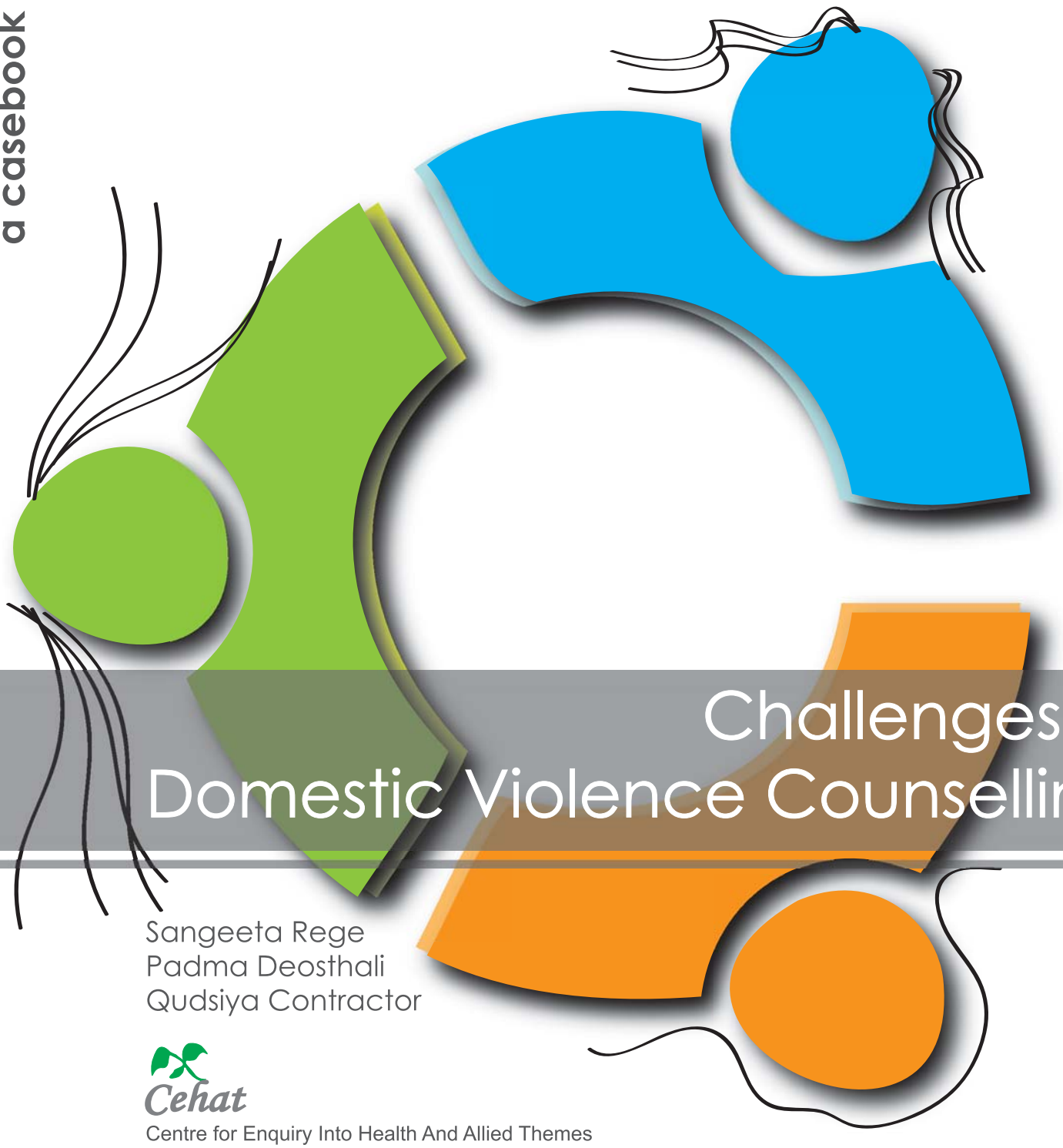
a casebook



Challenges in Domestic Violence Counselling

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Cehat
Centre for Enquiry Into Health And Allied Themes

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Foreword

Ethics of counselling care: Making a difference

On Sunday mornings in Nairobi, I was struck by empty streets and utter silence in otherwise vibrant city. It reminded me of how cities in India displayed the same 'tranquility' during the telecast of the serial on Mahabharat on Indian television in the early 1990s. My curiosity led me to explore the reasons for this calm and quiet in Nairobi on Sunday mornings. I soon learnt that it was the weekly church services around the city which explained the 'still' of the streets! Eventually, I noticed TV channels fully devoted to church services and their popularity in African continent which also reminded me of *Astha* channel that gained popularity in India and also in Indian Diasporas outside of India. It might be my unfamiliarity or even ignorance about such a "mass appeal" these services enjoy. It was astonishing to know the phenomenal scale of these appeals when I watched yet another popular show by Pastor Joel Osteen on this TV channel. I saw amongst the audience, people from all walks of life and interestingly also of all ages.

My reflections led me to think that these sermons being grounded in the contemporary day-to-day challenges, disappointments, frustrations, and anxieties in our common peoples' lives resonate very well with anyone and everyone amongst those thousands attending such services. A smart and eloquent pastor such as Joel Osteen with a poignant narrative style can easily touch people's hearts and often offer people hope and help developing a sense of support and 'feel-good'. This helps us appreciate might of our own resilience and inner strength to fight the odds that we all are confronted with in our lives. To me, it simply appears to work as powerful psychotherapy sessions with an unbeatable "professional" and "personal" touch! The most distinguishing of these sermons is that people could access this "psychotherapy" care not only in a non-stigmatised environment but in fact in socially acceptable and respected spaces. The same stands true when we use spaces with our dear and near ones wile in "distress" to speak our hearts out with the hope to appreciate our plights from alternative perspectives and to know the different ways out of seemingly impasse situations. Once again these are often safe and accessible spaces and as such not stigmatized. Many of us would find it hard to have not done this in our own lives and at times might have aspired to seek professional counselling care during difficult times in our life journeys and tried fighting battles against odds and feeling lonesome.

However, this might not always be adequate to address wide ranging needs in varieties of complex situations. The needs for counselling care and the barriers to access it could indeed be wide ranging. The counselling care needs for those subjected to domestic violence is one such situation. Dilaasa was set up to meet this situation. While the social capital that we

develop through our own social networks could be enormously valuable I don't know precisely the form and scale of casualties that the stigma attached to seeking professional counselling care in our cultures could lead to, but won't be a surprise if any research came up with substantial numbers. I am delighted to be here to set the stage for you before you soon find yourself immersed in a thought provoking case book in counselling care in the context of care to survivors of domestic violence. Prepared by the counsellors at Dilaasa the case book brings you experiential insights into ethical complexities of counselling care to women survivors of domestic violence.

Many of you might have had opportunities in the past to either directly interact with Dilaasa initiative or to read about it or in some other ways to learn and know about it. Dilaasa was set up in 2000 against several odds and operational challenges to "mainstreaming" the concept of setting up such services within the public health care system. First, although domestic violence was recognized by women's groups as a cause of concern it was not acknowledged as public health concern in the mainstream and by women's group alike. Second, counselling care in general continues to be stigmatised resulting in the both invisibility of the extant counselling care services and a reluctance to seek them. And third, domestic violence because of its nature poses severe challenges for survivors in seeking help from outside their families, if such facilities do exist.

An approach of integrating such an initiative – counselling care to survivors of domestic violence - within the established public health care system was well grounded in the comprehensive understanding of the problem at hand. Against this backdrop, over these last about 10 years, the initiative has emerged to be an encouraging "model" vindicating such a need. It has created its own mark also for strengthening the perspective that domestic violence as a public health concern. The overall seminal contributions of the women's movement in India over the last five decades have undoubtedly enabled the shaping and establishment of such an initiative.

Counselling care has become more acceptable in India since the onset of HIV/AIDS but is not yet free from stigma. The three major challenges to establishing counselling care are: (1) stigma counselling care suffers from the unavailability of general counselling care services, and (2) the counselling care profession is not perceived either lucrative or prestigious and reputable which indeed leads to a vicious circle. As a result, generally, it is a less explored area, and therefore also less discussed in our context. In that, ethics of counselling is the least appreciated and discussed. Peoples' movements, health activism, and women's health movement in India have stayed grounded in values such as social justice and equity which are foundational to ethics discourse in any and all contexts. Also, due to the sustained efforts over these last two decades research ethics has now come of age despite the lack of support and space in the mainstream academic settings. However, to

date, counselling ethics has remained fairly in the Indian context.

This case book presents 15 narratives bringing forth fairly common but some of the most complex real-life scenarios in the lives of women's facing domestic violence. Each narrative has woven together the case scenario as it developed and counsellor's response to the woman concerned to the unfolding of complex issues with ethics at the centre stage. The perspectives are that of counsellors as they grappled to resolve the ethical challenges involved.

I found them extremely engaging and stimulating which, is because they are such deeply candid presentations of the counsellors who dealt with them in person. Each case is accompanied by a set of questions to stimulate further discussion and evoke alternative view points on the ethical dilemmas faced.

As you will notice the women clientele of Dilaasa seem to come from a particular "class" living often with meagre access to resources which could have offered them a better sense of security. This particular profile of the women clientele of Dilaasa is probably because of its location in a public health care institute which more often is utilized by poorer families. Readers need to be mindful of this context and not attribute the prevalence of domestic violence to poorer families alone. Evidence from around the world demonstrates that the prevalence of domestic violence is not class specific.

