

3.4.1 Techniques to help the child relax

- i) Offer clear age-appropriate explanations for the reasons for each procedure, and offer the child some control over the exam process.
- ii) Proceed slowly, explain each step in advance.
- iii) Use curtains to protect privacy, if the child wishes.
- iv) Explain to parent or support person that their job is to talk to and distract the child, and the findings of the exam will be discussed with them after the exam is completed.
- v) Position the parent near the child's head.
- vi) Use distracters. For example, ask the parent to sing a song, or tell a familiar story, or read a book to the child. A nurse or other helper can do this if the parent is unable.
- vii) Use TV, cell phone game, or other visual distraction.
- viii) Do not forcibly restrain the child for the examination

3.5 Sedation for Medical Treatment

- i) Sedation is rarely needed if the child is informed about what will happen and there is adequate parental support for the child.
- ii) Consider sedation or a general anesthetic only if the child refuses the examination and conditions requiring medical attention, such as bleeding or a foreign body, are suspected.
- iii) If it is known that the abuse was drug-assisted, the child needs to be told that he/she will be given a sedative or be put to sleep, that this may feel similar to what he/she has experienced in the past.
- iv) Reassure the child about what will take place during the time under sedation and that he/she will be informed of the finding.
- v) However, conscious sedation is an option if examination and evidence collection is required, and the child is not able to cooperate.
- vi) Speculum exam on a pre-pubertal girl should be done under anaesthesia, not conscious sedation.

3.6 The following pieces of information are essential to the medical history:

- i) Last occurrence of alleged abuse (younger children may be unable to answer this precisely). *When do you say this happened?*
- ii) First time the alleged abuse occurred. *When is the first time you remember this happening?*
- iii) Threats that were made.
- iv) Nature of the assault, e.g. anal, vaginal and/or oral penetration. *What area of your body did you say was touched or hurt?* (The child may not know the site of penetration but may be able to indicate by pointing. This is an indication to examine both genital and anal regions in all cases.)
- v) Whether or not the child noticed any injuries or complained of pain.
- vi) Vaginal or anal pain, bleeding and/or discharge following the event. *Do you have any pain in your bottom or genital area? Is there any blood in your panties or in the toilet?* (Use whatever term is culturally acceptable or commonly used for these parts of the anatomy.)
- vii) Any difficulty or pain with voiding or defecating. *Does it hurt when you go to the bathroom?* (indication to examine both genital and anal regions in all cases.)
- viii) Any urinary or faecal incontinence.
- ix) Whether or not the child noticed any injuries or complained of pain.
- x) In case of children, illustrative books, body charts or a doll can be used if available, to elicit the history of the assault. When it is difficult to elicit history from a child, please call an expert.

3.7 When performing the head-to-toe examination of children, the following points are particularly noteworthy:

- i) Record the height and weight of the child (neglect may co-exist with sexual abuse).
Note any bruises, burns, scars or rashes on the skin. Carefully describe the size, location, pattern and colour of any such injuries.
- ii) Check for any signs that force and/or restraints were used, particularly around the neck and in the extremities.
- iii) Record the child's sexual development stage and check the breasts for signs of injury.
- iv) If the survivor is menstruating at the time of examination then a second examination is required on a later date in order to record the injuries clearly.
- v) Some amount of evidence is lost because of menstruation. Hence it is important to record whether the survivor was menstruating at the time of assault/examination.

vi) The same applies to bathing, douching, defecating, urinating and use of spermicide after the assault.

3.8 Role of Medical Professionals as Expert Witnesses

Deciding cases of child sexual abuse would be much easier if it left clear-cut physical evidence. Unfortunately, child sexual abuse often leaves no such evidence. Child sexual abuse is often exceedingly difficult to prove. It usually occurs in secret, often over a prolonged period of time, and does not always leave physical marks; in addition to this, the child is usually the only eyewitness. While many children are capable witnesses, some cannot give conclusive testimony, and consequently, children's testimony is sometimes ineffective. In such cases, the testimony of an expert medical witness can be useful. Physicians can provide opinion testimony that is based upon the child's history, statements, and medical examination, even if the physician's examination of the child reveals no concrete physical evidence supportive of the child's allegations.

