HIV test issues; HIV status and its implication; medical and legal issues in reporting, examination and HIV testing; supporting PEP adherence; and supporting clients, helping them understand their rights and seek redress through the justice system.

Activity 3: Review medical and legal issues for counselling and other health care services

Time: 6 hours

Method

Participants discuss whether they had any challenging medical and legal issues:

- Preparing clients to face the legal system
- Talking to survivors about reporting the assault to the police, even when the survivor saw no need for it
- Handling clients who came late for PEP because they spent too much time at the police station

LEARNING POINT

Counsellors should briefly give clients information about the legal issues involved in sexual violence. Clients need to have an idea how the legal system works, the challenges clients face when reporting the assault at the police station, and the time it takes before the perpetrator is brought to justice. The client may need to come to counselling several times because every court appearance rekindles memories.

SESSION 3**UNIT 2: SHARING EXPERIENCE****Objectives**

By the end of unit 2, participants should be able to

1. Review and reflect on module 2.
2. Share experiences and learn from each other, while identifying areas of strengths, weaknesses, opportunities and threats.

Key content

- Establish participant strengths, weaknesses, opportunities and threats faced
- Sharing and learning by participants

Activity 1: Review module 2 and share experiences

Time: 2 hours

Method 1

In a round, participants each give a brief answer to the following questions:

- From module 1, what was most useful during the practical counselling in module 2?

- What was most challenging in your practice?
- How practical was applying the protocol?

or

Method 2

For one hour participants share experiences in the field. Sharing should be on a voluntary basis, although participants should be made to understand that each person's experience is important and that sharing can help them become more effective and confident in handling clients at the end of this course. From these experiences, ask the group to list what went well. The group discusses them.

The next hour participants form groups, preferably with someone from each site or district to share the challenges encountered practising trauma counselling. These challenges should be written down. The facilitator and whole group discuss whether the challenges were personal or institutional or gaps. They will be addressed later in the week.

LEARNING POINTS

The participants should

- Reflect on their counselling and issues that emerged.
- Acknowledge their successes, what worked and what they achieved.
- Understand that the challenges, frustrations and successes apply to all counsellors and are part of the training.

DAY 2

SESSION 1

UNIT 3: SELF-AWARENESS, PERSONAL DEVELOPMENT, SEX AND SEXUALITY

Objectives

By the end of unit 3, participants should be able to

1. Freely share their personal experiences with the rest of the group.
2. Develop self-awareness on sexual issues to support survivors effectively.

Key content

- Self-awareness
- Linking gender and sexuality to sexual violence and counselling
- Defining quality sex encounter

Activity 1: Self-awareness

Time: 45 minutes

Method

In a round, participants share their sexual experiences and how they might have affected the counselling. Participants who are sexual violence survivors describe how they felt about their counselling at the time of occurrence and in retrospect.

Establish from the group:

- What their clients' experiences reminded them of and how it made them feel
- How they handled client issues
- How they dealt with transference and counter-transference
- Client issues that really affected them

LEARNING POINTS

- Client issues and experiences can bring out issues the counsellor has and might not remember.
- Counsellors need to constantly address their own sex and sexuality issues to appropriately deal with client issues.
- Counsellors must not expect clients to accomplish what the counsellors did not, because that will not support the client.
- Counsellors need to be aware of transference or counter-transference and their negative effects.
- Counsellors often think about how they could have counselled differently. Counsellors need to acknowledge these feelings and deal with them.

Activity 2: Linking gender and sexuality to sexual violence and counselling**Time: 60 minutes****Method 1**

Participants discuss and agree on the meanings, connections and relationships among sex, socialization, gender, and sexuality. Participants discuss the how gender identity affects counselling.

or**Method 2**

In groups of three or four, participants discuss and give examples to these questions:

- In what ways did your gender influence your perceptions of clients and counselling?
- In what ways did you experience gender bias when providing services to clients in hospitals, social services and police?

The whole group discusses questions and issues.

LEARNING POINTS

- Counsellors need to understand their values, beliefs and the influence of socialization and gender.
- Counsellors should understand how socialization and gender might influence counselling and client services.
- Counsellors should know how gender influences health care and care for sexual violence survivors.

Activity 3: Defining quality sexual encounter

Time: 30 minutes

Method

Participants form two groups. If there are almost the same number of men and women, they form separate groups. Participants define and describe, with details, their idea of good or quality sex, its workings, expression and outcome. Each small group then reports to the whole group.

LEARNING POINTS

Counsellors should become comfortable in discussing sex and sexual issues, and with personal sex expectations compared with reality. Counsellors may have to support clients to deal with rape and sex, but they should support clients towards appreciating sex as a good thing.

- Socialization influences sex expectations, expression and how counsellors can support clients deal with their feelings.
- Survivors have a right to good quality sex even when their experience of sex is otherwise. Counsellors must consider their own sex issues to support clients.

SESSION 2

UNIT 4: CHILD COUNSELLING

Objectives

By the end of unit 4, participants should be able to

1. Establish how counsellors handle sexually violated clients.
2. Discuss indicators of child sexual abuse.
3. Explain strategies for safety.

Activity 1: Personal development exercise

Time: 60 minutes

Method 1

Participants are asked to remember from when they were 5–12 years old, two adults, one they liked and one they did not like. They should share with someone, and list the qualities each had and the reasons why they were liked or not liked. The whole group discusses these qualities and how they influenced the relationship with that person and how the person influenced their lives. The participants discuss how they feel about the same people today.

or

Method 2

Participants pair with the immediate neighbour and each shares one positive and one negative childhood experience, who was responsible for it and how it affected the participant's life. Participants then voluntarily share their experiences with the whole group.

LEARNING POINTS

- Some clients will find it hard to open up to the counsellor during the first session because of socialization.
- Counsellors need to be patient and ensure the counselling room is child friendly.
- What happens in childhood shapes adulthood.
- Counsellors need to support the child survivor, so the survivor can return to normality.
- Counselling quality will determine how well a child recovers and copes with the trauma.

Activity 2: Exercise

Time: 30 minutes

Method

Participants write what they see in the 'face' handout.

LEARNING POINT

Handle each client as a unique person.

SESSION 3

Activity 3: Sharing experiences on child counselling

Time: 60 minutes

Method 1

In the groups, participants share some counselling experiences, considering

- What went well during child counselling
- The challenges faced

or

Method 2

Participants give a scenario of a child survivor they saw and they establish

- The child's age
- Whether they separated the child from the parent or guardian and how they did it
- How they passed on information, including test results, to the child or parent and guardian
- How the session was different from others

Activity 4: Challenges faced

Time: 45 minutes

Method

In a round, the participants share the challenges they faced. Each person should be encouraged to share. The counsellors discuss how they handled

- The child sero-converted after PEP
- Transference
- Survivors defaulted on therapy
- A communication barrier
- The child accompanied by parent or guardian

LEARNING POINT

Counsellors who understand their strengths and weaknesses will develop confidence in handling sexual violence survivors.

CONTENT: ABUSE INDICATORS

Child sexual assault and abuse indicators are varied and should be considered with *what else is happening in a child's life*. Any one indicator, by itself, is but one sign that something may be affecting a child's wellbeing.

Behaviour indicators

- Unexplained drastic change in attachment or fear around a family member, adult close to the family or any person in trust or authority for the child
- Abrupt changes in performance in school or work
- Abrupt changes in socializing, going out with friends or staying in the house
- Extreme avoidance to someone the child once liked, or to a certain house or room in a house
- Sexual behaviour, often in front of others, such as exposing oneself, masturbation, touching other people's private organs and sexually charged language
- Language and knowledge, especially detail specific, which is not age appropriate or has not been taught or shown in the school or household

Physical indicators

- Bruises, scratches, irritation and itching around genitals not consistent with explanation of how they happened
- Signs of any sexually transmitted disease or infection, such as crabs, herpes and gonorrhoea for those not sexually active
- Unexplained pregnancy
- Tenderness or soreness around areas of penetration
- Blood in stool or urine, such as in nappies and underwear, that is pervasive and not explained by any other action

Strategies for safety

No one can protect a child from everything. All people are susceptible to sexual violence. Isolation, low self-esteem and limited support can increase one's risk for becoming a survivor of sexual violence.

Some simple strategies and habits can help children be a bit safer:

- Let your children say 'NO' when they need to. Saying or yelling 'NO!' lets children know they have the right to say it.
- Teach children they can talk about anything that affects them. Let them know they can talk to you and identify whom else they can talk to.
- Teach children their bodies belong only to them. The parts of their bodies covered by underwear are no one's business but theirs.
- Let children know they do not have to hug, kiss, sit on the lap of any adult they do not want to, including relatives. They can set their own physical boundaries.
- Teach children not to keep secrets. If someone asks them to keep a secret about anything they did, let them know they should talk about it. A good rule of thumb is a 'good' secret is something you are very happy to tell about later, such as surprise gifts or parties.
- Teach children that not only strangers can be dangerous and if ANYONE violates them, even a family member or someone close to the family, they can talk about it.
- Teach children to tell if something happens. If they are not believed by the first person they tell, they should keep telling until someone believes them.
- Teach children accurate words for parts of their bodies. Baby talk can create a challenge when a child is explaining an assault.

