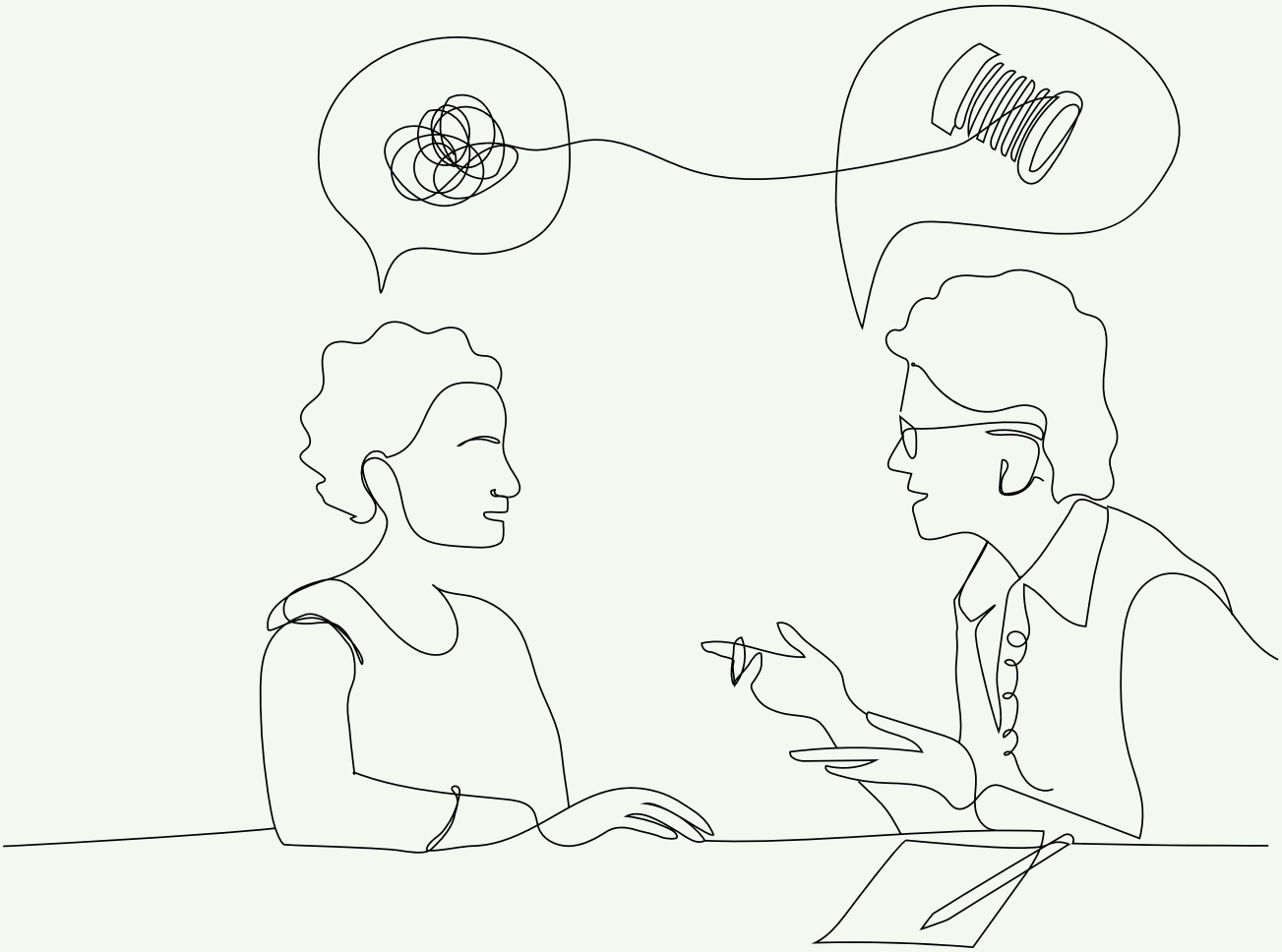
ENFOLD PROACTIVE HEALTH TRUST

DEMYSTIFYING SEXUALITY HANDBOOK

–

FOR STUDENTS AND TEACHERS OF PSYCHOLOGY AND MENTAL HEALTH PRACTITIONERS



For use in conjunction with Demystifying Sexuality Reference Book
Looking at sexuality with a Rights-based, Restorative and Gender Transformative Lens

enfold

Demystifying Sexuality Handbook

- For students and teachers of psychology and mental health practitioners

For use in conjunction with

Demystifying Sexuality Reference Book[1]