- i) Courts in India in their judgments described an expert as a person who has acquired special knowledge, skill or experience in any art, trade or profession. Experts have knowledge, skill, experience, or training concerning a particular subject matter that is generally beyond the knowledge of the average person. Such knowledge may have been obtained by practice, observation or careful study. The expert thus operates in a field beyond the range of common knowledge.
- ii) Expert evidence is covered under Ss.45-51 of Indian Evidence Act. The subjects of expert testimony mentioned by the section are foreign law, science, art and the identity of handwriting or finger impressions.
- iii) In general, whether or not the testimony of an expert will be useful in any given case is almost always left to the discretion of the trial judge before whom the testimony is proffered. However, even where the Court has some degree of knowledge or familiarity with the subject, an expert's testimony may be valuable to add insight and depth its understanding of the matter, or to educate them as to commonly held prejudices and misconceptions which might negatively impact upon an impartial and just decision.
- iv) In general, the opinions of medical professionals are admissible upon questions such as insanity, the causes of diseases, the nature of the injuries, the weapons which might have been used to cause injuries or death, medicines, poisons, the conditions of gestation, etc. In the case of questions pertaining to age determination, positive evidence furnished by

birth register, by members of the family, with regard to the age, will have preference over the opinion of the doctor: but, if the evidence is wholly unsatisfactory, and if the ossification test in the case is complete, such a test can be accepted as a surer ground for determination of age.

- v) In their testimony regarding a forensic examination, medical professionals typically describe the process of examining the victim, the physical findings that were observed, and their interpretation. It is important to remember that the medical professional cannot be asked to testify to "diagnose" sexual abuse. The doctor cannot make any definitive conclusions regarding the degree of force used by the abuser or whether the victim consented to any sexual activity. What he/she can appropriately conclude is whether there is evidence of sexual contact and/or recent trauma. He/she can state whether the medical history and examination are consistent with sexual abuse.
- vi) In many child abuse cases, experts have firsthand knowledge of the child because the expert treated or examined the child. However, an expert may be called upon to render an opinion concerning a child without personally examining the child.
- vii) However, it is important to remember that doctors are rarely expert in interviewing, and often assume the truth of what the patient tells them. The testimony is presented as if the doctor's opinion is based on physical findings when it is not. It is often largely or wholly based on statements made, a far different and less scientific basis than objective findings upon examination.
- viii) In addition to this, opinions may be sought from mental health experts as to the psychological effects of child sexual abuse, such as PTSD and Child Sexual Abuse Accommodation Syndrome.
- ix) It is for the legal representative who proposes the use of expert testimony to establish his/her credentials, preferably listing his/her formal qualifications. The adequacy of the qualification of the expert and the admissibility of his/her testimony are within the discretion of the Special Court.
- x) Before giving evidence the expert will usually have prepared a report, either assessing one or more parties to the case or assessing other experts' reports. His/her report should be reliable on the basis of the following criteria:
 - a) It should provide a context in layman's terms from which to understand the basis of his/her opinion
 - b) It should be clear when the expert is stating corroborated fact and when he/she is merely repeating what he/she has been told by the alleged offender. Assertions

which are based entirely on the alleged offender's perception are likely to be misleading.

- c) The expert must review the information impartially rather than ignore matters which are inconvenient to his/her conclusions.
- d) The report should avoid restating incidental trivia and give preference to examining and analysing the crucial issues of the case.
- e) The expert should demonstrate knowledge of the process and dynamics of child sexual abuse and help to make sense of the child's and non-abusing parent's experiences and perceptions. Victims and non-abusing partners of offenders often do not act rationally and can appear collusive with the offender, whereas their behaviour results from the control the offender exercises over them. It is useful to have this explained in the expert report.
- f) All professions have their exclusive language, but it is best that the expert present the issues in language that the court, advocate and parties can understand.
- g) The expert must not rely solely on quoted research to support his/her arguments, and should refer to clinical experience as well.

An expert opinion must be premised on a reasonable degree of certainty. The expert cannot speculate or guess. It is clear, however, that an expert need not be absolutely certain about a subject before offering an opinion. All that is required is reasonable clinical certainty.