I had an opportunity to interact more closely with the team of counsellors at Dilaasa during the training program on counselling care and ethics between 2005 and 2006. As a faculty my effort was to translate the feminist discourse in counselling care and ethics developed in the western context and of a more generic nature to our context and specifically to domestic violence care. In the process we employed the lens of feminist perspectives in counselling care and ethics to analyse retrospectively the cases at Dilaasa from the past. The wide ranging strategies used to resolve dilemmas were characterized by deep feminist perspectives that the team was grounded in from the very beginning and yet was grappling to capture them in a normative lexicon shared by feminists. This collective process helped us to capture issues, concerns and the strategies used by counsellors in doing so. We hoped that the documentation of these cases will sharpen our own understanding of feminist tools in counselling care and ethics resolutions.

The contributors to the case book are to be congratulated for their impressive efforts in bringing this experiential wealth to the public domain. A case book often could be an effective learning tool for peer community for it provides real-world scenarios; the treatment or response it received by counsellor and the questions and dilemmas the case might have generated. This very typicality of case books holds promise for both novices and trained professionals. This case book possesses these typical features but what makes it distinct is its experiential

wealth. I also hope that this will encourage others concerned to contribute to the discourse on ethics of counselling care practices in domestic violence and other interventions involving counselling care. The lessons and discourse from biomedical research ethics indicate the need to arrive at a middle ground and most importantly to continue to engage with issues and challenges in the practice of ethics in wide ranging social cultural contexts.

Furthermore, the long term goal of such efforts to document and disseminate should be ultimately to afford the much required recognition to the potential key contribution that ethical counselling care could make to prevent the avoidable trauma that women suffer from and also avert the loss of life due to domestic violence. Ultimately ethics discourse and ethical practices are to serve those affected.

Together, we can make a difference!

Sunita Sheel Bandewar

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Introduction

Counselling as a discipline has been recognised only in the past two decades in India, especially with the wide network of counsellors for pre and post test counselling in HIV. Counselling calls for a close relationship between the counsellor and counsellee, one that deals with extremely sensitive and private/ intimate issues. From counsellors' own values to patient's decisions and its consequences, relationship with partner/family and many other areas of a person's life fall within the purview of a counsellor's role. These throw up various challenges and also create situations where counsellors have to take decisions related to what they should or should not do. There are no spaces where these could be discussed with peers/experts.

There is little information/documentation available in India. Nor are there ethical codes for counselling. Ethical codes for counselling essentially describe the rights and responsibilities of counsellors and provide standards for principles, values, conduct, attitudes for using the knowledge and skills of the profession. Most importantly, the codes focus attention on the welfare and rights of the clients as the social and professional obligation of the professional. These exist in the US, Canada but except for efforts by organisations like the Bapu Trust there is very little effort made to even articulate ethical issues/dilemmas in counselling care.

In India, until recently ethical guidelines had not been formulated even for social science research. As a leading institution in health research in India, CEHAT brought together a multidisciplinary group evolve "Ethical Guidelines of social science research in health" through a consultative process. These guidelines provide an ethical framework based on the four normative principles. The discourse on research ethics was institutionalized through the setting up of Institutional ethics committee that reviews projects of CEHAT at various stages of implementation for observance of ethical guidelines. This meant that all projects were tuned into the ethics discourse and enthused to reflect on their actions in this perspective. The Dilaasa[1] project too was implemented in this overall organizational environment.

CEHAT, through its collaboration with a public hospital, has set up counselling services for women facing domestic violence. These were set up as a demonstration model on how a public hospital could be sensitised to respond to the issue of domestic violence. Domestic violence was brought into the public domain by the feminist movement in the 1980s in India. Women's activists have advocated changes in the legal and police procedures through numerous protests against dowry deaths, custodial deaths, abduction of women, sati, sex determination and sex selection, sexual harassment, trafficking and prostitution. Some of the autonomous women's groups did set up services for individual women and strongly rallied for legal and social reform. The later part of the 1990s, however, has witnessed a greater

[1] Dilaasa is joint initiative of CEHAT and the Municipal Corporation of Mumbai

involvement of mental health activities, counsellors in planning interventions to respond to specific needs of survivors. There has been a growing acceptance that matters concerning the individual such as her mental health needs and individual therapy is critical and needs to be addressed and understood within the larger socio-political context.

Dilaasa is the first public hospital based crisis centre where in professionals were trained in providing social and psychological support to women facing domestic violence. The critical components of the counselling services set up at Dilaasa by CEHAT were:

- A counselling practice with a feminist perspective
- Response system to psychological as well as social needs.
- Process of dealing with suicidal ideation.
- Sensitisation of health care providers on DV so that they could identify abuse amongst patients coming to them.

During the course of counselling, we were faced with several challenges; most often there were no answers to those challenges. As counsellors, we often grappled with questions such as, Did I provide the woman with all the alternatives? Could I have done something differently? How would another counsellor have dealt with this situation? Can my intervention put her at a life threat?

These challenges were often discussed and debated during case conferences and training sessions with colleagues and experts. In the course of these debates, we were drawn to the discourse on counselling ethics. Counselling ethics involves the study and evaluation of moral beliefs and actions of counsellors within certain professional domains. Ethics in counselling is primarily concerned with two questions: How should counsellors act? How should counsellors justify holding one set of moral values rather than another? Ethical decision-making involves choice. In the context of counselling, these choices have to be made keeping in mind the best interests of the client (Cross and Wood, 2005).

This was because the field of ethics offers the scope to deliberate on questions such as: why do some options seem more appropriate than others, how should choices such as good/ bad, right/ wrong be understood? The framework of ethics helped us to understand the implications of our work. Nevertheless a need was felt to document all the challenges faced in the course of counselling, and ways in which we attempted to resolve them. Ethics discourse for any profession provides a perspective that guides practice. In India, ethics in medical practice and ethics in social science and medical research have gained significant ground in recent times. However, counselling ethics has not received any attention.

The casebook presents a range of challenges faced in DV counselling through 15 case studies. Though the challenges pertain to DV counselling, counsellors in other fields may also be able to identify with these challenges. We also hope that the book will be used as a training tool enabling the development of counselling ethics in an Indian context. Lastly, this document will be a useful contribution in the training and sensitisation of various services providers and protection officers in the implementation of the newly enacted act, Protection of Women from Domestic Violence Act (PWDVA), 2005.

Theoretical framework

There are various approaches to bioethics such as deontological ethics (founded on the ideas of Kant), utilitarian ethics (based on the writings of Hume, Bentham and Mill) and feminist ethics (based on feminist philosophy and political theory) among others. This reflects the diversity of ethical models within moral philosophy. The principles of bioethics as they apply to counselling ethics are presented here followed by a description of the Critical Decision-making Model that we found useful for deliberating on the challenges faced from an ethics perspective.

Principles of counselling ethics:

The principles of biomedical ethics have heavily influenced the development of ethical principles for counselling and psychotherapy. The four principles proposed are:

- *Autonomy - Respect and protect rights and dignity of clients*

The principle of autonomy involves taking client's interests into account when considering what to do in a counselling situation or during the course of the counselling process. This principle essentially means involving clients in decisions which affect them with the presumption that they are the best guardians of their interests. It recognises that clients have agency. This is done not increasing their risk of illness or death, misinform them, violate the integrity of their intimate relationships or treat with indifference what they deeply value. Central to this principle is to support a client's sense of self worth and self respect in order to help create conditions in which they can lead worthy and meaningful lives.

- *Non-maleficence - Cause no harm to the clients in particular and the community in general*

The principle of non-maleficence is based on the assumption that any intervention including counselling carries some risk to clients and to society. Therefore, application of this principle involves taking adequate precautions, minimising and mitigating risks is essential. Client's participation in the counselling process should not expose them to risks.

- *Beneficence - Ensure a positive contribution towards the welfare of clients*

This principle refers to an action done to benefit others. In other words, the principle of beneficence involves balancing benefits and risks or drawbacks to produce the best overall

results in a counselling situation or process. The principle refers to the moral obligation to act for the benefit of others and to help further their important legitimate interests.

- *Justice - Benefits and risks of any intervention should be fairly distributed among people*

Justice implies fair, equitable and appropriate treatment in the light of what is due or owed to the client. Injustice involves a wrongful act or omission that denies people benefits to which they have a right or distributes burdens unfairly. The principle of justice in ethics refers to the distribution of all rights and responsibilities in society, including for e.g. civil and political rights.

Several counselling associations in the West[2] have added two more principles to the above framework namely – fidelity and self respect (Bond, 2000).

Fidelity refers to notions of loyalty and commitment towards the client. Clients must be able to trust the counsellor and have faith in the therapeutic relationship if growth is to occur. Therefore, the counsellor must take care neither to threaten the therapeutic relationship nor to leave obligations unfulfilled.

Self respect refers to fostering the counsellor's own knowledge and care of self. There is an ethical responsibility to use supervision for appropriate personal and professional support and development, and to seek training and other opportunities for continuing professional development. The British Association of Counselling and Psychotherapy (BACP) (2007) further adds that the principle of self-respect encourages active engagement in life-enhancing activities and relationships that are independent of relationships in counselling or psychotherapy.

The Critical Evaluation Model in Ethical Decision Making

The critical evaluation model is a guide to ethical decision making which is based on the principles of ethics. It provides some direction to counsellors in making ethical decisions and resolving ethical dilemma. The ethical decision making model described here is based on that of the American Counselling Association (ACA) (1996) which seems the most comprehensive and is based on the theoretical and philosophical work of several others. The following describes the seven steps within the critical evaluation model:

Step 1 - Identify the problem

It is important to gather all possible information about the situation. There are questions a counsellor must ponder over – is it a therapeutic, legal or professional dilemma?

Other questions that it may be useful to ask yourself are: Is the issue related to you as a counsellor and what you are or aren't doing? Is

[2] These include the American Counselling Association (ACA), Canadian Counselling Association (CCA), British Association for Counselling and Psychotherapy (BACP), etc.

it related to a client and/or the client's significant others and what they are or aren't doing? Is it related to the institution or agency and their policies and procedures? If the problem can be resolved by implementing a policy of an institution or agency, you can look to the agency's guidelines. It is good to remember that dilemmas a counsellor faces are often complex, so a useful guideline is to examine the problem from several perspectives and avoid searching for a simplistic solution.