Adapted from www.rapevictimadvocates.org

DAY 3

SESSION 1

UNIT 5: COUNSELLING SKILLS AND ATTRIBUTES

Objectives

By the end of unit 5, the participants should be able to

1. Explain the skills used in module 2 while attending clients.
2. Discuss advanced counselling skills.
3. Develop self-awareness of sexual issues to support survivors effectively.

Key content

- Review skills applied in module 2
- Review attributes of applying counselling in module 2
- Empathy compared with sympathy
- Challenges in applying counselling skills
- Practising counselling skills

Activity 1: Reviewing skills application in module 2

Time: 30 minutes

Method

In groups of three, participants review cases they handled and discuss

- The skills used and how they applied them, with examples
- Skills easy to apply
- Challenging skills, how they were used, the lessons learned and improvements needed

Each group makes a presentation to the whole group. During presentations, facilitators pick out the easily applied skills and the challenging ones. The whole group discusses what makes certain skills

easy or hard. The discussion should focus on the difficult skills.

Note: Often, counsellors find silence difficult to apply in module 2, though it is very appropriate and useful for rape trauma clients. It may be necessary to review using silence. Discuss dealing with and breaking silence.

Review all counselling skills. The facilitator asks participants why they did not use some skills.

Activity 2: Review applied counselling attributes in module 2

Time: 30 minutes

Method

Participants list counselling attributes. Participants pick an attribute they think they applied well and one they thought was a challenge to use. For each attribute explain

- How were the easy and difficult attributes offered, with an example how the counsellor did or did not offer the attribute
- What stopped the counsellor from using unconditional positive regard
- What the counsellor did to show empathy
- What the counsellor did that felt judgemental towards clients

Activity 3: Empathy compared with sympathy

Time: 30 minutes

Method

Participants compare empathy with sympathy while reviewing client issues they handled during their practice. Participants discuss how they would feel or what they would offer clients:

- Rape of commercial sex worker
- Young woman raped on her way to or from a night club
- Wife raped by her husband

- Pregnant woman gang raped
- A child raped by a parent
- A teenager raped by a group of friends while in a drinking spree
- Date rape
- Matatu passengers hijacked and forced to have sex with each other
- Matatu passenger raped by hijackers

LEARNING POINT

Counsellors should avoid being emotionally involved in client issues and offer unconditional positive regard and empathy to all clients and not pity them.

CONTENT: EMPATHY COMPARED WITH SYMPATHY

Empathy

'Empathy' is projecting one's own personality into the personality of another for better understanding.

Empathy is defined as the 'identification with and understanding of another's situation, feelings and motives' (*American Heritage Dictionary*, 3rd ed). Empathy has suffix *-'pathy'*, which means 'feeling; suffering; perception.' It means being able to feel, not only your own life, but the lives of others. It means caring, but most importantly, it means feeling.

In other words, we connect ourselves into the other person and they into us.

Empathy is not only to know or detect what others feel, but also to experience the emotion.

'Empathy is awareness of the thoughts, feelings or state of mind of others, perhaps by means of some degree of vicarious experience of others' feelings or mental states.' (*Wordnet Dictionary*).

Sympathy

Sympathy is:-1 *a.* relationship or an affinity between people or things in which whatever affects one correspondingly affects the other. *b.* Mutual understanding of affection arising from this relationship or affinity. 2. A feeling or an expression of pity or sorrow for the distress of another; compassion or commiseration.' *American Heritage Dictionary*, 3rd ed.).

- Empathy is to feel the emotion.
- Sympathy is to feel *for* the emotion.
- In empathy, we 'borrow' another's feelings to observe, feel, and understand the person, but not to take them into ourselves.
- Sympathy can be burdensome, emotionally exhausting and can lead to burnout because it implies sharing the pain with the sufferer.

SESSION 2

Activity 4: Challenges in applying counselling skills

Time: 30 minutes

Method

The facilitator guides the group in sharing some of the challenges they had in applying certain skills with different clients.

The group can also use role plays to address these challenges. They can share a case in which they were not able to use a certain skill, such as be non-judgemental, because the client was a rapist or a scantily dressed client narrates how she was raped in a disco.

LEARNING POINT

Counsellors must identify and accept the challenges they faced, keeping in mind that every case will require certain skills. It is not the number of skills used that is important, but how effectively the counsellor uses them to help clients by providing unconditional positive regard.

SESSION 3

Activity 5: Practising counselling skills

Time: 45 minutes

Method

In small groups, while the trainer observes, participants practise skills they found challenging. The following should be emphasized:

- Different skills can be applied in different counselling situations.
- Unconditional positive regard should be provided each client.
- Some skills should be applied sensitively to traumatized clients.

LEARNING POINT

Counsellors should have ongoing counselling practice, supervision and personal therapy to prepare them for counselling challenges.

DAY 4

SESSIONS 1 AND 2

UNIT 6: STRESS MANAGEMENT AND SUPERVISION

Objectives

By the end of unit 6, the participants should be able to

1. Identify stressors from personal or client issues and manage stress.
2. Identify counselling situations that cause stress.
3. Discuss the aim, forms and results of supervision.
4. Demonstrate ability to present a client for supervision.

Key content

- Sharing stressful experiences
- Supervision

Note: Counselling trauma clients can be stressful and so the participants must be well prepared.

Activity 1: Sharing stressful experiences

Time: 4 hours

Participants voluntarily share situations in which they experienced stress. Some participants could be nursing the effects of stress from offering trauma counselling to survivors.



SESSION 3

Activity 2: Practising counselling skills

Note: The remaining session of the day will be used to practise counselling skills



DAY 5

SESSION 1

Activity 3: Supervision

Time: 30 minutes

Method

The facilitator briefly discusses the importance of participants attending supervision sessions for counsellors in their institutions.

LEARNING POINT

Everyone experiences stress and everyone handles it differently. Counsellors need to attend counsellor supervision sessions regularly to avoid burnout. Rape and sexual violence survivors come to counselling with diverse issues and the counsellor needs to offer quality services. Counsellor supervision is mandatory.

CONTENT: AIM OF SUPERVISION

Counselling supervision is to safeguard the client's welfare. It also

- Helps counsellors with personal and professional growth and development.
- Provides support for the counsellor's emotional well-being.
- Enables counsellors to monitor and evaluate their own competence.
- Facilitates professional growth by learning from other counsellors.
- Monitors the profession and the organization providing the counselling.

Function of supervision

- *Educative.* The counsellor is given regular feedback to develop new understanding and receive information. The counsellor can integrate theory and practice.

- **Supportive.** The counsellor can share dilemmas, be validated, and deal with stress evoked by clients.
- **Managerial.** Supervision ensures quality work and the counsellor is helped plan work and use resources.

Major forms of supervision

- **One-to-one or individual supervision** involves one supervisor and one supervisee. The supervisee can learn about a particular counselling approach in a supportive environment. However, it can become difficult if the supervisory relationship breaks down when only one person supervises.
- **Group supervision** can be peers or a group with a leader. It provides a supportive atmosphere and emotional support, especially for new counsellors. However, the group may not have sufficient experience for learning, some members may not get to discuss concerns if group is too large and the group dynamic may interfere with learning.
- **Peer supervision** involves spending time with a colleague to discuss work in a structured, confidential manner. This is usually available to counsellors and does not involve travel. Counsellors who can learn from the experiences of their colleagues are likely their coworkers. But if the counsellors have little experience, peer supervision can be limited.
- **Self-supervision** monitors or assesses the counsellor's own work. Supervisees examine their own work and evaluate it. Doing this builds up the counsellor's confidence. However, the counsellor may miss significant factors in the client relationship.

Results of counselling supervision

- Improvement in counselling skills and practice
- Increased personal growth of the counsellor
- Increased professional growth of the counsellor
- Awareness of personal limitations and the need for further training
- Evaluation of self and self-competencies
- Sharing and learning from other counsellors and the supervisor

Presenting a client for supervision

- Identification—client's first name, age, sex, first impression, physical appearance

- Contact information and any other information the counsellor may have already about the client
- Contract
- Problem
- Counsellor's question or issues for supervision
- Focus on client content and problem—client's account of problems or situation, define the problem, the counsellor's assessment of the client's problem and counselling plan
- Focus on process—skills used and how used, relationships between counsellor and client, evaluation of process

SESSION 2

COURSE EVALUATION

Objective

1. By the end of the training, participants will evaluate the entire course and certificates will be given to those qualified.

Key content

- Future counselling sessions
- Evaluation and certification

Activity 1: Future counselling sessions

Time: 60 minutes

Method

In small groups, participants share what they are going to do in counselling after finishing the course. They can also suggest some challenges they might have after they graduate.