It is important to remember that while an expert's testimony may be deemed relevant, necessary, reliable, and therefore admissible under the aforementioned guidelines, it is ultimately the prerogative of the judge to determine what weight should be afforded the testimony. No matter how qualified the expert, the court is not bound by an expert's conclusions and can exercise its discretion in this regard, keeping in mind all the other evidence presented to it.

4. FAQs on Medical Examination

Doctors may be faced with some of these questions from children as well as parents and caregivers:

- i) Why is the medical examination necessary?

The medical exam is a very important tool in evaluating sexual abuse. The physical examination can identify both new and old injuries, detect sexually transmitted diseases

and provide evidence of sexual contact. If done in a sensitive manner, the examination can answer any questions or concerns the child may have and reassure the child about their well-being and that their body is private. The exam also has evidentiary value in a court of law.

- ii) The last time my child was touched in a sexually inappropriate manner was over a year ago. Is the medical exam still necessary?

Yes. Most children reveal their experience of abuse after a long time has passed, for example, when they are older or feel that they are no longer in danger of being abused again. Some even reveal it accidentally. In such cases, the medical examination can reassure the child about their well-being and address any worried the child may have about the injuries they suffered due to the abuse. Some children may have injuries that healed a long time ago but can be seen with the help of special equipment.

- iii) Is the examination uncomfortable for the child?

No. the examination itself is rarely physically uncomfortable for the child; however, what may cause discomfort is the attitude of the person conducting the examination. For this reason, it is important that all medical health care professionals be trained in conducting medical examinations of children in a sensitive manner. The doctor is expected to explain the procedure to the child and his/ her parents and obtain their consent prior to conducting the examination, as well as answer any questions they may have.

- iv) Can the parent(s) be present while the examination is being conducted?

Yes. Section 27 of the new POCSO Act, 2012 specifically requires that the examination be conducted in the presence of the child's parents/ guardian or other person in whom the child has trust and confidence.

- v) Is the medical examination of the child conducted in the same manner as an adult female gynaecological examination?

- vi) Will the doctor/ nurse be able to tell if there was penetration?

- vii) How is the examination of a boy different from that of a girl?

- viii) Why can't a family doctor or another doctor known to the child do the examination?

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- ix) Will the child be tested for HIV/ STDs?
- x) Will the doctor/nurse give evidence in court if needed?
- xi) Will the child have to be sedated for the examination?
- xii) Where will the medical examination be conducted?
- xiii) Who will conduct follow-up examinations, in case the child needs treatment for STDs or HIV?
- xiv) What happens after the medical exam, will the child and his/her parents be allowed to see the report?
- xv) What about the child's mental health needs?

Chapter 5

Psychologists and Mental Health Experts

1. Relevant Legal Provisions in the Act and Rules and related laws:

Rule 4(2)(e): Where an SJPU or the local police receives any information under sub-section (1) of section 19 of the Act, they must inform the child and his/her parent or guardian or other person in whom the child has trust and confidence of the availability of support services including counselling, and assist them in contacting the persons who are responsible for providing these services and relief.

Rule 5(4)(v): Wherever necessary, a referral or consultation for mental or psychological health or other counselling should be made by the medical professional rendering emergency medical care to the child.

Thus, the rules made under the POCSO Act, 2012 provide that the child may be referred for counselling either by the police or by a doctor.

2. Counsellors

2.1 Role of Counsellors

The counsellor's duties will include:

- i) To understand the child's physical and emotional state
- ii) To resolve trauma and foster healing and growth
- iii) To hear the child's version of the circumstances leading to the concern
- iv) To respond appropriately to the child when in crisis
- v) To provide counselling, support, and group-based programs to children referred to them
- vi) To improve and enhance the child's overall personal and social development, and his/her health and wellbeing
- vii) To facilitate the reintegration of the child into his/her family/ community

2.2 Who may be appointed as a Counsellor?

Counselling for children and families at risk is an integral component of the ICPS. The ICPS envisages the development of a cadre of counsellors to provide professional counselling services under various components of the scheme. Counselling may be provided under ICPS by any of the following:

- i) CHILDLINE Service

- ii) Counsellors appointed by the District Child Protection Society, who will report to the Legal-cum-Probation Officer and will be responsible for providing counselling support to all children and families coming in contact with the DCPS
- iii) NGOs and other voluntary sector organisations

In all cases of penetrative sexual assault and all aggravated cases, arrangements should be made as far as possible to ensure that the child is provided counselling support. Where a counsellor is not available within the existing ICPS framework, the State Government may secure the engagement of external counsellors on contract basis.