Step 2 – Apply the code of ethics

After you have clarified the problem, it would be useful to refer to a code of ethics or ethical guidelines to see if the issue is addressed there. If there is an applicable standard or several standards and they are specific and clear, following the course of action indicated should lead to a resolution of the problem. To be able to apply the ethical standards, it is essential for a counsellor to understand their implications. If the problem is more complex and a resolution does not seem apparent, then a counsellor probably has a true ethical dilemma and needs to proceed with further steps in the ethical decision making process.

Step 3 – Determine the nature and dimensions of the dilemma

There are several avenues to follow in order to ensure that a counsellor has examined the problem in all its various dimensions:

- Consider the moral principles of autonomy, non-maleficence, beneficence and justice[3]. Decide which principles apply to the specific situation, and determine which principle takes priority in this case. In theory, each principle is of equal value, which means that it is a challenge to determine the priorities when two or more of them are in conflict.
- Review the relevant professional literature to ensure that you are using the most current professional thinking in reaching a decision.
- Consult with experienced professional colleagues and/or supervisors. As they review with you the information you have gathered, they may see other issues that are relevant or provide a perspective you have not considered. They may also be able to identify aspects of the dilemma that you are not viewing objectively.
- Also consider referring to ethical codes of other professional associations to see if they can provide help with the dilemma.

Step 4 – Generate potential course of action

Brainstorm as many possible courses of action as possible. Be creative and consider all options. If possible, enlist the assistance of at least one colleague to help you generate options.

[3] As mentioned above some counselling associations including the American Counselling Association have added 'fidelity' as a principle in their code of ethics to the four mentioned above. Fidelity refers to notions of loyalty and commitment towards the client. Clients must be able to trust the counsellor and have faith in the therapeutic relationship if growth is to occur. Therefore, the counsellor must take care neither to threaten the therapeutic relationship nor to leave obligations unfulfilled.

Step 5 – Consider the potential consequences of all options, choose a course of action.
Considering the information you have gathered and the priorities you have set, evaluate each option and assess the potential consequences for all the parties involved. Ponder the implications of each course of action for the client, for others who will be effected, and for yourself as a counsellor. Eliminate the options that clearly do not give the desired results or cause even more problematic consequences. Review the remaining options to determine which option or combination of options best fits the situation and addresses the priorities you have identified.

Step 6 – Evaluate the selected course of action
Review the selected course of action to see if it presents any new ethical considerations. It is important to reflect from an ethics perspective, the possible consequences of a selected course of action.

Step 7 – Implement the course of action
Taking the appropriate action in an ethical dilemma is often difficult. The final step involves strengthening your ego to allow you to carry out your plan. After implementing your course of action, it is good practice to follow up on the situation to assess whether your actions had the anticipated effect and consequences.

Summing up:

The case studies included here have been contributed by counsellors in Dilaasa based on their experiences of working at the centre. All names used in the cases have been changed to protect identities. These case studies were discussed Dr. Sunita Bandewar during a training session on Counselling ethics for the counsellor and researchers working on Dilaasa. Largely, this model helped us to deliberate on actions in challenging situations (as perceived by counsellors) and decide on appropriate steps. It is important to note here, that on several occasions there was a strong feeling that certain 'dilemmas' presented were due to lack of competence of the counsellor. And we realised that the issue of competence, therefore becomes important when one is debating on "whether it was right or wrong". An important lesson learnt is that an exercise of self reflection, ongoing discussion, capacity building, case presentation and supervision are pivotal to building a good counselling practice.

There is a definite need to evolve a code of ethics for counsellors. However, such a code will offer directives to counsellors rather than absolute answers. A code by itself may not be able to address many issues. For instance, there could be conflicts at times among the articles in the code, values, organisational practices confounding the application of the code, and so on. In this context, counselling casebooks offer useful insights and clarifications of challenges and dilemmas.

We hope that this casebook promotes discussion on ethical issues in counselling practice and sets in motion development of ethical guidelines for this profession.

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Case study 14

Respecting autonomy: Even at the cost of client's safety?

A is a 22-year-old unmarried woman staying with her mother and brother S. She works as a secretary in a private firm. Her brother takes drugs and constantly demands money from her and her mother. If refused, he threatens them with dire consequences. S had also sold his mother's ornaments as well as household assets such as utensils and the television set to procure drugs. Both mother and daughter live in constant fear of her brother, because his rage is so unpredictable.

A returned home one night from a Navratri party hosted by her friends. S questioned her about coming home late and accused her of being a 'bad character' and staying out late. A asked her brother to stop using such language and said that she had in fact told their mother about that she would be late. A's mother tried to intervene in the argument, but in a fit of rage, S stabbed A in her chest with a kitchen knife. She was rushed to the hospital and that is how she came in touch with the crisis centre.

When the counsellor approached A, she told her that she and her mother have been living with an extremely abusive brother for many years. The counsellor validated her experience. A's mother had recorded a statement with the police that the current incident was an attempt at suicide. When A came to know of this, she wanted to correct the statement and record the true facts of the incident. But her mother was trying to dissuade her, by saying that it was after all a family matter and it was not right to get him arrested. She promised A that it would be her responsibility to ensure that she did not face any more abuse. The counsellor explained to A that her mother had failed to protect her from this severe assault and also helped her to accept that her brother was also abusive to the mother. The counsellor explained to A that S could be arrested on the charges of threat to their lives if the true statement was recorded This was the only way out of the situation as the intensity of violence had increased significantly.

The counsellor also showed the MLC papers where her mother had reported that this was an attempt to suicide by A and told her that this could also be used against her as suicide is seen as a crime in India. When this was explained to A, she felt ready to some extent to make a complaint. The counsellor also provided her information about shelter facilities and working women's hostels and said that accommodation could be arranged for her if she decided to leave the house.

But A's mother was trying to convince her that once S joined the de-addiction centre, he would definitely change. This prompted the counsellor to conduct a joint meeting with A and her

[4] The case studies included in the case book have been contributed by counsellors in Dilaasa based on their experiences working at the centre. All names used in the cases have been changed to protect identities

mother. In the meeting the counsellor expressed concern about S's increasingly violent behaviour and explained that his consumption of drugs was not the sole reason for the abuse. If he was arrested this time, he would probably think twice before getting abusive again. It was further pointed out that if he was willing to admit himself to a de-addiction centre, the counsellor could give them information about available centres and contact a centre as well. Though A's mother was concerned about her daughter's safety, she was finding it very difficult to register a police complaint against her son. She kept saying in the joint meeting that she would ensure that her daughter did not face abuse any more. It was a difficult choice for A to make because she felt that she might lose her mother's support if she lodged a complaint. Finally A did not change her statement.

Two years later, A was admitted to the hospital after an attempted rape by her brother. When the counsellor went to meet her in the ward, she refused to talk to her and said that the counselling centre had not done anything for her in the past. The counsellor tried to explain that she could not have forced the decision of giving a true statement the last time that she was admitted when she was stabbed. But A maintained that the centre had failed to provide her the support and refused to talk further.

Questions:

1. Was A exercising her agency or was she protecting her family?
2. Did the counsellor fail to ensure A's safety?
3. What are the steps that could have been taken to resolve the differences between client's wish and her mother's dilemma?

Case study 2

Client's suicide: What is the counsellor's responsibility?

35 year old G is married for 15 years. She had been deserted by her husband six months before. When she asked for custody of children, he refused to give the custody claiming that she had a mental health problem. G had tried various ways of reconciling with her husband but nothing had worked. She was not allowed to talk to her children in these six months; she was extremely disturbed about this fact. She came to the counselling centre with an expectation that the counsellor should help her to go back to the matrimonial home.

G reported that though her husband had a steady income from a boating business, he had never paid the childrens' school fees. It was G who finally started to earn money by taking up some tailoring: stitching rags together and selling them to manage the expenses of the house. Throughout her marital life, the husband had had a string of extra marital affairs, but she had ignored it as she was staying there for her children. She was always labelled as being slow in her work and the family used to taunt her as being mad. Divorce was the biggest threat she faced throughout her married life One day the husband accompanied by the brother in law brought her back to her parental home on the pretext that she needed rest and they would take her back once her health improved.

G wanted the counsellor to help her in cohabiting with her husband. The counsellor explained to the woman that she was justified in wanting to stay back in the matrimonial home, but doing so forcibly could further aggravate her husband's abusive behaviour towards her. The counsellor also tried to explain to her that several attempts by her family as well as community had been made to bring about a reconciliation but the husband had refused to live with her. The counsellor explained to her that making a marriage work was a joint effort; she had done everything to make it work, so she should not blame herself for anything. The Counsellor assured her that she would be able to overcome this difficult phase soon because she also had supportive parents.

G told the counsellor that if reconciliation was impossible, she at least wanted custody of her children. The counsellor explained to her that there was a provision under the law where she could not only try and seek custody of her children but also seek maintenance/ monetary support from the husband.

In the course of the slow court proceedings, G got increasingly restless. She would often come to the centre and cry for a long time. The counsellor would explain to her that court procedures were always long drawn out and that if she should try to engage herself in activities that would take her mind off her situation. Various suggestions were made, but G but she turned them down. The counsellor was increasingly unable to reach the woman. In one of the case conferences, it was decided that there was a need to examine if she was

depressed. But the reports of the clinical psychologist did not indicate this.

The counsellor tried various methods of strategising in order to make counselling most effective. In one such attempt, G was requested to bring her parents to understand the nature of support received by her. The parents were very sensitive and reiterated that G should engage in activities that gave her pleasure. They too were very concerned about her constant crying. They had also asked her friends to visit her so that she did not feel lonely. They told the counsellor that they were planning to visit their older son who was fond of G, and this would hopefully provide some diversion and a change of place at least for some time.