LEARNING POINT

Each counselling session should be conducted according to the issues presented by the client. The counsellor always conducts a client-centred session.

SESSION 3**Activity 2: Evaluation and certification**

Time: 20 minutes

Method

Participants will be given course evaluation forms to fill out. Certificates will be given to those who qualify; those who did not qualify will be told what they must do to qualify.



ANNEXES





Annex 1. Rape trauma counsellors pre-course and post-course evaluation

1. What comprises sexual violence?

2. What are key procedures to be undertaken when a survivor presents:
o within 72 hours

o after 72 hours

3. What type of drugs are used as PEP and EC?

4. Who is to conduct the examination of a survivor?



160 *Trainer's manual for rape trauma counsellors*

5. What specimens are to be collected?

6. Where and how are these specimens to be stored?



Annex 2. Participant evaluation scorecard

RAPE TRAUMA COUNSELLING 3-MONTH COURSE

MODULE 1

Participation, self awareness, acquisition of skills, practicals on protocols 15%

Evaluation done by the trainer

End module—assessment form filled out on the last day by participant 15%

Written evaluation by the participant

MODULE 2

Observed practice (2 months) 15%

Report by the observing counsellor

Diary—should have client name, age, presenting issue (one-liner) and follow-up sessions 15%

Consistent input on clients in the diary and any accompanying remarks

Two written case studies 20%

Studies present counselling issues and not case facts

MODULE 3

Module 3—Participation, self-awareness, skills competence, practicals on protocols 20%

- Observations on the counsellor
- Skills, attitudes during presentations, ability to share, self-awareness and the movement made by each counsellor as determined by the trainer

Trainers should fill out the scorecard at the end of each module as shown below:

Class _____

Year _____

| Participant name | Facility | Phase 1 | | Phase 2 | | Phase 3 | |
|------------------|----------|--|--------------------------|-------------------------|-------------|----------------------------|--------------------------|
| | | Trainer observation of participant (15%) | Written evaluation (15%) | Observed practice (15%) | Diary (15%) | Written case studies (20%) | Trainer evaluation (20%) |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

Annex 3. Timetable

MODULE 1

| Day/ session | Day 1 | Day 2 | Day 3 | Day 4 | Day 5 |
|-----------------|---|--|---|---|---|
| 8.00–10.30 | Introductions Gender and power relations Break | Counselling and counselling issues | Clinical care | Rape trauma protocols | Self-awareness and childhood experiences |
| 10.30– 11.00 | Break | | | | |
| 11.00–1.00 | Self-awareness and personal development Socialization | Counselling theories | Sexual violence and legislation | HIV and sexual violence HIV test preparation | Child counselling |
| 1.00–2.00 | Break | | | | |
| 2.00–5.00 | Self-awareness and sexual violence Effects of sexual violence Self-awareness and rape trauma syndrome | Counselling theories practicals | Counselling skills Practising skills Sharing experiences on sexual violence | Advanced counselling skills | Counselling of perpetrators Stress management Way forward |

MODULE 3

| Day/ session | Day 1 | Day 2 | Day 3 | Day 4 | Day 5 |
|-----------------|---|--|---|----------------------------------|---|
| 8.00–10.30 | Introductions Concerns emerging | Self-awareness, sex and sexuality | Review counselling skills Challenges faced in applying skills | Sharing stressful experiences | Supervision |
| 10.30– 11.00 | Break | | | | |
| 11.00–1.00 | Review protocols Medico-legal concerns | Child counselling Personal development exercise | Sharing experiences | Stress management | Course evaluation |
| 1.00–2.00 | Break | | | | |
| 2.00–5.00 | Sharing module 2 experiences | Sharing challenges faced in child counselling | Practising counselling skills | Practising counselling skills | Certification and evaluation |

□ □ □ □ 4. Case studies

CASE STUDY 1. Kanini

My name is Kanini. I was the first-born in my family and grew up in an evergreen place, known as Embu, in the eastern part of Kenya. We lived in a hilly area, called Kanja—a blessed area where there is lots of water, rocks, parks and wild animals.

I finished class 8 when I was 14 and did my secondary education at Embu Girls High. I was the shortest and youngest in the class. At first I was teased, but I was mischievous and became very popular in the school. I finished my O levels and passed three of them. When I was 18 years old I came to Nairobi, the capital city, to look for work. I stayed with my mother's sister and was sent to a dressmaking college in the city. For the first six months I was a good girl, but then I met Mutua. He was a really nice guy and I couldn't believe he was my boyfriend. He'd spent the last three years working in South Africa, which made me feel prestigious. We were always together like trousers and a belt. I was 19 years old and he was 23. He took me to show me to an aunt—as is normally done in our culture—and I introduced him to my sister. Everyone said you fit each other perfectly.

We married and six months later I became pregnant. I gave birth to a baby boy, Kioko. Three years later I had another son and named him Kilonzo. By this time I knew Mutua often 'met with' girlfriends at beer halls and hotels. He was a ladies' man. I didn't like it, but it was inevitable and I knew if I mentioned it to him he would become angry. My friend Mary told me I should suggest using condoms. If I did, he would accuse me of infidelity or charge me with accusing him of infidelity. If I asked him to use condoms with his girlfriends, it would reveal I knew about them. Again, that would make him angry. I needed Mutua to support the family with money for food and clothes. I decided to talk to him about HIV in a general way. He dismissed what I was saying and told me HIV didn't exist in our area.

When Kilonzo was three years old I became ill. By that time, Mutua didn't love me any more. He said I was using all his money—staying in hospital

and not looking after the children at home. His sister came and said I was culturally infected and should be sent back to my parents. Mutua said he couldn't keep me any more, so for months I was on my own, looking after the children and selling tomatoes and fruit to raise money for the bus fare back to my parents' home.

My mother looked after me, but no one knew what was wrong. I was ill for six months, but I recovered and returned to Nairobi. By this time, Mutua started getting ill. He went for tests, which showed he was HIV positive, but he never told me. One day I told it to him straight. We were just talking and I asked him, 'Do you remember when I got ill and you told me to go back to my parents? You never took care of me, my dear, so now that you are the one who is ill, you must go to your parents.' I tried to chase him away. He refused and said, 'Men can't keep wives while they are sick, but you can keep men.'

It is very difficult for a man to accept he's positive. He can be diagnosed positive, but he'll say that he's just got flu or malaria and that now he's OK. Mutua continued to get ill, but none of his relatives visited him. For three years he kept his secret about being HIV positive. One day, the doctor ordered me to the hospital. She told me Mutua had HIV and counselled me. I knew if he was positive, I must be too.

I worried about my children and who would look after them. The doctor referred me to Utumishi, a day centre for people with HIV. There I met many women who were positive. I was thin, tattered and torn. I didn't laugh or talk. I saw people laughing there and wondered, 'Do they realize that they are HIV positive and going to die?' I worried, but as time went on I began to accept it and realize I must live life positively. I started visiting every day and talking to the other women about HIV. We talked about people we knew who were HIV positive. Many had become infected through their husbands, but we realized we knew many more women who were positive than men. We discussed whether this was because women were more open about HIV or whether we were more susceptible to the virus. It was good for me to share my experiences with other HIV-positive women and to hear their stories. It was a big relief and I became a counsellor to help others.

Meanwhile, Mutua became more ill. I wanted to tell him I had the disease too, but it was impossible because he was becoming too harsh. Most of the time he was confused in his brain. So, I just kept quiet. He was discharged from hospital. We spent most of the time together. Then one day, the sisters from Utumishi took him to St Mary's hospital. Ah, that day he smiled, but it was to be his last smile. He was thinking that was the place where the cure was and he loved that place very much. He spent almost two weeks there, but they were his last days. I was really worried. He never talked to me. I was always crying, sitting by his bedside with no one to comfort me. Late one night he passed away.

When Mutua died, his brother took everything away, even the blankets. They left me with just two blankets to share with my children. They took everything and left me with nothing, just a tiny room where you couldn't even stretch your legs. It was very difficult for me—how was I going to maintain the children? Things were hard in Kenya at that time. Inflation was high and people were unhappy with the prices. In Nairobi we were struggling to survive. My friends selling fruit, vegetables and clothes were seeing their profits fall. People didn't have money in their pockets on the streets. I needed to earn some money to pay for my children to go to school and buy them clothes.

Utumishi gave me strength. I did some counselling there and I decided I had to go public about being HIV positive. I'd go into companies too and they'd give me money for my testimony. That helped pay the rent and feed the children. Kilonzo—who is HIV positive—is still alive and well. It's still very difficult for me to believe that my husband is gone forever. I really miss him a lot, but I can't do anything about it. One day we will meet in heaven—if he is there. I always pray to God for more days on earth, for I still need to take care of my children. But only God knows the day, the hour and the minute.