2.3 Criteria for engagement as Counsellor

In order to enable the engagement of counsellors from outside the ICPS, including senior counsellors for the more aggravated cases, the DCPU in each district shall maintain a list of persons who may be appointed as counsellors to assist the child. These could include mental health professionals employed by Government or private hospitals and institutions, as well as NGOs and private practitioners outside the ICPS mechanism, chosen on the basis of objective criteria.

As indicative criteria, for any counsellor engaged to provide services to a sexually abused child, a graduate degree, preferably in Sociology/ Psychology (Child Psychology)/ Social Work is a must. In addition to this, at least 2 to 3 years of work experience related to providing counselling services to children in need of care and protection as well as their parents and families and training on handling cases of child sexual abuse is essential in order to ensure that the child receives counselling from those qualified for and experienced in providing it.

2.4 Counselling Services under the Integrated Child Protection Scheme: Training of personnel

Counselling can be difficult for children because of the nature of being a child and the difficulty in relating to an adult, especially an adult that they don't know. Counselling for abused children therefore requires that the counsellor is trained in the subject and understands how children communicate. The ICPS therefore provides that only trained professionals provide services (including counselling) to children.

If untrained persons are holding these posts, the State Government or the Officer-in-charge should provide for in-service training to them. The State Government may take the help of NIPPCD, National Institute of Social Defence (NISD), NIMHANS and recognized schools/institutes of social work or expert bodies/institutions specialized in child related issues for organizing specialized training programmes for different categories of personnel. The training programmes should include issues relating to child rights, child psychology, handling children sensitively, counselling, life skills training, dealing with problem behaviour, child sexual abuse and its impact, child development, trauma, neurobiology, handling disclosure and basic counselling skills. These training programmes could be arranged as:

- i) Orientation and training for newly-recruited staff and in-service training for existing staff.
- ii) Refresher training courses for every staff member at least once in every two years.
- iii) Participation in periodic staff conferences, seminars and workshops with the various other stakeholders or functionaries of the Juvenile Justice System and the State Government at various levels.

2.5 Payment to Counsellors

Counsellors employed by the DCPU are entitled to receive their monthly salaries at the pre-determined rates. They will be performing their duties in relation to the POCSO Act, 2012 in the scope of their work and will not receive additional remuneration for this work, except reimbursement of local travel costs and other miscellaneous expenditure.

Counsellors engaged externally may be remunerated from the Fund constituted by the State Government under Section 61 of the JJ Act, or under any other Fund set up by the State Government for this purpose. The rates for payment shall be as fixed by the DCPU.

2.6 Basic Principles of Counselling Young Children

Sexually abused children are traumatised and vulnerable. They may show certain identifiable behavioural signs of abuse, but often, these are not immediately obvious and will reveal themselves only over a period of time. As a counsellor, one must be aware of the signs of sexual abuse. Children often find it very difficult to disclose sexual abuse, due to the following reasons:

3. Why a child may not disclose abuse

Reasons include but are not limited to:

- i) He/she is embarrassed
- ii) He/ she does not know if what is happening to them is normal or not
- iii) He/ she does not have the words to speak out
- iv) The abuser is a known person and the child does not want to get them in trouble
- v) The abuser told the child to keep it a secret
- vi) The child is afraid that no one will believe him/ her
- vii) The abuser bribes or threatens the child
- viii) He/ she thinks you already know

Being aware of these signs would alert the counsellor to the possibility of sexual abuse.