Around a month later, G's matter came up for court hearing. G's husband said that he was willing to pay her a one time settlement of Rs. 2 lakh if she decided to agree to a divorce by mutual consent. G was very clear that she did not want the money but wanted justice for the way she was humiliated and treated for so many years. The counsellor explained to G that if she would accept this settlement, it would take care of her financial needs. Further her husband had already decided to remarry so reconciliation at this point would be difficult. The counsellor suggested that a joint meeting could still be conducted in order to ensure that she got custody of at least one child.

G was not convinced of this deal and was unwilling to divorce her husband. The counsellor told her that the monetary amount would support her to establish her future life, but she said that she was not interested in the money at all. G did not follow up for the next few days. When the counsellor called her, she told her that she would come to the centre the following week.

Only a few days later the lawyer called the centre to say that G had doused herself in kerosene and attempted suicide. She died of burns. It was a shock for the counsellor. When she contacted G's parents to offer condolence, they said that they wanted to pursue a criminal case against her husband as he was responsible for G's death.

G's case was discussed at length in a case conference, where the counsellors tried to explore what they could have done differently to reach out to her, how they could have prevented her from the suicide / where they had missed that she may have been thinking of ending her life? Through the discussion, the team also realised that her understanding of justice was different from ours, and it was impossible to change that. But the question that remained and continued to exercise the minds of the counsellors was whether G's death was avoidable.

Questions:

1. Do you think that the counsellor could have prevented the woman's death?
2. What are the various perceptions of justice for women? How should the counselling process address these?

Case study 3

Is the Counsellor justified in imposing her values with a view to ensuring the client's safety?

X is a 26 year old woman with two sons aged, 6 and 3 years. Her husband used to constantly torment her by saying that he would not treating her as a wife but would not divorce her either, even if she wanted it. He refused to have sexual relations with her for two years. X learnt from the women in the community that he was having an affair with another woman.

X came to the counselling centre on hearing about it in the community. She told her counsellor that her husband used to constantly hurl abuses at X's family which used to cause her immense agony. She was not allowed to visit her parents who stayed at five minutes' distance. She told the counsellor about an occasion when after a visit to her mother who was sick, her husband accused her of being a prostitute engaging in sexual relations with her brother-in-law. This angered her and she protested, saying that he had no right to make such an accusation. His response was to hit her and kick her. She came to the counselling centre to decide upon a future course of action as she was tired of being subjected to the emotional and physical abuse.

She told the counsellor that she wanted a joint meeting with her husband to get him to stop the abuse to ensure that he treated her like a wife. The counsellor provided her emotional support and prepared X to draw up an alternative plan of action in case her husband refused to fulfil her expectations. It was decided that if he was unable to have her expectations fulfilled, she would ask him to buy her an independent place and provide financial support for her and the children. The counsellor prepared X for the joint meeting.

On the day of the meeting, X's husband did not come alone but was accompanied by his mother, sister and her husband. In the course of the negotiations her husband raked up issues from the past and insisted that his MIL should apologise to his mother as she had behaved badly. X found all this absurd and said that these issues were very old and that the meeting should concentrate on the current differences and issues. Her husband became very angry and said that it was this behaviour that annoyed him. He kept saying that he would not treat her as a wife and make her suffer. The meeting was not progressing well, so the counsellor intervened and said that if he was unable to treat her with the dignity that a wife deserved, he should make provide for her welfare so that she could live properly. To this he coolly pointed out that both the sons would have to be transferred to a municipal school, because he could not afford any better, only Rs. 2000. X did not find this acceptable as the children were now in a private school till date the husband refused to accept this and said that if she wanted custody of the children she would have to pay the amount.

As the meeting was coming to an end, X confided in the counsellor that she was pregnant. It was a revelation to the counsellor; she spoke to X in private and explained to her that it would be advisable not to divulge this information in the meeting. But X felt that her husband was falsely claiming that he had not had sexual relations with her. The counsellor tried to explain to X that he was unwilling to take responsibility of both the sons and it was unlikely that he would be able to provide support for the third child. But X felt that she should share this information in the meeting, so she confided in her mother in law (MIL). Upon hearing this news her mother in law said that the negotiations could not go on and she would take care of X as giving a divorce to a pregnant woman was not permissible in their community.

When X followed up later, she told the counsellor that her husband's behaviour had worsened as he was very angry that she had revealed her pregnancy. But her MIL was somewhat supportive and she was currently living with her.

The counsellor tried explaining to X that her husband was clearly refusing to take any responsibility, and was not providing any economic support so she should think of terminating this pregnancy. But X firmly believed that if she had a daughter things would change and her husband would come around. The counsellor tried to explain to her the inherent contradictions in her husband's behaviour, but X decided to continue with the pregnancy. .

Questions

1. Was it appropriate for the counsellor to ask the woman to conceal her pregnancy status at the joint meeting?
2. Do you think the counsellor tried to impose her values on the client in doing so?

Case study 4

Right to self determination: Defining competence in case of mental illness

R, a 19 year Muslim girl was admitted to the hospital after she consumed poison. The counsellor at the crisis centre met her and provided her emotional support. During the session, the girl revealed that she had consumed poison because she was pregnant and her boy friend had refused to marry her. She wanted to have abortion. She was underwent a medical termination of pregnancy (MTP) procedure and asked to follow up for counselling sessions because R looked shaken after the episode.

In the subsequent counselling sessions, R, one of four siblings, had throughout her life, seen her father being abusive to her mother. R was married at a tender age of 16 but was soon divorced and was living with her parents. She felt bitter about her broken marriage as well as the desertion by her current boyfriend. The counsellor explained to her that the failure of her relationship was not her fault and she was encouraged to recognise the irresponsible behaviour of her partners.

The counsellor engaged with her to decide upon a future course of action. In the many sessions that followed the counsellor noticed that R did not seem alert, often forgetting the time of day, or where she was staying, and yet she would not be perturbed by it. This made the counsellor suspect that there may be an underlying mental illness that required psychiatric attention. In order to understand the severity of the condition, she was counselled to visit the psychiatry department. After having received a sufficient explanation about the need for such a referral, she agreed to visit the department. There, she underwent psychological testing and psychiatric assessment which revealed that she was suffering from “paranoid schizophrenia”

The counsellor explained the psychiatric illness to *R* and also asked her to come regularly for counselling and continue with the medication. She was also provided information about the side effects of the medication and emphasised the need to continue the same. But in a few days, she stopped coming to the centre and also quit taking her medication. It was her mother who approached the counselling centre when R left her house and had not returned even after a couple of days. Her mother was determined to get her married to a 45 year old man. The counsellor explained to the mother that she should give R some time to make a decision,

A few days later, R approached the counsellor, saying that she wanted to get married to the man chosen by her parents. She left the matrimonial home within a few days and started staying with various people. She would come to the counselling centre every day, saying that she was staying with a friend one day, and a relative another day and with someone else another day. The counsellor could see that she

was making up stories; her physical health had deteriorated significantly. Whatever was being said in the counselling was not reaching her at all. One day when she came to the centre, the counsellor noticed several injury marks on her body and blood stains on her clothes. The counsellor suspected that she was being sexually exploited and sought to find out more about it. The counsellor was also aware that her mental health condition had deteriorated significantly.

When the counsellor expressed concern about her injuries and her condition, *R* said that she had consumed half a bottle of pills after a man she has been living with refused to marry her. But soon, in a matter of a few minutes, she changed her story and said that it was her gharwali who had hit her. The counsellor urged her to seek treatment for her injuries and also spoke to her at length regarding the risks and exploitative nature of sex work. However, this conversation too did not have any impact on her. In the midst of the session, she sought information on HIV/ AIDS.

The counsellor felt a growing concern for her deteriorating mental health and suspected sexual exploitation. In spite of repeated counselling sessions, R's condition was not improving. Her choice of sex work was made in order to survive independent of her parents because she was also plagued by thoughts of being a burden on her parents. The counsellor feels that her mental condition which is deteriorated substantially is making it impossible for her to recognise consequences of what she is doing. The counsellor was left with suggesting that the safest place for her to live in would be her mother's house. She refused the alternative.

Questions

1. Should the counsellor have called the parents against her will and involved them in taking care of her?
2. Does a woman with a deteriorating mental health condition have the right to decide on her treatment? Why/ why not?
3. How important is it to admit her in a hospital or insititutionalise her against her will?

Case study **5**

Difficult clients: Is such labelling judgemental?

C, is a middle aged woman who came to the counselling centre on seeing the posters of the centre. She had been living with an alcoholic husband for the past 15 years. She had a daughter who is 12 years old. She told to the counsellor that her husband did not provide any income at home. He also threatened to poison her and their daughter. She feared for their lives. She said that many years back, her brother had sold the house to her and her husband. As the ownership of the house was not very clear she feared that her husband would throw her out of the house.

The counsellor provided her emotional support and also developed strategies to ensure that she and her daughter are safe. The counsellor suggested that C should seek support of her neighbours and refuse to the let the husband enter the house when he was drunk. In the next counselling session, C said that things at home had worsened and she felt unsafe in the house. The counsellor suggested that in such a situation it would be advisable to file for an injunction which would ensure that the husband would have to stop violence. The counsellor asked C to make a police complaint as injunction would take some time.

In the next counselling sessions, C made various demands from the centre such as monetary provision for getting electricity, books for her daughter, and so on. But it was not possible for the counsellor to provide financial support, though books and uniform for her daughter was provided through garnering support from donors to the hospital. It was difficult to explain to C that counsellors were also paid staff and the role of counsellors was not to provide financial support to women.