DISCUSSION POINTS

- How does Kanini's experience as a woman in Kenya influence her ability to negotiate for safe sex?
- How has Kanini's relationships with men shaped her experience as a woman with HIV?

- To what extent does the political and economic situation, and society's norms and values affect
 - o The risk of becoming infected with HIV in Kenya?
 - o People living with HIV?
- What do you see as the main risks in Kanini's experiences?
- What are the similarities and differences between Kanini's experiences and the experiences of women affected by HIV with whom you are familiar?

CASE STUDY 2. Ellen

Ellen lives in the northern part of Kwale District in Coast Province, Kenya. She lives with her husband and his family in a rural village. She moved in with her husband's family when they were married. Since then, her father-in-law has died and her sister-in-law has moved back into the compound with her three children. Ellen and her husband have five children. Ellen's husband has worked away from home most of their married life. He used to work in the mines before retrenchment and, since then, has had various jobs in town. He came home two years ago when he became unwell. Since he came home, they have not had as much money. When he was working, he used to send some money home—not every month, but at least it was something. If she needed to buy school uniforms or materials for repairing the house, she would ask him for the money and he would usually send it. Now, the whole family relies on his mother's government pension, which is 1200 Kenya shillings a month. Ellen's eldest son, who is 18, is in town and sends money when he is able. Ellen's sister-in-law's husband is unemployed, so he has no money, and anyway, the relationship has broken down. Ellen used to farm, mostly to feed the family, but also to sell some of the produce. Now she doesn't have as much time, because of looking after her husband, but her sister-in-law helps.

At first when Ellen's husband was sick, he was able to move around and do some things for himself, but for the last two months he has been bedridden because he is so weak. He has a cough and a bad chest, sores and swollen, painful feet. Ellen has to do most of the work of looking after her husband, but she is supervised by her mother-in-law. Every day Ellen has to wash and feed her husband, give him the medicine for his cough and help him go to the toilet when he wants to. Giving him the medicine is difficult and takes a long time because he has to eat something first and he finds this difficult. Sometimes he is sick after he has his food, so she has to wait and feed him again before she gives him his medicine. She also has to do all the usual housework as well—washing clothes, fetching water, cleaning and looking after the younger children. She gets up earlier than she used to, so that she can do some work in the garden or fetch water. She doesn't have time to do these things later in the day because her husband might need her. If she goes to fetch water she worries about him needing

her help. His sister can't take him to the toilet or bathe him—it wouldn't seem right—and his mother is quite frail herself.

Ellen's two daughters help her around the house. Her younger daughter is at primary school and Ellen doesn't want her to be distracted from her schoolwork—she knows it's important for her to get an education. Her elder daughter is in secondary school. She is doing well and could obviously go to university, but Ellen doesn't know where they will get the money. As it is, she isn't sure she can keep up with payments for fees, books and uniform. If her daughter leaves school, maybe she will be able to get work as a maid in town, which would be really helpful for the family. But, Ellen worries about her daughter's future if she doesn't get a good education—there are few opportunities for her in Kwale. Her older son also didn't go to university. He wanted to help support the family and, anyway, he didn't see the point in staying on at school—there are no jobs anyway.

Ellen isn't sure what is wrong with her husband. When he came back from town looking really thin, she knew there was gossip about AIDS, but nobody said anything directly. She doesn't dare ask her husband about it—how could she suggest something like that? He might say it is her fault. She got medicine for his cough from a private clinic in town, but he hasn't been to the hospital—it is so far away and anyway, they couldn't afford to have him admitted. She knows that if it is AIDS, there might be danger for her, but since she is not sick now, perhaps that means it is not AIDS. Anyway, she had heard that you get AIDS through sex and her husband is too weak for that. She doesn't know if there are any other ways to get AIDS, but people seem to avoid those who are sick with AIDS, so there probably are. She does worry about her own future, but what can she do? If she went to the hospital to get a blood test, people would find out and talk. Still, she does worry about what would happen to her if she became sick.

Some of her neighbours and women from church are very kind and help her out sometimes. Mostly she just needs their company and support, but she is worried that if she discussed this AIDS business with them they would avoid her. Sometimes the community health worker visits and gives some advice—says how to clean and bandage his sores. Ellen

appreciates her help but she is worried about what people think about the community health worker's visits—everyone knows that they visit people with AIDS. Also, she often doesn't have money to buy the things suggested, like Vaseline and bandages for the sores. Even buying enough toilet paper is difficult sometimes. Ellen wishes she had more money to enable her to look after her husband properly. She knows he might need more medicines soon, but she doesn't know how she will buy them.

DISCUSSION POINTS

- How does Ellen's experience as a woman shape her experience of the HIV epidemic in Kenya?
- How do Ellen's relationships with her family influence the care she provides her husband?
- To what extent do the political and economic situation, and society's norms and values affect

The risk of becoming infected with HIV in Kenya

People living with HIV and AIDS?

- o What do you see as Ellen's main problems in caring for her husband?
- o What are the similarities and differences between Ellen's experiences and the experiences of women affected by HIV with whom you are familiar?
- What do you see as Ellen's main problems in caring for her husband?
- What are the similarities and differences between Ellen's experiences and the experiences of women affected by HIV with whom you are familiar?

CASE STUDY 3. Chebet

My name is Chebet. I live in Cheptiret in Uasin Gishu District. I am 32 years old. Eight years ago I married a soldier at the barracks. Within a year of our marriage, we had a son. Within the year, I got pregnant again, but this time I was not very lucky because I became sickly. As the pregnancy advanced, I became weaker and weaker.

At the same time, my husband became sickly also. He went in and out of hospital. I finally had my second child, but this did not bring in any luck at all. The baby was born weak, so the three of us were sick at the same time. We were, at one time, hospitalized at the same time. The baby and my husband finally died within a day of each other, with the baby dying first. I was too weak to attend their funerals.

I became so ill that everybody had given up on me, when my situation began to improve and I was discharged from hospital. I went home to Cheptiret to my parents but I found the situation unbearable in the village because of the stigma I got, on account of the tuberculosis I had suffered from and the death of my husband from what people concluded was AIDS. I went back into town to try to make a living, but I did not have any education.

I tried vegetable, rice and flour selling, but I was not successful. A friend introduced me to beer selling, which proved more successful than the other businesses. Because most of my customers were men, I also found some of them asking for sex from me. I found myself combining beer and sex selling.

Before I went into beer selling, when I was still a patient at the Uasin Gishu District Hospital, I had the privilege of being entertained one afternoon, together with the other patients, by a group of women who came to perform traditional dances at the hospital. Their songs presented special AIDS messages and later they gave a talk on AIDS and HIV prevention, which touched me so much. Later, this group of women became my colleagues at the beer tavern and I also got a chance of joining them. Today I am one of the members of this group, known as Nariri Peer Educators. Our task is to spread AIDS prevention and practising safe sex

messages. I am a strong advocate of condom use, and personally, I never engage in sex without a condom. I cannot take any chances with my life, especially after the long illness. It is now five years since I came out of hospital.

My mother protested against my beer business and threatened to bring my son to town for me to look after him. I assured her that I was going to sell beer to make a living and not go beyond that. I would be assisting her and my son with the proceeds of the business. She is not aware of the other part of my business, but I have a feeling that she knows but, what can I do?

DISCUSSION POINTS

- How does Chebet's experience as a woman shape her experience of the HIV epidemic in Kenya?
- How do Chebet's relations in the village influence her life choices after the illness?
- To what extent do the political and economic situation, and society's norms and values affect
 - o The risk of becoming infected and reinfected with HIV in Kenya
 - o People living with HIV?
- What do you see as Chebet's main problem at the moment?
- What are the similarities and differences between Chebet's experiences and experiences of women affected by HIV with whom you are familiar?

□ □ □ □ 5. World upside down

Objective

1. Use an imaginary situation so people can experience the way beliefs about women and women's roles affect their lives.

Method

The facilitator asks participants to get comfortable. The facilitator, or two readers reading alternating sections, reads a story about an imaginary world. The participants may close their eyes and focus on the story. (3 minutes)

Read the following story in a clear, soothing voice.

Have you ever been bothered by the way the word 'man' is used to include all people? Does it bother you, for instance, that when people refer to 'the rights of all men', they mean the rights of men and women or the rights of all people?

Imagine a world similar to our own, but slightly different. In this world, 'woman' refers to all people. When we use the word 'woman', we mean everyone.

Close your eyes and imagine that when you read the daily newspaper or listen to the radio, you see or hear about women politicians, women trade union leaders, and women directors of large companies. Imagine a world in which most books, plays, films, poems and songs have women as their heroes. Imagine that women are the people you learn about when you study the great scientists, historians, journalists and revolutionaries. Imagine women making major decisions about the future in this different world.