4. Indicators

4.1 Behavioural Indicators:

- i) Abrupt changes in behaviour such as self harm, talks of suicide or attempt to suicide, poor impulse control etc.
- ii) Reluctance to go home.
- iii) Sexualised behaviour or acting out sexually.
- iv) Low self-esteem.
- v) Wearing many layers of clothing regardless of the weather.
- vi) Recurrent nightmares or disturbed sleep patterns and fear of the dark.
- vii) Regression to more infantile behaviour like bed-wetting, thumb-sucking or excessive crying.
- viii) Poor peer relationships.
- ix) Eating disturbances.
- x) Negative coping skills, such as substance abuse and/or self-harm.
- xi) An increase in irritability or temper tantrums.
- xii) Fears of a particular person or object.
- xiii) Aggression towards others.
- xiv) Poor school performance.
- xv) Knowing more about sexual behaviour than is expected of a child of that age:

- a) child may hate own genitals or demand privacy in an aggressive manner.
- b) child may think of all relationships in a sexual manner.
- c) child may dislike being his/her own gender.
- d) child may use inappropriate language continuously in his or her vocabulary or may use socially unacceptable slang.
- e) child may carry out sexualised play (simulating sex with other children).
- f) Unwarranted curiosity towards sexual act like visiting adult sites or watching adult images or content.

4.2. Physical Indicators:

- i) Sexually transmitted diseases,
- ii) Pregnancy,
- iii) Complaints of pain or itching in the genital area,
- iv) Difficulty in walking or sitting,
- v) Repeated unusual injuries,
- vi) Pain during elimination, and
- vii) Frequent yeast infections.

7. Effects of child sexual abuse:

Counsellors have a very important role to play in limiting the short-term and long term effect of child sexual abuse. These are as below:

- i) Feeling of powerlessness;
- ii) Anger;
- iii) Anxiety;
- iv) Fear;
- v) Phobias;
- vi) Nightmares;
- vii) Difficulty concentrating;
- viii) Flashbacks of the events;
- ix) Fear of confronting the offender
- x) Loss of self esteem and confidence
- xi) Feelings of guilt

If childhood sexual abuse is not treated, long-term symptoms can go on through adulthood.

These may include:

- i) PTSD and anxiety
- ii) Depression and thoughts of suicide
- iii) Sexual anxiety and disorders, including having too many or unsafe sexual partners
- iv) Difficulty setting safe limits with others (e.g., saying no to people) and relationship problems
- v) Poor body image and low self-esteem
- vi) Unhealthy behaviours, such as alcohol, drugs, self-harm, or eating problems. These behaviours are often used to try to hide painful emotions related to the abuse.
- vii) Issues in maintaining relationships

8. The language of the child

- i) The first step in counselling a sexually abused child is to establish a trusting relationship with the child, so that the child can communicate freely with the counsellor. Thus, the counsellor would need to speak to the child in its own language, taking into account his or her age, maturity and emotional state.
- ii) It is important to explain the purpose of counselling to the child and to explain that it will include discussion about the abuse suffered by the child. This will help the child to be prepared for the discussion, and prevent him or her from withdrawing when an uncomfortable topic comes up.
- iii) Allow for free flow of talk without too many intensive questions. Don't begin questioning the child immediately about his/her problem.
- iv) Try not to be intimidating authoritarian or too patronizing. Don't control the child's conversation – follow the child's lead.
- v) Children often lack the vocabulary to discuss sexual acts, and it is important for the counsellor to be aware of the child's sensitivities and difficulties before talking about sexual issues with him or her. To gain this insight, all relevant legal, medical and family history of the case should be collected from the Probation Officer or parents/guardian.
- vi) While the police or other investigative agency may have already obtained a disclosure from the child about the main incident of abuse, the child's sessions with the

counsellor may reveal new incidents. It is thus advisable to get the counsellor involved as early as possible into the pre-trial process.