In each counselling session, C reported that the intensity of the abuse was increasing but when the counsellor offered her the option of alternate accommodation, she would shoot them down. The counsellor had expressed concern over the fact that she had said that there was a threat to her life. One day C came to the centre with a big gash on her forehead. The counsellor accompanied her to the casualty and ensured her treatment as well as medico legal documentation of the assault. She again reiterated that violence was clearly escalating so it was not safe for her to live in that house. Therefore temporary shelter was suggested as an alternative to her but C refused to move out of the house because she said that she was the rightful owner of the house and it should be her husband who should leave. She was clearly refusing to see the threat to her life and her daughter's.

C asked the counsellor to call for a joint meeting with her husband and brother. The counsellor said that several attempts had been made to talk to both of them, but they were refusing to do so. The counsellor had also spoken to the brother if he could sell the current house and provide her a separate accommodation in another place. But C had

turned it down because she wanted to stay in the same locality. In fact when the broker sent by her brother came to visit her, she told him that he should not interfere in their personal matter. Clearly her brother was annoyed and was not interested in a joint meeting. But C kept insisting on such a meeting. When the counsellor reiterated that the past contacts made with her family had not led to any support therefore they may not even come for the meeting. But C insisted that the centre should call for a joint meeting. So her family were asked to come to the centre to discuss matters pertaining to her house as well as to extend support to her because her husband was abusive .

In the joint meeting, both her brother and her sister started blaming her for the abuse and lent support to her husband. They said that she fought with every one and was argumentative. The counsellor tried to explain to the family that if they could not give her ownership of the house, they should ensure that she did not face any further abuse from her husband at home. But no one was willing to take that responsibility.

After the joint meeting when counsellor tried talking to C, she said that the centre had failed her and left. She returned after a few days and said that she wanted to file a case for maintenance. The counsellor explained to her that her husband had not been regular at his workplace, for the past two years, he had also not been receiving a salary therefore it may not be feasible to seek maintenance. Further it was her brother who was providing him money. But C felt that he had not yet been sacked from his job so he should be able to pay monthly maintenance.

The lawyer helped her to file a maintenance case in the court and after a month she received a court order stating that she should be paid a monthly amount of Rs. 600. C reported to the counsellor that he had not paid the amount. It was explained by the counsellor that it may be difficult to get him to pay the amount, but he could be charged with a contempt of court so she should inform the police so that they could take the needed action. The counsellor also suggested that C should start some work as well. But she felt that if she started working then the chances of her husband providing for her would reduce further. The counsellor asked C to reflect upon her own life and appreciated the way in which she had handled her life and her daughter single handedly. She also told her that she had to move on in her life because various options had been tried by the centre as well as her , but he was not attempting to change his behaviour. But C said that now she would file a criminal case against her husband. After a lot of assistance, the counsellor along with a lawyer was able to file a 498A. Her husband was arrested on the charges of threat to the life of C and her daughter and various NC's filed in the past. After a few days, C heard that her husband's health had deteriorated in prison and went to the police station to withdraw her criminal case.

In case of C, various strategies and alternatives

were tried in order to reach out to her and provide her support, but the counsellor faced various difficulties. In one of the case conferences these issues were discussed, thus it was decided that the other counsellor would take over. But after a period of some days most counsellors were facing the same difficulty as C would go in the same circles. At this point it was felt that C could have developed a mental health problem due to the abuse she has faced and get her mental health support. But after referring her for such an assessment it was seen that she did not have any underlying mental health condition. For most counsellors C remained a difficult client.

Questions:

1. Is there anything else that the counsellor could have done in this case?
2. Is it appropriate to call a client difficult?

Case study 6

Informed consent: Can it be totally free of any sense of obligation to the counsellor?

B is a 48 year old woman, educated till class 10. Her husband had been abusive towards her; often had extra marital affairs and would bring women home in her presence. He repeatedly tried to throw B out of the house and on one instance also tried to kill her by poisoning her. Following her husband's attempt at poisoning her, she filed a formal complaint with the police. Since the past 10 years, she had been thrown out of her home and deserted by her husband who also had custody of her two children aged 19 and 16. She had no contact with them as her husband has severed all ties.

Initially her sister provided her shelter, but not for long. Her three brothers refused to take care of her. Eventually she started working as a domestic worker where her employer helped her to get a lawyer in order to get custody of her children and maintenance from her husband. However, the lawyer duped her into settling for a mutual consent divorce.

In the past 10 years, she has been to several shelters in the city as she was unable to take up work and get a rental accommodation. None of the places could offer her a permanent residence. During her stay in one of the shelters, she fell ill and was brought to the hospital where Dilaasa is located. So many years of abuse had had an impact on the woman and she suffered from mood swings. She also suffered fits. Her health condition was a further barrier to getting a shelter.

A temporary staying arrangement was made. In the course of counselling, an attempt was made to address the violence that she faced and the shelterlessness/destitution that she suffered. To address the lack of shelter, the counsellor thought about *U*, another client with the centre who had moved on to become independent and had offered to help any woman facing violence including shelter at her house. The counsellor thought of asking *U* for help since she felt that B needed a home to regain her health and move towards being self sufficient. B was happy too to stay in someone's house instead of a shelter. So the counsellor spoke to U over the phone and explained B's condition and history. U was willing to provide shelter. The counsellor asked her to come to the centre to meet B first and then take the decision. U came to the centre where the counsellor spoke to her at length and told her about B's health problems and all that she had gone through. Then U met B and they spoke to each other. U then told the counsellor that she would be happy to take B home. *U* also offered to get B a job at the place where she worked.

Soon after B moved into *U's* home, problems emerged between the two. B accused *U* of stealing her belongings. Arguments and quarrels were frequent between the two. Often

this led to U reaching her workplace late. Soon *U* lost her job, losing her only source of income.

Informed consent was sought from *U* by explaining to her B*'s* situation and that she could disagree to shelter B in her home and yet the relationship that the centre shares with *U* would not get affected. However it is possible that *U* felt compelled to shelter B since she felt a sense of gratitude towards the centre for having helped her in her time of crisis. So she may have consented to providing shelter to B out of a sense of obligation and because she was unable to refuse the request

This raises questions about the influence that the counselling centre can have over its clients. In spite of the fact that the centre sought to get informed decision from U there is enough reason to question the extent to which her decision would have been "her own" or was based on her gratitude towards the counselling centre.

Questions:

1. How can one be sure that consent is free of gratitude or obligation? Do you think the centre took adequate steps to ensure that?
2. One of the principles of feminist counselling calls for women survivors to join the feminist movement and reach out to other women. This clearly has consequences. How should this be operationalised?

Case study 75

Caring for the client: Does it include lying on her behalf?

A 30-year-old married woman was facing extreme forms of violence from her husband, who was also very violent to their two young children aged 2 and 4. In one of his violent spells, the husband burnt to death both the children. The husband was arrested, and was facing long-term prison sentence for killing.

The woman was pregnant at the time of this incident. Her mother was the only local support she had. However, mother was old and poor, without resources to support her or the time to care for her during the pregnancy. So she was sent to a shelter for women. During her stay there, the care givers at the shelter discovered that she suffered from epilepsy. They also found that the violent death of her children had deeply affected her, and she was showing signs of mental health problems. There were doubts whether she would be able to take care of herself, on her own; more so after giving birth to the child. They concluded she needed counselling support and also referral to mental health and medical professionals. She was referred to the hospital-based crisis counselling centre that provided emotional and psychological support to women facing domestic violence.

During the course of counselling, she talked about her grief, anxieties and insecurities with the counsellor. She was very concerned about the future of the child in her womb in the context of the violent death of two of her children by their own father. She told the counsellor that she feared the worst for her child and so wanted an abortion. Given her pathetic economic condition – including her inability to support herself, the social stigma of being wife of a person imprisoned, and her delicate mental health status, the counsellor was sympathetic to her demand. But her pregnancy was already more than 20 weeks old, and the law did not permit medical termination at such an advanced stage of pregnancy. The counsellor explained to her that an abortion was not a legally available option for her.

But anxiety about the security of her child was a really disturbing her, and so they explored other option which was to give birth to her child but immediately give it up for adoption. However, the adoption laws in the country require the consent of the father of the child if it was born to a married couple. Even in this case, despite extreme cruelty and criminality of her husband, the law still recognised him as child's father. With the history of violence and the killing of her children, she could not imagine involving her husband in a decision regarding their unborn child. Also with no way to support herself, she felt it was not right for her to give birth to her child. But she felt that if child were to be adopted by a good family, at least s/he will have a good life. She indeed liked such an option and pleaded with the counsellor to find a way out so that she could give up her child for adoption.

The other provision in the adoption laws is with regard to children born out of wedlock, in which case there is no need for consent from the father of the child. She thought this to be a good option for her to use. This also helped her to avoid the stigma that went with the name of her criminal and imprisoned husband. She felt that there was nothing wrong in stating that she was unmarried and that her child was born out of wedlock in order to be able to give up her chid for adoption. She was ready to state this to the hospital where the child would be born and also to the adoption agency which would accept the child.

She wanted the counsellor and the Centre to help in implementing this plan. In fact, given her poverty and helplessness, only a reference from the Centre would provide the credibility to her story the adoption agency would require.

The counsellor contacted the adoption agency, and sold the story. The adoption agency agreed to pay for the delivery of the child in a reasonably good private maternity home.

Questions:

1. Should the abortion laws of the country more considerate about the need of women like the one described in this story and allow medical termination even in advanced stage of pregnancy? Why?
2. Do you agree with woman's choice of either abortion or giving away child in adoption? Explain.
3. Although the woman made a choice to lie, should the counsellor accepted her request to lie on her behalf? What are the consequences of accepting or rejecting such request to lie for her? Was there an ethically less problematic way out available in this situation? Discuss.

[5] drafted by Amar Jesani

Case study 8

Morality and widowhood: Should service providers revisit their own moral values?