Imagine everything you have ever read uses only female pronouns—'she', 'her'—meaning both girls and boys, both women and men. Imagine that no men represent you in government. All decisions are made by women. Men, whose natural roles are husband and father, find fulfilment in nurturing and making the home a refuge for the family. This is only natural, to balance the role of the woman, who devotes her entire body to the human race during pregnancy and her

emotional and intellectual powers to ensure progress and survival of the planet throughout her life.

Imagine further about the biological explanations for woman as the leader and power centre. A woman's body, after all, represents perfection in design. Even female genitals, for instance, are compact and internal and protected. Male genitals are exposed, so the male must be protected from outside attack to assure perpetuation of the race. His vulnerability clearly requires sheltering. Thus by nature, males are more passive and timid and have a desire to be protectively engulfed by the compact, powerful bodies of women.

In the world that we are imagining, girls are raised as free and self-confident beings. They play, they run, climb trees, take risks with the encouragement of all adults around them. The family puts a priority on the physical and intellectual development of girls, since they are the ones who will be responsible for the future of our society.

Boys, on the other hand, are raised to be timid and obedient. They are encouraged to play quiet games in the home to prepare them for life as family caretakers. From an early age, they are expected to help their fathers. They learn to look up to women, try to please and care for them. They are taught to become the mirror in which the strength of women can be reflected.

Now remember the birth of your first child, if you have one. In your last month of pregnancy, your husband waits with anxiety, wondering what the sex of the child will be. Your first child is a boy. Your husband sits by your side holding the newborn, already instinctively caring for and protecting it. There are tears in your husband's eyes and you know that at the same time that he is filled with joy at your son's birth, he is also looking forward to having another, hoping for a girl child that will carry on the family name. (15 minutes)

Participants number off into four groups to discuss the feelings they had when they listened to the story. Were they angry, amused or confused? Did any part of the story make them laugh? (10 minutes)

The whole group discusses (40 minutes):

- How the imaginary world compares with the world in which we live. Is it a complete role reversal? If the word 'man' was in each place 'woman' as mentioned, would it accurately describe the world in which we live? Why or why not?
- Would the participants like to live in the imaginary world? What would be wrong and what would be right? Would women want to have the power men currently have? If they did, would they use it similarly?
- What would an ideal world be like?

Note: If this activity is done in a mixed group, ask men how they would feel about taking on women's roles.

Annex 6. Real-life cases

- A 30-year-old woman is raped by her brother-in-law.
- Rose is an 18-year-old girl, who has lived on the streets of Nairobi almost half of her life. She was one of the street children taken into the youth service. She now comes for counselling after being gang raped.
- A father brings his 5-year-old daughter after she was raped by two 12 year-old, boys. The father was not around on the day of the rape. The mother had gone to the market and had left the 5-year-old cooking porridge for the 3-year-old sister in their kitchen, when the two boys came and took the smaller girl outside, then came back, locked the kitchen door and raped the girl in turns, while closing her mouth.
- Peter, a single man aged 27 years, came in the testing room after being referred from the outpatient department. This is what he shared with the counsellor:

I'm feeling bad about what happened to me yesterday.

Yesterday morning I went to meet with my cousins at my aunt's place. One of my cousins was planning to wed, thus we were preparing for the wedding. We were having a good time at home, there was home-made beer. I took three glasses, just like the rest. One of my cousins escorted me at around 6.30 pm. Between my place and my aunt's there is an estate. It was dark and I was alone. Somebody followed me, cycling recklessly. I didn't bother with who he was. He knocked me with the bicycle from behind. I gave him way to pass, but he kept on knocking me until I felt down. An argument started and we started fighting each other. I realized he was stronger than me. It's because I was drunk.

The man had an intention. He started abusing me and said, 'Today you will know that I am a man. I will make sure I will have sex now.' He pulled out a knife and pointed it at me. He forced me to lie down and remove my trousers. There was no otherwise but to do so; I felt as if I were a woman. I never imagined such a thing could happen to me, bending down to a man to have sex. It's painful.

- Kizito was coming from the office at around 6.30 pm. He crossed a river and met with a neighbour, who asked him whether he could accompany

him on his journey home. After a short silence, the neighbour grabbed him so tight that he was not able to scream. He dragged Kizito to a nearby bush and sodomized him, until the neighbour had no energy to continue. The neighbour left Kizito in the bush.

- Jane came, accompanied by her father, for counselling after having been raped by her neighbour's 30-year-old son when she went to pick up her book. He forced her to have sex with him and used a condom.
- During the school holidays, Rachel met with a friend who attended the same primary school. This being her friend, she did not hesitate to invite him to their house, so they could talk. Unfortunately, the boy raped her.
- Gangsters attacked client A, with her husband in their house. One of them raped client A. They also murdered her husband. Client A starts crying.
- Pamela comes to the hospital accompanied by policeman, after having been raped by her workmate, who came to her house at midnight pretending to have an urgent message for her. He didn't use a condom. She has not shared with anyone about what happened, she had taken a bath and changed her clothes.
- A man raped Mercy around 7 pm, when she had gone out of college to the nearest kiosk.
- Alice, a 4-year-old girl went to school one morning, but was sent back home by the teacher because her fees had not been paid in full. When she went home, the house was locked because the mother had gone to town. As she was wondering what to do next, a neighbour boy, with whom she was familiar, appeared and asked her to follow him to his house. Alice obediently followed. There was nobody else in the house. The boy did not even close the door; he took her straight to bed and proceeded to remove her panty and defile her. Around 11 am Alice's mother sent the house help, who had gone with her to town, to go and check on Alice. She didn't find her at home, but was told that Alice had been crying from the neighbour's house. The maid went to check and met the boy running out of the house. She found Alice on the bed, naked. She dressed her up and sent for the mother, who went to report to the chief, who did nothing. They come to counselling five days after reporting to the chief and police.

- Jane, a 54-year-old woman is using PEP after having been raped two weeks ago. She is referred to counselling because she had been counselled for HIV testing at the diagnostic clinic.
- Client X, travelled from upcountry, having been promised a job by her sister through a friend. When she came to her sister's place in town, the friend came with a man who was said to be offering the job. Client X was handed over to the man and they took off in a matatu around 4.00 pm to the place she was to work. After alighting, they walked quite a distance, until it was late in the night. Around 9.00 pm, the man turned to Client X and ordered her to lie down and not make any noise, otherwise she was going to die. He showed her a knife. He raped her and ordered her to stand up and go without looking back.

□ □ □ □ 7. Protocols

GENERAL TRAUMA COUNSELLING PROTOCOL

Counsellors may adapt the protocol to fit the client, but all issues must be covered.

| Protocol | Content |
|---|---|
| Contract with the client | <ul style="list-style-type: none"> • Introduce self and establish reasons for client visit, if it is rape, ensure the client received emergency care • Contract with client, include counsellor role, time, shared confidentiality, possibly counselling an accompanied client alone |
| Support the client through rape trauma | <ul style="list-style-type: none"> • Provide core conditions • Explore client concerns and fears from the trauma • Provide support and address client issues |
| Give information to the client | <ul style="list-style-type: none"> • Information on health and legal services and their purpose • Information and implications on preventive therapies, PEP, emergency contraception, STI prevention, required tests and drugs • Legal issues for the client, such as the option to terminate pregnancy, litigation, reporting, rights and responsibilities • Counselling schedule and follow-up |
| HIV pre-test counselling | <ul style="list-style-type: none"> • Consider client age and implications, parent HIV status and assault time for assessing and reducing HIV risk • Client concerns about HIV test • Review client understanding and readiness for HIV test • Signed consent, refer client to laboratory for HIV test |
| HIV post-test counselling | <p style="text-align: center;">HIV negative result and HIV positive result</p> <ul style="list-style-type: none"> • Contract again, assess client readiness for result and give result • Result implications, reducing risk • Disclosing sexual violence and HIV test result • Ongoing counselling <p style="text-align: center;">For HIV negative include</p> <ul style="list-style-type: none"> • Adherence, legal issues and referrals <p style="text-align: center;">For HIV positive result include</p> <ul style="list-style-type: none"> • Positive living and refer for HIV care • Plan of action |
| Ongoing counselling | <ul style="list-style-type: none"> • Introduction and contracting • Explore issues, concerns and fears • Reducing risk • Adhering to PEP or follow-up care |
| <ul style="list-style-type: none"> • At least 4 more sessions, coinciding with clinical follow-up • Should coincide with clinical follow-up | |

CONTRACTING WITH THE CLIENT

| Protocol | Content |
|---|--|
| Introduce yourself to client and establish reason for visit | <ul style="list-style-type: none"> • Introduce yourself and your role as a counsellor to the client • Establish client reasons for coming, if rape, establish whether client received other health care: • PEP, emergency contraceptive • Examination and documentation: client should have a completely filled out and signed PRC 1. If not, refer client back to casualty for emergency services. |
| Contract with the client | <ul style="list-style-type: none"> • Describe your role as counsellor • Contract time <p>Make sure to explain</p> <ul style="list-style-type: none"> • Confidentiality, including shared confidentiality • Possibly separating the client from the accompanying person • The client can terminate the session at any time • The number of sessions required, but do not explain before exploring • Different counsellors may have to support the client |