– Looking at sexuality from a

Rights-based, Restorative and Gender Transformative Lens

[1] © Enfold Proactive Health Trust, May 2026

Published - May 2026 by Enfold Proactive Health Trust

The copyright and other intellectual property rights in respect of this Handbook belong exclusively to Enfold Proactive Health Trust ("Enfold"). Enfold license(s) this reference book under the terms of Creative Common License (CC BY-NC-ND 4.0), the details of which are found at https://creativecommons.org/licenses/by-nc-nd/4.0/. Any use or reproduction of this reference book contrary to or in violation of the terms of the aforesaid creative commons license will be illegal and Enfold reserves the right to take suitable action in respect thereof. Enfold also reserves the right to modify, terminate or revoke the license granted as aforesaid or otherwise exercise any and all rights in respect of its intellectual property without further notice and the same shall be binding on the licensee or user or reader thereof.

Enfold Proactive Health Trust
No 42, 3rd main,
1st cross, Domlur 2nd Stage,
Bengaluru- 560071, India

www.enfoldindia.org

Acknowledgement 4

Introduction 6

Chapter 1. Diversity in Sex 10

Chapter 2. Structure and Function of Sexual and Reproductive systems 10
Case 1 10

Chapter 3: Diversity in gender identity and sexual orientation 12
Case 1 12
Case 2 13
Case 3 14

Chapter 5: Gender Bias 18
Case 1 18
Case 2 19
Case 3 20
Case 4 22
Rights and laws in the context of discrimination and violence 22

Chapter 6. Self-esteem and Body Image 23
Case 1 24

Chapter 7. Attitude towards sexual health and issues with reproductive health 28
Case 1 28
Case 2 29
Case 3 30

Chapter 8. Sexual Development in Children and Adolescence 31
Case 1 32
Case 2 33

Chapter 9. Attitudes towards sexuality 36
Case 1 36
Case 2 37
Case 3 38

Chapter 10. Sexuality and Disability 40
Case 1 40
Case 2 41

Chapter 11. Sexual Relationships 44
Case 1 44
Case 2 45

Chapter 12. Sexual Preferences and Practices 47
Case 1 47
Case 2 48
Chapter 13. Pedophilia 51
Case 1 51
Chapter 14. Intersectionality 54
Case 1 54
Chapter 15. Sexual Violence against Adults 58
Case 1 58
Case 2 59
Case 3 60
Chapter 16. Sexual Violence against Children 64
Case 1 64
Case 2 65
Chapter 17. Restorative Practices 67
Case 1 67
Case 2: 67

Acknowledgement

We thank all the mental health professionals who informed us, shared their perspectives with us and helped us draft this handbook. We also acknowledge all those who have reached out for mental health support, overcome their inhibitions and wariness and reposed their faith and trust in the process and the practitioners. We hope that all the individuals continue to seek and find support in ways that help them heal and grow through their journeys.

Special thanks to Enfold team members (in alphabetical order) **Saakshi Agarwal, Smita Chimmanda** and **Sangeeta Saksena** for their contribution in conceptualizing the content and flow of this handbook.

Saakshi Agarwal is a practicing counselling therapist who specializes in individual and family psychotherapy, working with children, adolescents and adults. Apart from being associated with Enfold as a Gender Equity, Sexuality and Personal Safety Educator, she has worked as a counselling therapist at CultFit; School Counsellor at GD Goenka School, Hyderabad, Strategic Facilitator and Career Counsellor at Univariety; Corporate Trainer at Pervacio. She is a private practitioner as well.Saakshi completed her Master's in Applied Psychology (Specialization in Counselling Psychology) in 2016 and since then has specialised and got certified in various areas such as: mindfulness, career counselling, sexuality education to name a few.

Smita Chimmanda is a practicing psychotherapist who primarily uses the transactional analysis approach in her work. She has a Master's degree in Psychology and ~15 years of corporate experience in Human Resource, Learning and Development. She is a Gender Equity, Sexuality and Personal Safety Educator and trainer at Enfold. Currently she is also associated with Enfold in the capacity of Content Development Lead.

Our gratitude to **Mahesh Natarajan** (counsellor at www.innersight.in, Bengaluru) and **Dr. Maribon Viray (**Associate Professor, Department of Psychology and Dean of Students, Martin Luther Christian University, Shillong; Advisor, Meghalaya Association of Professional Counsellors) for reviewing this handbook, and to **Neeraja Sajan** (PhD scholar TISS, Mumbai, and Intersex Human Rights India (IHRI) member), for her valuable inputs.

This Handbook is part of a project aimed at preventing gender-based violence by developing and implementing a formal curriculum for teachers and students of undergraduate and graduate studies from nursing, social studies, psychology, education, special education and allied disciplines. As envisaged in the project, this curriculum is based on gender equity, personal safety and sexuality education and has been developed using rights-based, restorative and gender transformative approaches. We gratefully thank Ford Foundation for supporting this project.