She was referred to the centre by the CMO as she had been badly beaten up and had suffered injuries. She was 28 years old and had been married at the age of 14 years. She had five children, a widow for the last four years. Her husband X had been working as a police informer. He would often come home drunk and beat her up for trivial reasons. The family lived with his mother and his sister. They constantly instigated him against her.

She had been married 11 years, when she lost her husband who was murdered by gangsters. She was witness to her husband's murder. Since her husband's death her marital family- mother in law, brothers in law and sister in law had been harassing her. They wanted her to move out but she had been fighting and claiming her right to the matrimonial home which belonged to her father in law. They were verbally abusive to her, humiliated her in public and her brother in law even beat her when she argued or demanded her rights. The brother in law runs the shop that was owned by her husband and she wants a share of what he earns. The family would rather have her out of their house.

On the day she came to the centre, the family had beaten her very badly because she had a paying guest in the room. Her injuries were severe and she had to be admitted to the hospital. She wanted support to stop the physical, emotional and economic violence that she was facing. Her only support was her husband's friend S who had a tailoring shop. Her family objected to her relationship with him too. Her parents lived in a small town in UP and were not willing to extend support.

She followed up with the centre consistently and it provided her support through various ways, viz, letter to local corporator for space, registering a complaint with the police, legal advice and assistance, reiterating her strengths and courage, validating her feeling for S and so on. She was also referred to a local mahila mandal so that she could get support any time. However, she was not happy with the way the mandal responded her problems. She perceived them to be on her mother in law's side. She continued to be in ouch with the centre and sought help. Within a year, she reported that the situation was in control and her marital family had stopped the abuse.

After a gap of two years she came to the centre again in a distressed state and kept repeating "*If you don't get me justice, I will take rat poison here and die".* After calming her down a little, she reported that S's wife had come down from the village and registered a case against S with the same local mahila mandal. The wife had alleged that S was forcing her into prostitution. The mahila mandal members barged into the house, beat up S and the woman, continually abused them verbally and dragged them to the police station. At the police station no case was

made against them but she felt humiliated and angry. She approached the local shakha pramukh[6] who had earlier intervened when her marital family was abusing her. She had sought police protection but was disturbed with the entire episode. She had lost a lot of weight and looked ill. She had been having fainting spells and felt tired all the time. She was unable to eat or drink anything. She also told the centre that a few weeks back her brother in law had beaten her badly at night and the shakha pramukh took her to the hospital and registered a police case.

She also said that she was now part of the political party and was going to work for them. The party she was referring to had played a key role in the violence against the Muslim community in Mumbai in 1993 riots. They were at that time wooing Muslims and the counsellor knew that there was a grand mela that had been organised by them for Muslims. She said that she was going to the mela as her shakha pramukh had asked her to do so and would also become a member of the party. The counsellor spoke to her about 1993 and that she should remember their agenda. She immediately responded by saying that throughout her struggle the only support she had had was from her shakha pramukh. The mandal which was from her own community had abused her, humiliated her, labelled her as a 'bad' woman based on false allegations. That night when all this took place, the only person who came to her rescue and came with her to the police station was the shakha pramukh.

One of the feminist counselling principles is to raise consciousness about the various forms of exploitation within society and help the woman understand the interlinkages among these. The counsellor could understand the woman's anguish and her sense of loyalty to the shakha pramukh who had been extremely supportive and had clearly made a difference in her life. But she was concerned that she would be used by his party. The other thing that was worrying was the functioning of the local mahila mandal that had been set up by a feminist group. The mandal had not only used violent methods but also had been extremely moralistic in their attitudes and actions regarding a single woman.

Questions:

1. What should the counsellor bear in mind when supporting a single woman (widowed) in terms of obstacles to normal functioning at the societal, family and individual levels? Do you think the centre was able to do that?
2. Do you agree with the method adopted by the mahila mandal in dealing with the complaint of S's wife? Why/Why not?
3. The woman finally joined the political party and became its active member. Do you think her identity was misused and what could be done?
4. Should the centre stop referring women to the mahila mandal? If no, then what should it do?

[6] Shakha pramukh- head of a local branch office of a political party

Case study 9

Should a counsellor vouch for a client's sexual orientation?

M is a 40-year-old woman living with her young daughter. She has been deserted by her abusive husband and is living on the verge of destitution. She has been doing so by struggling to make ends meet and somehow taking care of her daughter's needs. She had no support from her natal family members. M had been a client with the counselling centre for the past few years has and had sought support for the violence she had been facing from her husband. M's husband worked in a pest control outfit and often threatened to kill her and their daughter. He scared them by stating that he would mix the pesticides in their food. M had been living in fear for the past few years. Over the years, she had been able to strike a rapport with some of the community women, who stayed the night with her whenever she was scared that the husband might physically abuse them. This strategy had, to some extent, deterred her husband from threatening them in the past.

After a recent spat between M and her husband, M was apprehensive that her husband might create trouble in the house, so she requested a woman from the neighbourhood to spend the night at her place .While sleeping, *M* accidentally touched the neighbour at which the latter accused her of making a pass at her calling her a lesbian. In the morning, the neighbour narrated this to her family and this information soon spread around the neighbourhood. *M* was verbally abused and thrashed by the people in her locality. The news soon reached *M's* employer. On hearing this, *M's* employer asked her to leave and *M* lost her job.

M was rendered without support because the community had turned hostile towards her. Further, when she was at work, her daughter would be alone at home, therefore she also feared for the safety of daughter. This incident prompted M to reach the counselling centre. She narrated the entire incident and demanded that the counsellor should call the employer and dismiss these speculations about her sexuality and state that she was not a lesbian.

The counselling centre had known M for a long time. However this issue sparked off several questions in the mind of the counsellor. Was M a bisexual? Had the counsellor provided adequate space for M to share such intimate information? Had the counsellor assumed that she was heterosexual because she was in a marital relationship? At the same time the counsellor was convinced that her sexual orientation had nothing to do with her employment.

The counsellor explained to M that her being a homosexual/ heterosexual should not have any binding on her job, she further assured M that she would talk to the employer along these lines. But M clearly asked the counsellor to vouch for her sexual orientation. The counsellor found it difficult to make such a statement because vouching for a sexual orientation

clashed with the values of the counselling centre; secondly, it would mean that if M felt attracted to another woman, she would not be able to confide in the counsellor, because the counsellor had already vouched for her heterosexuality. But if the counsellor did not vouch for her sexual orientation, she would lose her job, which would push her to destitution.

In order to prevent further physical abuse from the community, the counsellor spoke to M about filing a police complaint, but she turned it down as this might create more gossip about the episode that had occurred. As the current job was her only source of employment, the counsellor made the phone call to her employer with the aim of stating that this was her only source of income and that they should not fire her. She spoke to the employer about M's situation in terms of the violence she was facing from her husband and how she was struggling to construct a livelihood for herself and her daughter. The counsellor also stated to the employer that they should provide M with feedback about her work, if they wanted any change in her method of work. But the employer was adamant that he did not want her back as they had already hired someone else. M did not get her job back. M felt that if the counsellor had categorically stated that she was not a lesbian, she would have got her job back.

Questions

1. Should the counsellor have vouched for M's sexual orientation?
2. Do you think the centre provided adequate space for her to discuss issues related to sexuality? For example, if she was bisexual, would she be comfortable speaking about it to a counsellor who is helping her deal with abuse by her husband?
3. Do you think that a counsellor working on domestic violence should be trained on issues related to sexuality? Why?

Case study 10

Violation of abortion rights: Does it escalate violence?

A 31-year-old woman came to the crisis centre after reading the board that had been put up near the entrance. She wanted to know what services the centre provided. She said that her husband had been abusing her since they got married. He had also been having an extramarital affair for a long time. She had three children, two sons and one daughter; the youngest son was mentally challenged. Currently her husband had even taken to stay with the other woman for days together. He worked as a mason and had never given money for the household on a regular basis. With the increasing pressures now, it was becoming impossible for her to continue. The day before she came to the centre when she had asked for money, he had created a scene, called his mother who stayed close by and started abusing her. She came to find out if the centre could help her file a case for maintenance and divorce. She also wanted to file a police case so that he did not dare touch her again.

The counsellor helped her in drafting a letter to the police and making an FIR. A lawyer too was consulted who advised the woman on a future course of action. After she registered the complaint, the police called her husband to the police station, beat him up very badly and threatened to put him behind bars if he ever beat up his wife. This episode made her story known to the entire community. The *jamat* called a meeting and the husband was warned again. The woman therefore did not follow up with the lawyer hoping that this would change his behaviour.

After a month she came to the centre after a visit to the Gynec OPD for an MTP. She told the counsellor that she did not want the child at all but the doctor said that as she *did not "have blood",* an MTP could not be conducted. The doctor advised her to take iron tablets for a week and then come for the abortion. The counsellor advised her about a diet that would help her increase her haemoglobin levels. She came back after 10 days but the doctor refused to do the MTP on the same ground. She was 6-8 weeks pregnant then. The counsellor went to the doctor and spoke to the unit about the urgency of the abortion. The doctor told the counsellor that if this time the haemoglobin did not increase, they would give her local anaesthesia and carry out the MTP and not delay it further.

S came after a month but because she came after the OPD was closed, the doctor refused to admit her. She was now desperate as her pregnancy was progressing. She came to the centre and reported all this. The counsellor then traced the doctor from the gynaec department. Their team was not on duty the next day so he gave her an appointment for the MTP in the following week. This date was communicated to S but she did not come on that day. The counsellors thought that she may have taken

admission directly without coming to the centre. But they soon found out that this was not the case.

S came to the centre after 14 days and told the counsellor that her community had found out that she was pregnant as her bulge was obvious now. They were pressurising her to continue the pregnancy. She was completely distraught. She did not want to continue it at all but her mother-in-law along with other older women had called a meeting to convince her not to commit this sin. S told them that she was seeking a divorce and did not want to have another child at this stage. But this did not help, they went ahead and called her husband and told him to behave himself.