SUPPORTING THE CLIENT

| Protocol | Content |
|-------------------------------------|--|
| Explore client concerns from trauma | <p>Give clients time to share, giving unconditional positive regard</p> <p>Support clients to share</p> <ul style="list-style-type: none"> • Their experience—always painful and client may not share in first or second session • Key concerns about the visit • The trauma facts: when, where, how many assailants and what may have been used <p>Explore and address client issues</p> <ul style="list-style-type: none"> • What feelings are at the moment • Those directed to self, such as blame, shame • Those directed at others and who the others are • Address client issues systematically • Address family and social concerns for psychological recovery • Address client fears about consequences • Health care consequences • Consequences in the family • Social consequences <p>When client is an accompanied minor</p> <ul style="list-style-type: none"> • Explore and address the fears, issues and concerns of the accompanying person • Support both client and guardian • When necessary, separate the client and the accompanying person |

GIVING INFORMATION

| Protocol | Content |
|---|--|
| Give the client information on health and legal services and their purpose | <ul style="list-style-type: none"> • Establish if a PRC 1 was filled out • Establish if the client was given the 3-page, original PRC 1 form • Ask the client if the doctor filled out any other forms <p>Discuss the examination, documentation and purpose</p> <ul style="list-style-type: none"> • Establish crime and provide evidence • Necessary for police investigation • Necessary for court and litigation • Discuss the P3, tell client a duplicate PRC 1 will be attached to it <p><i>The client must keep the original PRC 1 form. If the client is abused within the homestead, discuss with the client that the PRC 1 form may get 'lost'.</i></p> <p>Discuss disclosing the rape and whom the client can rely on for support</p> |
| Information on preventive therapy PEP and emergency contraceptives should only be discussed with clients who come within 72 hours, unless the client asks | <p>HIV, STIs and pregnancy</p> <ul style="list-style-type: none"> • Establish client's understanding of HIV and STI transmission and infection and pregnancy <p>Discuss preventing HIV</p> <ul style="list-style-type: none"> • HIV infection risk • PEP 80% effective • PEP started within 72 hours and client HIV negative • Dosage and duration of PEP • PEP side effects are common and mild, rarely severe • Immediate HIV test implications <p>Discuss preventing STI</p> <ul style="list-style-type: none"> • Prevention of many STIs • Client must know screening may still be required <p>Preventing pregnancy</p> <ul style="list-style-type: none"> • Doses, side effects and effectiveness • Discuss pregnancy termination and child adoption |
| Legal issues for the client | <p>Reporting and litigation</p> <ul style="list-style-type: none"> • Discuss whether the client intends to report and the rationale • Encourage reporting to the police, knowing it provides legal support, if the client might wish to report later. However remember clients have their rights and can make informed decisions <p>Discuss the reporting procedure</p> <ul style="list-style-type: none"> • Record in Occurrence Book • Sign a written statement; clients should sign only after they are completely satisfied what is written represents them |

| Protocol | Content |
|--|---|
| Legal issues for the client | <p>Reporting and litigation</p> <ul style="list-style-type: none"> Client may need writing support, especially if not very literate <p>The client should expect</p> <ul style="list-style-type: none"> Cross-examination on many occasions by different people An identification parade, but can demand anonymity Their story to be challenged and disbelieved in the court The case to take some time, with many court visits <p>The rights and responsibilities of the client</p> <ul style="list-style-type: none"> To be accompanied by an officer of chosen gender to the health facility To tell nothing but the truth <p>Explore client concerns and issues about reporting</p> <p>Refer the client appropriately: some to the officer, others to legal support groups</p> |
| Contract the counselling map and sessions required, minimum 5 counselling sessions, coinciding with clinical follow-up | <p>Counselling sessions will be conducted alongside</p> <ul style="list-style-type: none"> Days 1–3 – Baseline HIV test, PEP, STI prevention, emergency contraceptive Week 1 – Clinician follow-up Week 2 – Second half of regime, clinical follow-up Week 4 – HIV test after completing PEP¹ Week 6 – HIV test after window period Week 12 – follow-up on counselling <p>Much of this information can be expounded on in subsequent visits. However, clients require a basic understanding of all these issues because they have immediate and long-term implications</p> <p>¹ PEP and emergency contraceptives should only be discussed with clients who come in within 72 hours of the trauma</p> |

PRE-TEST COUNSELLING

| Protocol | Content |
|--|---|
| <p>Assess previous risks This should facilitate discussion on the window period</p> | <p>Establish with the client</p> <ul style="list-style-type: none"> • Their sexual exposure in the past • Nature of past exposure: vaginal penetration? Condom used? • Any concerns about partner risks • Their knowledge of their own HIV status and that of their partners, where applicable <p>If the client is a child less than 5 years old, do a risk assessment with the parent for their HIV status because they need to be prepared</p> |
| <p>Discuss risk of HIV infection from assault and the implications of HIV test results</p> | <p>Work with the client to list and order risk, considering past risk and risk from sexual violence</p> <p>Discuss and explore</p> <ul style="list-style-type: none"> • The possible implications of client HIV status • Client expectations of the test result and its implications • Implications of a positive HIV result at baseline, an existing infection • Explore the implications on client, family and community • Address client concerns • Address PEP initiation and continuation or discontinuation • Discuss possible HIV positive result at end of treatment • Discuss window period, implications and client concerns • Client's sexual relationships • Risk-reduction and client concerns |
| <p>Address client feelings about being tested</p> | <p>Discuss:</p> <ul style="list-style-type: none"> • HIV testing and the need for client to have an HIV test today • The test process and interpretation the client should expect, such as rapid testing or laboratory assays • Where the test will be conducted, the laboratory |
| <p>Client readiness for a test</p> | <ul style="list-style-type: none"> • Review client expectations and understanding of HIV test and results • Establish client decision about being tested today, if ready, refer to the lab <p>Client consents by signing a lab request form</p> |
| <p>HIV test between day 1 and day 3</p> | <p>If the client is not ready, explain the decision must be made within 3 days for PEP; if client is not ready for HIV test, summarize the session</p> <ul style="list-style-type: none"> • Disclosure: report to police, HIV test and implications, window period and reducing risk, how the client and family cope • Explore client issues and concerns about HIV testing • Review information on PEP • Review HIV testing and implications, window period and reducing risk • Review discussion on disclosure |

HIV POST-TEST COUNSELLING

Between Day 1 and Day 3 after presentation

HIV-negative result

- | | |
|---|--|
| Contract again | <ul style="list-style-type: none"> • Welcome the client back and contract on time and shared confidentiality |
| Clients readiness for the results | <ul style="list-style-type: none"> • Establish how the client is feeling • Explore concerns the client might want addressed before seeing the results • Explore client understanding of the test results |
| Give results | <ul style="list-style-type: none"> • Allow the client time to process them • Ask client the interpretation and meaning of the result |
| Review implication of the results | <ul style="list-style-type: none"> • Discuss the implications of the HIV test and PEP for rape victims using information from the previous session • Review the window period |
| Reduce risk | <p><i>Review and discuss</i></p> <ul style="list-style-type: none"> • Need to reduce risk while on PEP and to end of window period • Possible sero-conversion while on PEP • Possible HIV transmission • Possible HIV infection, even when on PEP <p><i>Discuss and prepare clients for possibility of sero-conversion even while on PEP</i></p> |
| Disclose sexual violence and HIV test results | <ul style="list-style-type: none"> • Review client issues on disclosure of sexual violence and HIV status • Discuss importance and benefits of disclosure • Review client concerns about disclosure • Allow client to make informed choice about disclosure • Establish to whom, how and when the client will disclose |
| Adherence counselling | <p><i>Review and discuss PEP, including</i></p> <ul style="list-style-type: none"> • Time of PEP regimen • Side effects of PEP • PEP available for two weeks, then client must come for clinical evaluation and counselling • Importance of adhering to PEP for 28 days |
| Legal issues and referrals | <ul style="list-style-type: none"> • Review reporting, if the client has not done it • Refer the client for other services, where possible |
| Ongoing and adherence counselling | <ul style="list-style-type: none"> • Refer the client appropriately for legal action and medical care • Book the next visit, preferably after one week, to coincide with STI prophylaxis, if the client has not already been given it • Subsequent visits to coincide with clinical visits |

HIV positive at baseline

- | | |
|-----------------------------------|--|
| Contract again | <ul style="list-style-type: none"> • Welcome the client back and contract on time and confidentiality |
| Clients readiness for the results | <ul style="list-style-type: none"> • Establish how the client has been coping and feeling • Explore concerns the client might want addressed before seeing the results • Explore client understanding of the test results |
| Give results | <ul style="list-style-type: none"> • Allow the client time to process the results • Ask client the interpretation and the meaning of the result • <i>Results not from rape or assault reflect an existing HIV infection, depend on how soon after the assault the client came for an HIV test</i> |

| | |
|---------------------------------------|--|
| Review the implication of the results | <ul style="list-style-type: none"> • Assess how the client feels about the results • Discuss and explore client feelings on stopping PEP • Available HIV care services and ongoing counselling |
| Positive living | <ul style="list-style-type: none"> • Nutrition • Ongoing counselling • Medical care |
| Disclosure | <ul style="list-style-type: none"> • Establish whether the client has disclosed to anyone about the assault and whether they have anyone they can lean on for support • Discuss the importance of disclosure and discuss how the client will go about disclosure |
| Plan of action | Explore with the client on the next course and refer appropriately |

Note: During ongoing counselling, counsellors should pay close attention to the clients to capture issues that clinicians may overlook, especially the psychological effects of using PEP that may influence adherence.