Introduction

As sexuality is an important part of one's identity for many people, sexual well-being is a key aspect of mental health. People identify with and express their sexuality in different ways that are unique to them. This handbook aims at enhancing one's understanding of sexuality from multiple perspectives including the biological and instinctual dimensions, and also its role in shaping human behaviour and its implication in an interpersonal and social context.

For practicing counsellors and other mental health professionals and individuals training to be counselling professionals, it is important to widen their knowledge about human sexuality and strive to reduce one's discomfort with discussing sexuality, being more accepting of diversity in gender, sexuality and sexual concerns, so that one can work with empathy and without judgements. This handbook strives to help counsellors and counsellors-in-training to develop their basic counselling skills (attending, reflecting and paraphrasing, summarising, questioning, focusing, immediacy, rapport building, silence, among others) while working on psychosocial and psychosexual concerns.

Structure of the handbook

Each topic starts with a description of one or more case scenarios, followed by a general discussion of the main theme and details of what a typical flow of the sessions might be like and how one might be able to reflect on one's own internal processes, emotions and biases. To that end, this handbook uses case scenarios to help the reader gain a practical understanding about the topics discussed in the main Demystifying Sexuality reference book and become aware of not only the approaches they would use in these situations, but also of their own biases and judgements that might impact the therapeutic process.

Approach

While the therapeutic approach and the case conceptualization may vary from counsellor to counsellor depending on their specialization and training, an attempt has been made to keep the narration and reflection exercises generic enough (and not prescriptive) so practitioners can use the outcomes irrespective of the approach they use. There is greater focus on self-reflection that can help the practitioner become aware of how they think about a particular topic, what may be issues they want to take to supervision or their own personal work/ therapy so they can work with their clients in an objective manner.

This handbook hopes to bring special attention of the reader to their own biases including what might be one's blindspots, by providing them with situations which are typical of our reality - complex, no single solution or way of thinking, situations stigmatized by social norms and requiring the reader to get past their own conditioning and unlearn and relearn. We also believe that using these case studies in role-plays and discussions in group-learning scenarios can deepen the learners' understanding - through the group's collective reflection and the feedback one may receive from being part of the group.

This handbook aims to provide a general understanding about issues related to sexuality and is a starting point in practicing counselling that promotes healthy sexuality. To continue to grow personally and professionally requires one to continuously invest in reflecting on one's own biases and judgements, stay in touch with current research, starting and continuing dialogue about sexuality with curiosity, seeking therapy for themselves and staying in supervision..

How to use this handbook

Discussing case studies

Each case study has several reflective questions and activities meant for either discussion or introspection and the activities could be completed as written assignments in a separate book or as class discussions or in the form of role plays.

The cases described in this handbook are loosely based on ones that counsellors and therapists support their clients with, revolving around various aspects of sexuality. We have ensured there is no identifying information about any particular person (practitioner or client) and have only taken the essence of the issues that were brought to the practice.

Things to keep in mind while discussing the cases:

- Key/ core issues of the client - which may be more than or different from what has been articulated
- Become aware of one's own biases and assumptions about human behaviour.
- Impact of client's issues on oneself
- Worldview of the client being discussed - what experiences and messages shaped it, what changed it and how it is expressed.
- Develop culturally responsive, individual specific intervention strategies.
- Broaden awareness of how various forces affect not only the clients but the therapeutic relationship as well.