S told the counsellor that she did not think that she was committing a sin in undergoing an abortion, but if she did do so now, she would be isolated in her community. She kept saying "*Kaash, jaldi ho jata*". She finally decided to continue the pregnancy but did not follow up at the centre till her 8th month when she was admitted to the hospital as she had gone into premature labour. She had a still birth. She had become very weak; her situation had worsened in the last three months as she could not go to work due to pregnancy and the tiredness.

Till date, she continues to live with her abusive husband. A woman, who had made up her mind to leave her abusive husband despite all pressures, was forced to continue in the same relationship. The delay in receiving an abortion had severe consequences on her life. The fact that medical fraternity and health services have very little or no understanding about the patient's social reality struck the counsellors. This story was taken up for discussion during meeting with doctors and nurses of the hospital and it was disheartening when almost all of them agreed with the line of treatment and some of them also felt that the delay ensured that she did not have a broken marriage and had 'adjusted' to live with her husband. Very few seemed to understand the contradiction in asking a woman with low haemoglobin to proceed with pregnancy but deny an abortion on that ground. The counsellors were also bothered by the fact that it might have been possible for S to have a different life, had the counsellor too intervened more sharply and ensured a quick abortion. For the centre, it was a lesson learnt, albeit late.

Questions:

1. Do you think the medical procedures followed by hospitals for abortion services are woman-friendly?
2. Do you think the doctor and other staff are fully aware of the social reality/ circumstances of their patients? Do you think this is necessary? Why?
3. Could the counsellor have ensured timely medical assistance? What steps should she have taken?

Case study 11

Client's demands vs organisational policy: Does client's autonomy take precedence?

N a 30-year-old woman with four children was facing physical and economic abuse from her husband. He was abusive since the day of the marriage. He even tricked her mother into buying a house in his name, to which request her old mother had complied. N's husband used to throw her along with her children out of the house after every episode of violence. He used to spend most of his time whiling away with friends and visiting game parlours. He used to work occasionally but would never contribute in the house hold expenses. Thus the entire burden of looking after the children as well as managing household expenses was on N. When N went out to work; he used to even lock the children in the room and go away to spend time with his friends. Whenever N asked the husband to look for work, he would get into a terrible rage and turn physically abusive.

After a very violent episode of abuse, N walked out of the house and decided to jump off a train, as she could not bear it any longer. This was the time a co passenger stopped her and brought her to the counselling centre. In the counselling centre N talked about the extent and intensity of abuse she had faced over the past years. She also stated that she did not want to go back to the abusive home. The counsellor provided her emotional support. The counsellor asked her if she had any alternative place that she could go to. She said that her mother stays close by. Counsellor asked N to bring her mother with her the next time. In the meeting her mother said that N's husband had been abusive for a long time. She had told N on repeated occasions to move out of his house and come and stay with her, but she would stay only for a few days and return back to him. Her mother stated clearly that she wished to keep her children but she was also tired of the constant *kit pit*. She told the counsellor that N should take a final decision. Counsellor encouraged N to reflect upon the fact that her husband had not changed, therefore N should also take an informed decision about going back to her husband.

After the counselling session, N returned to her mother's house with her children, but she stayed there for only a week. Her husband apologised about his bad behaviour, so she returned to him yet again. N returned to the centre after a month reporting that she had enough of the abuse and she wanted to move out. She told the counsellor to put her children in an institution as her mother would be unable to look after them. She had planned to buy a bangle-making machine, as this would help her sustain herself. She asked the counsellor if such a provision could be made by the centre for her.

The counsellor discussed this issue in a case conference and said that providing her this assistance was the only way she could leave the violent relationship. The reason given by

the counsellor was that she did not have adequate financial assistance to take a decision about staying separately. Opinion was divided on whether financial aid would enable her to move out of the house. To this the counsellor said that she was convinced that N was continuing in an abusive relation because she had no alternatives. She also said that N was going to admit her children to an institution so her decision seemed like an informed one. She also expressed concern about the increase in intensity of abuse. So, the sooner economic support was provided the earlier she could leave the abusive home.

The counsellor once again discussed with N her feelings about leaving the abusive home, to which she said that starting a small scale business would enable her to walk out of the relationship itself. N was desperate to buy the machine, the counsellor too felt that such a provision would release N from the violence, so the counsellor raised Rs. 6000 for the machine and supported N's decision to buy it.

But N returned to the centre after a month feeling extremely guilty because her husband had taken the machine away. She also reported that as soon as she had the machine, he persuaded her to go back to him for the sake of the children. He said that he would hire two workers to run the machine so that she would get some spare time with the children, but since then she had not received any of the income from the bangle making.

Questions

1. Do you think the counsellor made an appropriate decision by providing economic support to the woman when the centre's policy was not to provide economic support?
2. Do you think then that providing economic support comes in the ambit of counselling women facing violence?
3. Do you think that the counsellor is preoccupied with the woman leaving the abusive partner? Is there a conflict of values of the counsellor and the woman?

Case study 12

Accountability of counselling centre to referral agencies: Drawing boundaries

S a 21-year-old woman was in advanced stages of pregnancy. She was abandoned by her husband who was also very violent towards her. One day he sold the house and left *S*, who was pregnant and had to fend for herself in a city where she had no relatives, friends nor knew anybody. *S* was brought to the hospital late one evening by a stranger who found her on a bridge, attempting to jump off, badly injured and bruised. She was admitted to the hospital for two days. It was during her stay at the hospital that she was referred to the centre for counselling. She asked the counsellor to make some arrangements for her stay because she had no other place to go. The counsellor made arrangements with a shelter home in the city. In the course of counselling, S shared with the counsellor that she had tried to kill herself on 3 occasions because of the escalated violence. She was provided emotional support as well as suicide prevention counselling. After the shelter arrangements were made, S followed up regularly for her antenatal check ups as well as counselling.

A few days into her ante natal care visits to hospital, she had come for her session at the counselling centre as she usually did as part of her visit to the hospital. She told the counsellor that she was not feeling well and would want to rest a bit before the session. She lay down for sometime in the waiting room at the centre and then went out saying she needed to use the washroom. After half an hour the counsellor went looking for her, but could not find her. *S* did not return to the centre for another four hours nor did she inform anyone at the centre that she was leaving. The counsellor enquired about her whereabouts at the hospital but nobody seemed to know where she was. The counsellor then called the shelter she was living at, but she was not there either.

The counsellor feared for S's life, because she had a history of attempted suicide. To trace S, the counsellor thought of making a police complaint. However once such a complaint was lodged, the counsellor would be required to provide her past history of abuse as well as attempts at suicide. The Indian penal code looks at suicide as a crime. So the counsellor feared that such a complaint might jeopardise the woman's future further. The other option for the counsellor was to wait for S to return to the centre. The counsellor was disturbed and anxious as she feared that the woman may have committed suicide and if anything happened the centre would be in trouble. Before the counsellor could take an action, there was a phone call from the shelter home stating that she had just arrived at the centre.

Questions:

1. Do you feel that it the responsibility of the counselling centre to trace an adult woman who goes missing in their premises?
2. What do you feel about the current law where an attempt to suicide is criminalised? Do you think it affects the quality of care that a person receives? In what way?

Case study 13

Protecting client's confidentiality: Does it mean compromising on professional responsibility?

Y is a 28-year-old woman with a five-year-old daughter. Throughout the six years of her marital life, her husband had not taken on the responsibility of running the household; was extremely abusive towards her; followed her to her workplace, and created scenes there. She had lost two jobs because of his behaviour. He always suspected her of having an affair. Despite intervention from her natal family, he had not changed his behaviour. He would also force her to have sex with him and if she refused he would allege that she was sleeping with someone and so was not interested in him.

Over a period this became unbearable for her and so she sought help from a legal aid agency and filed for divorce. The husband continued to come to her house and force her to have sex even when her case was being heard in court. She found herself helpless as any resistance from her side would infuriate him and he would create a scene in the middle of the night. She was concerned about her little daughter and embarrassed about what her neighbours would say. She often had no choice but to give in. Her husband would also plead with her not to divorce him. He had told the family court counsellor too that he was willing to change his behaviour and loved her a lot. However Y had made up her mind.

One day she discovered that she was pregnant and she confided in her lawyer who then referred her to the counselling centre located within the hospital. During the counselling session, *Y* said with the counsellor that she wants to undergo an MTP and wants utmost confidentiality to be maintained. She was afraid that if her husband came to know about her pregnancy he would use it against her and spoil her case. She wanted the divorce at any cost. The counsellor explained the MTP procedure in the hospital and referred her to the Gynaec department.

The doctor she met advised her to come to his private clinic for the MTP since it would take less time. As she was desperate and did not want to waste any further time, she just followed his instructions. Later she realised that he had called her to his private clinic so that he could charge her high fees. The doctor charged her such exorbitant rates that she had to take a loan. She however just went ahead with the procedure.

After the abortion was done, she told the lawyer about it. The lawyer was in regular touch with the centre and immediately informed the counsellor about what had happened. The doctor had clearly taken advantage of her situation to make money. Y was angry and felt cheated by the doctor and wanted the centre to do something about it. The counsellor took up the issue with the higher authorities of the hospital and was told that a written complaint would have to be given stating *Y's* version of

the facts. The counsellor approached *Y* and told her about the need to make a formal written complaint. *Y* declined to make a written complaint as she was afraid that it would become public and her husband might find out. This would spoil her case.

Questions:

1. What should a counsellor/counselling centre do when confronted with unethical practice by another professional?
2. How can the counsellor question this malpractice without compromising on her promise to the client for ensuring confidentiality?

Case study 14

How to respond to individual violation during situation of conflict?