ONGOING COUNSELLING

Sessions last 30 to 45 minutes.

FOR ALL CLIENTS, whether on PEP or not

The client should have at least four additional counselling sessions, booked to coincide with the clinical visits, weekly or biweekly. This allows for

- Fewer visits to the health facility
- Clinical evaluation and counselling to be tied together
- Enhances PEP adherence

| | |
|---------------------------|--|
| Introduction and contract | Follow the main protocol |
| Exploration | <ul style="list-style-type: none"> • How the client and family have coped with the situation • Client fears and concerns • Disclosing sexual violence and HIV status according to the consensus at the last session • Discuss possible pregnancy, where applicable • Explore client options |
| Risk reduction | <ul style="list-style-type: none"> • Review discussion on infection risk or transmitting HIV • Sexual history since the sexual violence incident • Discuss the status of the adopted risk-reduction strategies and way forward |
| Drug adherence | <ul style="list-style-type: none"> • Client feelings about drugs taken • PEP side effects and the evaluation with the clinician • PEP for second half of regimen • Possible PEP discontinuation, where course is not finished • Need for HIV test at the end of the 28 day drug course |

Book client and refer as necessary

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The counselling environment should be child friendly.

- Allow room for children to play.
- Provide play materials or improvise, such as providing school-age children with pencil and paper and allowing them time alone to express themselves while talking to the adult.
- If the child can talk, establish rapport.

| | |
|--|--|
| Introduction and contract | Follow the main protocol, but separate the child from the adult at some point |
| Explore with the parent or guardian | <ul style="list-style-type: none"> • Get the story from the adult • Explore with parent or guardian what the child told them, how they feel about it |
| Explore with the child, if able to communicate | <ul style="list-style-type: none"> • Get the story from the child • Explore the child's fears and concerns <p>If the counsellor thinks the child is constricted by the presence of the adult, separate them. The counsellor will then contract with the child, establishing shared confidentiality.</p> <p>If the child's story and that of the parent or guardian conflict and the counsellor is unable to discuss the disparities with the guardian or parent, either because the child's story implicates the guardian or parent or because of confidentiality, the counsellor may seek help from a more senior counsellor or the clinician in-charge</p> |
| Sharing information with the parent or guardian in the presence of the child | Separate the child and the parent or guardian |
| Assess risk | <p>If the child is about 6 years old or younger, the counsellor must assess the parent's HIV risk, with adequate explanation. The child's HIV status may have implications for the parent</p> <p>Reasons for parent risk assessment</p> <ul style="list-style-type: none"> • Information on mother-to-child-transmission |
| HIV testing | <p>The rest of the session should follow the main protocol.</p> <ul style="list-style-type: none"> • The counsellor should explore disclosure to child's other parent The counsellor may adopt strategies supporting disclosure • The parent or guardian should give consent for the HIV test |

Children older than 12 years, parents and guardians

- The counsellor should provide core conditions for the child and parent or guardian
- Separate the child and the parent or guardian

| | |
|--|---|
| Introduction and contract | <ul style="list-style-type: none"> • Follow the main protocol • Separate the child from the adult at some point |
| Explore with the guardian or parent | <ul style="list-style-type: none"> • Get the story from the adult • Discuss what the child told them and how they feel about it |
| Explore with the child | <ul style="list-style-type: none"> • Get the story from the child • Explore the child's fears and concerns <p>The counsellor must contract with the child and establish</p> <ul style="list-style-type: none"> • Shared confidentiality on the child's information • If the child's story and that of the parent or guardian conflict, and the counsellor is unable to discuss the disparities with the guardian or parent, either because the child's story implicates the guardian or parent or because of confidentiality, the counsellor may seek help from a more senior counsellor or the clinician in charge |
| Sharing information with the parent or guardian in the presence of the child | Separate the child and the parent or guardian |
| Assess risk | <p>Follow the main protocol</p> <p>Also consider</p> <ul style="list-style-type: none"> • The child may already be sexually active. This has implications for the HIV test and disclosure, since the parent or guardian must give consent for the child's HIV test • The counsellor and child should reach consensus about disclosing HIV test results before the HIV test is done • Allowing the parent into the counselling room to discuss implications of test results • Getting consent for HIV testing and discuss disclosure with both the parent and the child |
| HIV test | Refer the child for HIV testing in the lab with the signed consent of the parent or guardian |



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Giving results should depend on the contract between the counsellor, client and parent or guardian
The counselling should follow the main protocol

| Protocol | Content |
|--|---|
| The child is alone and the HIV test results positive | <ul style="list-style-type: none"> • Discuss disclosure of HIV status • Support strategies may be discussed • Review the implications of positive HIV status with the parents before disclosing test result • Disclose as agreed • Discuss disclosure of positive HIV status to other parent, where applicable • Refer to legal services and HIV care • Book ongoing counselling |



Client comes after 72 hours after assault

The session will depend on the time passed from the assault to when the client arrives at the facility.

| Protocol | Content |
|------------------------|---|
| Contract | <ul style="list-style-type: none"> Contract follows main protocol <p>Do not discuss follow-up visits</p> |
| Explore | <ul style="list-style-type: none"> Explore client story, fears and concerns Explore reasons for late visit and address them Explore client's knowledge and concerns about HIV, STIs and pregnancy |
| Give information | <ul style="list-style-type: none"> STIs Pregnancy and the options Information on questions and issues about PEP <p>Information on PEP may be provided at the discretion of the counsellor or when assessing risk</p> |
| Risk assessment | <ul style="list-style-type: none"> Follow main protocol to prepare client for HIV test, omitting PEP requirement Explore client risk history and discuss the implications Establish client knowledge of their HIV status Discuss window period Support client understand importance of HIV test Discuss disclosing sexual violence and HIV results |
| Clients test readiness | <ul style="list-style-type: none"> Review client expectations, understanding of the HIV test and results Establish client decision about being tested today, if ready refer to the lab for the test Ensure client gives consent on a signed lab request form Disclosure: need to report to police, HIV test and implications, window period, reduce risk <p>When the client is not ready for HIV test, the counsellor must summarize the session.</p> |
| Give results | <p>After HIV test contract with client, give results, explore the feelings and implications of results, use the protocol below and book for ongoing counselling</p> |

HIV RESULTS

If negative

- Discuss window period
- Risk reduction measures
- Disclosure of sexual violence and results
- Review pregnancy
- Come up with action plan. This may involve another HIV test, so the client needs to be counselled on reducing risk

If positive

- Address clients fears and feelings
- Review pregnancy
- Discuss positive living
- Refer for medical care
- Action plan, SMART goals

Annex 8. Grace was raped last night

Grace is 16 years old. She was raped last evening as she walked home from a church meeting. Her parents brought her to the hospital casualty department right away. The clinical officer on duty examined her, did the paper work, and sent the family home until morning. At 8 am, he phoned a woman counsellor and asked her to meet with Grace and her parents. This is how the counsellor described the situation:

First, I asked the clinical officer whether he had remembered to have Grace take a Nevirapine tablet (to prevent HIV infection) and emergency contraceptive pills (to prevent a pregnancy). Fortunately, she had taken both the night before.

Then I went to the outpatient department and found the family had arrived a few minutes before. Grace and her mother were sitting together and crying quietly. Her father was pacing up and down the corridor and seemed angry.

I asked Grace to come into a quiet room alone. I managed to make her feel at ease and asked her to narrate the story of what happened. Every now and then, I asked for details. Grace cried often, and showed deep bitterness. Gently I tried to ask questions that would help Grace express some of the questions and emotions I thought she might be feeling—suicidal thoughts, wanting to kill the rapist, guilt, fear that her parents would reject her, shame about what her younger sister would think of her.

Grace told me tearfully that she had had dreams of remaining a virgin until marriage, and now all her dreams had ended. I was really affected by Grace's anguish—she could have been my own daughter. But I had to remember that it was Grace and *her* feelings and *her* family that I was dealing with, not my own.

Then Grace and I took a short break.