9. How to respond if the child discloses abuse

- i) **Believe him or her.** The most important thing is to believe the child. Children rarely lie about abuse; what is more common is a child denying that abuse happened when it did. Tell the child you believe him/her.
- ii) **Don't be emotionally overwhelmed** and try to remain composed while talking to the child.
- iii) **Do not interrogate the child.** It can be traumatic for the child to repeat his/her story numerous times. Leave the questioning to the legal and police personnel.
- iv) **Reassure the child that the abuse is not their fault.** The child's greatest fear is that he or she is responsible for the abuse. Be sure to make it clear that what happened is not a result of anything he/she did or did not do. This is particularly important when the accused person is a member of the child's family, such as his or her father, and the child feels guilty at having put that person to trouble. Reassure them that prompt and adequate steps will be taken to stop the abuse.
- v) **Do not make promises you can't keep.** Do not make promises such as the child will never have to see the abuser again, that nothing will change, or other such promises.
- vi) **Believing and supporting the child are two of the best actions to start the healing process.** Appropriate and helpful responses to disclosures are as follows:
 - a) "I am glad you told me, thank you for trusting me."
 - b) "You are very brave and did the right thing."
 - c) "It wasn't your fault."

The counsellor should be aware that the effects of child sexual abuse are long-term and can change the world view and the course of life of the child. The first step in the healing process is for the child to talk about the abuse, and it is the counsellor's duty to facilitate this; however, the process of recovery may be long and the child will have other needs that the counsellor can attend to. These include:

- i) Rapport Building,
- ii) working on the feelings of the child,
- iii) Psychological Education on safe and unsafe touches, feelings, thoughts and behaviour, safer coping techniques.
- iv) Helping the child to understand the abuse was not their fault,
- v) Helping the child to develop or regain their self-confidence;
- vi) Provide sex education;
- vii) Encourage appropriate social behaviour;
- viii) Help the child to identify people who can form a supportive social environment around him or her.

The counsellor is therefore a very important tool for the child in rebuilding his or her life after he has been sexually abused.

8. Counselling for families

Having to cope with the abuse of their own child may be the most difficult challenge of a parent's life. If the parent(s) can get counselling for themselves through this difficult period, it will also help the child with his/her counselling.

8.1 Experience of parents after a child sexual abuse disclosure

When parents first find out about their children being sexually abused, they will experience a wide range of feelings. They may experience denial, anger, betrayal, confusion and disbelief. Parents often tend to blame themselves for not paying attention to their child's behaviours or complaints earlier on. They may feel that they have failed as parents and they didn't protect their children. For some parents they may wonder why their children didn't disclose to them directly but to others. Some parents also become angry at themselves or at their spouses for not supporting the family. In addition to a wide range of emotional experiences, parents may also experience insomnia, change of appetite or other physical complaints.

Some parents also feel conflicting emotions, especially if the accused perpetrator is someone they have trusted, a close friend or a family member. There may be feelings of loyalty and love towards the offending person as well as towards the victim. Family members may choose sides with some believing it happened and others refusing to believe it could have. Parents may disagree about how to handle the situation.

If the offender is the spouse or partner of the parent, what the relationship is like can strongly influence the parent's actions once he/she learns of the abuse. If feelings toward the offending spouse/partner are positive or mixed, decisions about staying together, or to divorce or separate will be more difficult to sort through.

Parents may be faced with making decisions about whether to continue the relationship with the offender, how to deal with contact between the offender and the child, and re-establishing trust and communication in the family.

The feelings a parent has toward the offender may affect a parents' ability to believe in and support the child. When offenders deny or minimize the abuse or blame the child the situation gets very complicated. If a parent doesn't believe a child who has been abused and supports the offender, there can be severe damage to the child. The child will feel betrayed by the parent as well as the offender. What every child victim needs is to be believed and to know that he or she is not at fault. When the parent is able to support and stand up for the child, the child has an excellent chance of recovering from the effects of sexual abuse. It is very important to get help and support for their feelings because parents' reactions make a big difference in children's recovery. Families are children's most important resource for recovery.

8.2 Coping after the child's sexual abuse disclosure:

- i) The parents should be advised to try not to completely immerse themselves in supporting or worrying about their child. No matter how much they love and care about their family, they also need to consciously set aside time for their own needs.
- ii) As they are dealing with the police investigation, social workers' interview or other professionals regarding their child's sexual abuse disclosure, it is especially important for them to take care of themselves physically and emotionally.
- iii) Their child needs their care and their attention during this time of confusion and overwhelming circumstances. If they are experiencing insomnia or depression, they may need to talk to their doctor about treatment or seek professional counselling.