A had been married to M for about a year. Ever since the marriage, she had been facing violence. M refused to keep sexual relations with her. A suspected that he was impotent. She made repeated attempts to stay in her marital family. But the abuse kept escalating. A informed her parents of her situation and she was brought back from her marital home in Baroda to her natal family house in Mumbai.

A approached the centre as she wanted a joint meeting to negotiate her demands as well as to explore a possibility of reconciliation. A joint meeting was to be organised between A, her husband and his mother. They were based in Baroda and had come to Mumbai for some work. A narrated the abuse she had faced during the three months that she lived with her marital family. She was verbally abused; no one spoke to her in the family and taunted her for not getting enough dowry. The family also ridiculed her over her appearance and taunted her publicly. Her husband slept in another room and refused to keep any relationship with her. This became unbearable for her and she came back to her natal house. Her marital family did not get in touch with her even once. She said that if they did not want to continue the marriage, they should provide economic compensation.

During the meeting the counsellor learnt that the husband and his family had lost everything during the communal violence in March 2002. Their house has been burnt down in the violence. They have been left with no belongings. They were currently staying in a temporary shelter organised by relief workers in Baroda. M was a vegetable vendor and his family was trying to get their life back on track. M's mother asked the counsellor to come and visit Baroda to see the situation for themselves. They told the counsellor that they were in no position to provide compensation.

The counsellor found herself in a difficult situation. One hand there was this woman who was abused and was demanding maintenance, and on the other hand was a family that had lost everything in communal riots and were living in a relief camp. While the woman's demand was justified, the abuser was clearly in no position to provide for her and was in fact living currently in fear because of the state sponsored violence against minority community.

The counsellor weighed the pros and cons of the situation. A was conducting tuitions and was able to manage her own expenses. Therefore the counsellor suggested to A to think of other alternatives beyond compensation and helped her to renegotiate her idea of justice. But this also posed the risk of A feeling that the counsellor had not done adequately to address her issue. The counsellor ensured that the family was compensated in other ways beyond economic remuneration. A wanted a public

apology regarding the allegations that were made about her. This was important for A, as she was hurt by the lack of response from her husband and his family more than the lack of economic compensation.

Questions

1. It can be assumed that the man would start earning soon and so was the counsellor's action appropriate in asking A to reformulate her demands? If not what are the other alternatives?
2. How do you think domestic violence can be effectively addressed in a community which has been targeted and abused brutally by the state?

Case study 15

Unresolved counsellors' issues

We recognise that this work is demanding both emotionally as well as physically as the level of involvement in each case can be considerably high. Listening to repeated stories/narratives of abuse can be burdensome. As the results of counselling are most often not tangible, there is no visible impact of the efforts being taken by the counsellor. Burn out therefore is known to be high amongst care givers in general.

For those working with women facing domestic violence it can be greater. We did recognise this at the time of starting the centre. Considering that the hospital would most likely receive a high case load, severe forms of violence would be reported, it would be challenging to motivate women to seek counselling as they would be coming to the hospital for treatment only, it was expected that the job of counsellors would be extremely demanding and challenging.

At the outset we decided to introduce 'case presentations' where counsellors could present the cases handled by them during the week. The idea was that the case presentations would provide a space where counsellors could share the strategies/ techniques they had used; discuss alternate ways, and learn from co-counsellors. From the beginning, this was also the space where counsellors could share their own feelings about the case, their concerns and also where they could share personal experiences of resisting abuse. The principle 'personal is political' applies to individual counsellors too and they are expected to practice the feminist values and principles.

One afternoon Y came to the centre in complete distress. She had two children, one was 5-year-old and the other was 2 year old. She was facing sexual and emotional abuse from her husband since marriage. She was so tired of the constant abuse that she decided to walk out of the house. She went to the police station where she was told about Dilaasa and that is how she came to the centre. She spoke to the counsellor, C and told her that she wanted to leave her home. She asked for support from the centre for this. C spoke to her and explained to her the consequences of taking such a step. C told her that her children were really small and so she should think twice before taking such a step. The children too were at the centre with Y. The counsellor gave toys and books to the children so that they could be distracted.

After having spoken for some time, Y said that had made up her mind. The counsellor should help her draft a police complaint. At this point, the counsellor felt that she had not been able to reach out and so left the room and requested another counsellor to take over the counselling session. Meanwhile, the counsellor spoke to her supervisor and narrated the story and said that she had failed to get the woman to

understand the severe negative consequences of leaving her marital home especially because she had such small children. She expressed her anxiety about how the children would cope and so on. She admitted that she identified with the woman's situation and could not imagine her walking out of the relationship. The supervisor spoke to her at length and also asked her to speak to someone about what was happening in her personal life. She had one session with a counsellor for her own issues.

Later, in a case presentation meeting, co-counsellors pointed out that in several cases this counsellor was mechanically responding to women by asking them to pick up a job as a means to stop violence. This was discussed at length with the counsellor who reluctantly accepted the feedback. After some days, in a team meeting which was called to take stock of work, she broke down and complained of being overburdened. She was asked to stop counselling and seek help.

She opened up to a senior colleague and spoke about the abuse in her own life. At that point she admitted that when Y had come to the centre, she identified with her and could not imagine how a woman could walk out with such small children. The organisation then asked her to take leave, seek support for the ongoing abuse in her life. As she did not want to take leave as that would mean that she had to stay at home, she was given an alternate set of responsibilities at work. This continued for some months so that she could have the time and space to manage her own situation. However, her performance continued to deteriorate. She did not seem to be keen about getting back into her role as counsellor.

After some months, following a bitter experience when she spoke to the senior colleague, she confessed that she had not even informed her natal family. Soon it was evident that she was doing nothing to stop abuse at home. At work she would have lengthy phone conversations, not fulfil work responsibilities, nor complete any of the tasks assigned. It was distressing to see that the philosophy that was adopted by the centre was not being applied despite all efforts. She was advised to look for another job that would be less conflicting with what was happening in her personal life. Working on domestic violence brought her personal life to work on a daily basis. She identified with the job and the philosophy of work so much that she felt that this had given her an identity. She wanted to continue though she was not being able to practice it.

For the organisation, the question was about how long to continue to give her work that was much less that what was expected of her. She was finally asked to look for another job.

Questions:

1. Do you agree with the steps taken by the organisation for its counsellor who was facing abuse? Why/why not?
2. Should a counsellor facing abuse be allowed to counsel other women in abusive relationships?

Case study 16

Consequences of counsellor's discomfort: challenges for a supervisor

A 30-year-old woman accompanied by her mother came to the centre on being referred by the Casualty. She had gone to the police station after a severe episode of assault and the police had brought her to the hospital. The CMO referred her to the counsellor. The woman was accompanied by her mother. She had been married for four years and worked as a domestic worker. Her husband does not provide for any household expenses. His brother also lived with them. She had a three-year-old son and a 10-month-old baby girl.

She described what had happened. She was cooking while her husband was shaving inside. Her baby vomited close to where her husband was standing which made him angry. He started shouting and abusing her saying that she was incapable of taking care of the children. He was so infuriated that he picked up the wooden chapatti roller and hit her on her head. She started bleeding profusely. She rushed to her mother's house which was close by and then went to register a police complaint. The police brought her to the hospital for treatment of her injury and MLC. When she came to the centre, she had a bandage on her head and there was dried blood on her face. She told the counsellor that she had had enough and had decided to quit the relationship.

During the counselling she said that he constantly criticised her about her cooking, child care and housework. His brother who lived with them had made sexual advances at her and when she told her husband that, he did not believe her. Since then she just ensured that she was not alone in the house with her brother-in-law. She would go to her mother's house. She had purposely not wiped the blood off her face so that the police understood the seriousness of the matter and took immediate action. She was determined to leave her husband.

While the woman was sharing her past pain and agony, the counsellor took a break and told the senior counsellor that she could not 'see beyond blood' and so she should take over the counselling session. The supervisor assured her that she would be with her during the session but asked her to get over her feelings and continue the session.

Being located in a public hospital, counsellors meet women who have suffered severe burns, physical injuries, those who have attempted suicide routinely. It is painful to see women in this state. But the role of the counsellor is to instil hope and reach out to them. In doing so a counsellor has to deal with her emotions and draw on her inner strength. The counsellor was not on training but had been with the centre for over a year so such handing over the session was unexpected. The woman who was seeking support had clearly articulated that she wanted to keep the blood as it is so that it is useful in

negotiating with the police. Clearly, she was strategising and so to hand over the session to someone else because the counsellor could not deal with the blood might dampen her spirits. So the senior counsellor sat with her through the session instead of taking over. The counsellor gave her all the relevant information and reiterated that she should ensure her safety as the violence had escalated.

Later, the supervisor reflected on her actions.

1. Was she right in asking the counsellor to continue when she expressed her inability? Would that have compromised on the quality of counselling received by the woman?
2. Should she have taken over the session in the interest of the woman and dealt with the counsellor later?
3. What if the senior counsellor had not been around? As this was not a special situation but something that the centre witnessed routinely, how does one ensure that the staff is competent and capable?
4. When a survivor expresses that she is not wiping blood on her face as a strategy and the counsellor feels paralysed with the blood, is it a case of burn out or incompetence? What are the ways in which these need to be checked?

a casebook

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Centre for Enquiry Into Health And Allied Themes

CEHAT is the research centre of Anusandhan Trust, conducting research, action, service and advocacy on a variety of public health issues. Socially relevant and rigorous academic health research and action at CEHAT is for the well-being of the disadvantaged masses, for strengthening people's health movements and for realizing the right to health care. CEHAT's objectives are to undertake socially relevant research and advocacy projects on various socio-political aspects of health; establish direct services and programmes to demonstrate how health services can be made accessible equitably and ethically; disseminate information through databases and relevant publications, supported by a well-stocked and specialised library and a documentation centre.

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