When we came together again, Grace mentioned her fear of getting pregnant and having to have an abortion. I was able to reassure her that she had already taken medicine to prevent a pregnancy from happening.

I then mentioned AIDS and found that Grace had begun worrying about that too. I reminded her that she had already taken a preventive pill

(Nevirapine) the night before, and I explained that we would test her later in the morning. She was relieved to know that if she tested HIV negative, we could give her preventive medicines to take for a couple of months, even if the man who attacked her was not found and tested for HIV.

We then decided it was time to bring Grace's parents into our discussion. We went over some of the same concerns again with them. I discovered that Grace's father was accusing her mother for not watching Grace carefully and not being strict enough. As the father talked, he showed bitterness that all his dreams for his oldest child had been completely shattered. The mother was able to tell us how guilty she felt.

Annex 9. Observed practice learners' guide

Aspects of client service assessed

- Explain to the client what to expect
- SOLER: Sit, Open, Lean forward, Eye contact, Relax
- Use at least seven counselling skills
- Perform a risk assessment correctly
- Discuss a risk-reduction plan
- Ensure client understood meaning of test result
- Demonstrate confidence when giving result
- Discuss disclosure of test results and assault
- Support client to develop an action plan
- Deal positively with client's emotional reaction
- Give the three core conditions to the client throughout the session
- Give adequate time for the client to air out issues
- Discuss referral options with client
- Assess available social support
- Conduct a client-centred session

Annex 10. Observed practice form

Training dates: ___/___/___ Name of the trainee: _____

Trainers: _____ Session number: _____

Health facility: _____

Please score as follows: 0 = not done, 1= attempted with little success, 2 = achieved fairly, 3 = achieved successfully, N/A = not applicable.

| Aspects of service to the client being assessed | Score | Comments |
|--|-------|----------|
| Explained to the client what to expect | | |
| SOLER: Sit, Open, Lean forward, Eye contact, Relax | | |
| Used at least seven counselling skills. | | |
| Performed a risk assessment correctly | | |
| Discussed risk-reduction plan | | |
| Ensured client understood meaning of test result | | |
| Comfortable giving result | | |
| Discussed disclosure of test results and assault | | |
| Ensured client develops an action plan | | |
| Dealt positively with client's emotional reaction | | |
| Gave the three core conditions to the client throughout the session. | | |
| Gave adequate time for the client to air out issues | | |
| Discussed referral options with client | | |
| Assessed availability of social support | | |
| Conducted client-centred session | | |

Session: Start time ___:___ Stop time ___:___ Date _____

Name of supervisor: _____ Supervisor's signature _____

Annex 11. National rape trauma counselling data form



Date: _____

Facility name: _____

District: _____ Province: _____

Client name: _____

Parent or guardian name (for children): _____

Serial no.: _____ Return visit number: _____

Visit:

First visit: _____ Counsellor name: _____

Second visit: _____ Counsellor name: _____

Third visit: _____ Counsellor name: _____

Fourth visit: _____ Counsellor name: _____

Fifth visit: _____ Counsellor name: _____

CONTD NEXT PAGE

NATIONAL RAPE TRAUMA COUNSELLING DATA FORM

| | | |
|---|--|---|
| <p>1. Sex 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female</p> <p>2. Age (years)</p> <p>3. Education 0 <input type="checkbox"/> None 1 <input type="checkbox"/> Primary 2 <input type="checkbox"/> Secondary 3 <input type="checkbox"/> Post Secondary/Technical</p> <p>4. Marital Status 0 <input type="checkbox"/> Never 1 <input type="checkbox"/> Married 2 <input type="checkbox"/> widowed 3 <input type="checkbox"/> Separated/Divorced 9 <input type="checkbox"/> Other <input type="text"/></p> <p>5. Type of assault 1 <input type="checkbox"/> Penile anal rape 2 <input type="checkbox"/> Penile vaginal rape 3 <input type="checkbox"/> Use of objects in vagina 4 <input type="checkbox"/> Use of objects in anus 9 <input type="checkbox"/> Other <input type="text"/></p> <p>6. Client seen as 1 <input type="checkbox"/> Individual 2 <input type="checkbox"/> With partner 3 <input type="checkbox"/> With guardian/parent 4 <input type="checkbox"/> With friend/relative 9 <input type="checkbox"/> Other <input type="text"/></p> <p>7. Services required by client <input type="text"/></p> <p>8. Is the client the survivor 0 <input type="checkbox"/> No <input type="checkbox"/> Yes If no, specify <input type="text"/></p> <p>9. Was the PRC 1 form filled 0 <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>10. Who is the assailant? 0 <input type="checkbox"/> Known 1 <input type="checkbox"/> Unknown If known, specify relationship <input type="text"/></p> | <p>11. Did client know HIV status before the assault? 0 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes If Yes, 0 <input type="checkbox"/> Negative 1 <input type="checkbox"/> Positive</p> <p>12. Has the client reported to the police? 0 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes If no, reason(s) <input type="text"/></p> <p>a) Is the client willing to report to the police? 0 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes If not, reason(s) <input type="text"/></p> <p>13. How did the client present 1 <input type="checkbox"/> For VCT services 2 <input type="checkbox"/> Referred from a police station 3 <input type="checkbox"/> Referred from a hospital 9 <input type="checkbox"/> Other <input type="text"/></p> <p>14. Was the 1st dose of PEP administered? 0 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes If not, reason(s) 1 <input type="checkbox"/> Presented after 72 hours 2 <input type="checkbox"/> Client declined 9 <input type="checkbox"/> Other <input type="text"/></p> <p>15. Was ECP administered 0 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes</p> <p>16. 1st Visit a) HIV test done 0 <input type="checkbox"/> Negative 1 <input type="checkbox"/> Positive 1 <input type="checkbox"/> PEP continued 2 <input type="checkbox"/> PEP discontinued 3 <input type="checkbox"/> Client declined HIV test</p> <p>b) Disclosed SV to 1 <input type="checkbox"/> Partner 2 <input type="checkbox"/> Family 9 <input type="checkbox"/> Other <input type="text"/></p> <p>c) If not, reason(s)</p> | <p>17. 2nd Visit a) Disclosure of SV to 1 <input type="checkbox"/> Partner 2 <input type="checkbox"/> Family 9 <input type="checkbox"/> Other <input type="text"/></p> <p>b) Disclosure HIV results to 1 <input type="checkbox"/> Partner 2 <input type="checkbox"/> Family 9 <input type="checkbox"/> Other <input type="text"/></p> <p>c) PEP adhered to for the last 3 days 0 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes</p> <p>d) Still taking PEP 0 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes</p> <p>18. 3rd Visit a) If disclosure done so far 0 <input type="checkbox"/> No 1 <input type="checkbox"/> Yes</p> <p>b) Issues emerging <input type="text"/></p> <p>19. 4th Visit Issues emerging <input type="text"/></p> <p>20. 5th Visit Issues emerging <input type="text"/></p> <p>21. PEP adherence (reason(s) for discontinuation/non-adherence) <input type="text"/></p> <p>22. Client referred to <input type="text"/></p> |
|---|--|---|

Annex 12. Counsellor self-assessment form

| | | | |
|------------------------------|------------------------|--------------------------|------|
| Counsellor code, initials | Client's serial no. | HIV result Neg Pos NA | Date |
|------------------------------|------------------------|--------------------------|------|

Score range: 0–4

0 = very poor 1 = unsatisfactory 2 = satisfactory 3 = good 4 = excellent

- | | |
|---|--------------------------|
| 1. Did I explain to the client what to expect in the session? | <input type="checkbox"/> |
| 2. Did the client speak as much or more than I did? | <input type="checkbox"/> |
| 3. Did I perform a risk assessment? | <input type="checkbox"/> |
| 4. Did I discuss risk reduction? | <input type="checkbox"/> |
| 5. Did I give the client adequate information? | <input type="checkbox"/> |
| 6. Did I help the client understand the meaning of test results? | <input type="checkbox"/> |
| 7. Did I feel comfortable giving the results? | <input type="checkbox"/> |
| 8. Did I assess the availability of the client's social support? | <input type="checkbox"/> |
| 9. Did I discuss referral options with the client? | <input type="checkbox"/> |
| 10. Did I discuss disclosure of test results with the client? | <input type="checkbox"/> |
| 11. Did I discuss disclosure of the sexual assault with the client? | <input type="checkbox"/> |
| 12. Did the client determine an immediate plan of action? | <input type="checkbox"/> |
| 13. Did I prepare the client for the criminal justice system? | <input type="checkbox"/> |
| 14. Did I discuss issues of drug adherence with the client? | <input type="checkbox"/> |
| 15. Did I deal with the client's emotional reactions? | <input type="checkbox"/> |
| 16. Did I deal with my own emotional reactions? | <input type="checkbox"/> |
| 17. Did I give adequate time to the client? | <input type="checkbox"/> |
| 18. Did I conduct a client centred session? | <input type="checkbox"/> |

Annex 13:face handout



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