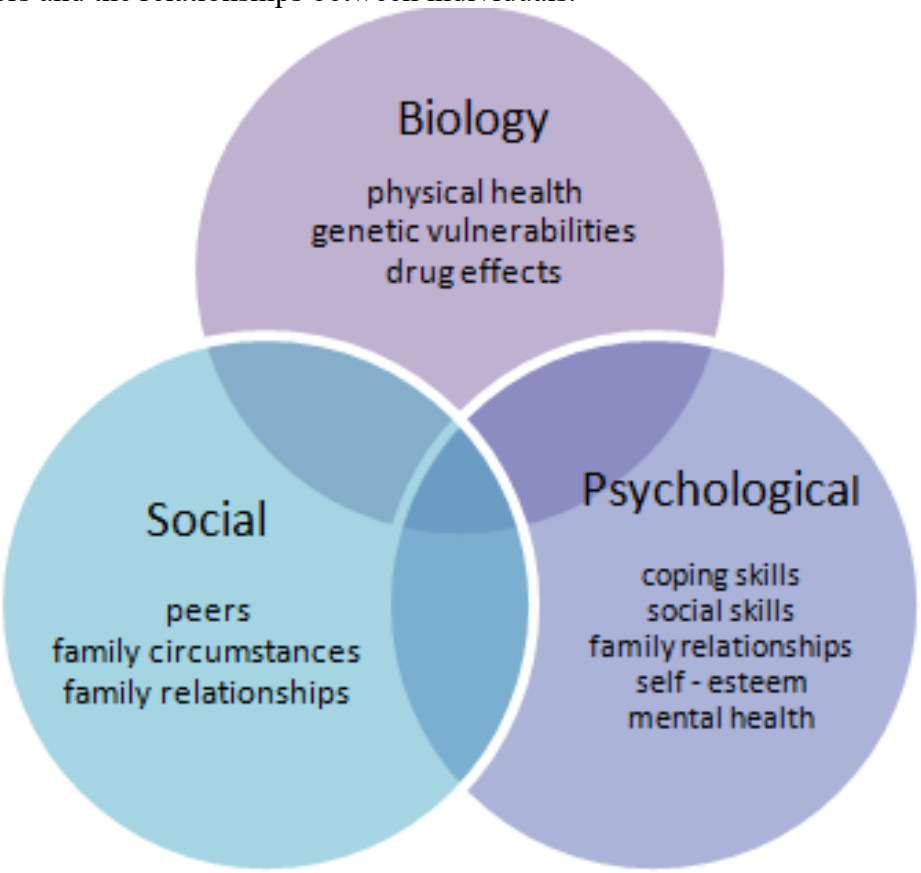
Facilitators and teachers are encouraged to use the book as a reference document - there may be occasions and situations where certain scenarios have to be altered to suit a particular discussion, or the length of the debrief has to be varied or other such revisions made. We encourage educators to use their discretion and use this material in any way that helps facilitate learning most effectively

A note on the Biopsychosocial model and using the 4 Ps.

The biopsychosocial model was introduced by George Engel in 1977 and it stated that an individual's well-being is defined not just by their physical but also by their psychological and social health and happiness (Gatchel et al., 2007). This was a big shift from the traditional biomedical model which considered well-being on solely a biological level and considered health to be an absence of illness rather than considering the psychological and social factors that contribute to the health and well-being of an individual. Elaborating on the biopsychosocial factors:

- 'Bio' refers to the biological and bodily concerns of a person

- ‘Psycho’ refers to the mental state of an individual, their thoughts, feelings and emotions about the particular issue that they are grappling with
- ‘Social’ refers to external factors like the value or belief system of a community, cultural factors and the relationships between individuals.



According to this model, any concern that the individual might be facing cannot be understood or addressed fully in isolation as the impact on one of these areas tends to impact the other areas of well-being as well. The aim of this model is to be able to treat the mind and body together and understand not just the illness or the condition but also the causes of the conditions and strengths that could help the individual deal with their condition in a healthy way. To do this, the biopsychosocial model uses the concept of the 4Ps for each of the biological, psychological and social factors. The 4 Ps are:

- **Predisposing factors:** these are the factors that make a person vulnerable to the presenting problem. These factors may be understood by exploring the history and events in the individual’s life that has brought them to this point. For example: the family history of illness, chronic social stressors, temperament, genetics.
- **Precipitating factors:** these are the stressors or events that directly caused the current problem. This is identified by isolating the events or experiences that triggered the problem. Precipitating factors are what trigger the vulnerabilities of a person (caused by their predisposing factors) Examples: sleep deprivation, serious injury, bullying, relationship conflict.
- **Perpetuating factors:** these are the conditions that exacerbate the clients’ concerns. They didn’t cause the problem but are making it worse or playing a role in the

continuation of the problem. Example: lack of treatment or medication, occupational or financial stress, substance abuse, abusive relationship.

- **Protective factors:** they are the client's strengths and play a role in the protection of the client. They could be the client's own competency and skills which serve as the coping mechanisms for the client to be able to deal with their concern in a healthy manner. They might also be what is available in their environment that gives them the strength and resilience to cope with their struggles. Example: healthy immune system, response to medications, positive relationships, financial support.

Understanding the role of these factors can help the counsellor in conceptualising the case in a comprehensive and efficient manner.

Readers can use the template given below to map each case discussed in this handbook.

4P Factor Model	Biological	Psychological	Social
Predisposing			
Precipitating			
Perpetuating			
Protective			

Chapter 1. Diversity in Sex
Chapter 2. Structure and Function of Sexual and Reproductive systems

Objectives:

- Understand the social dynamics of sex assignment, the impact of it and help clients with concerns related to this, feel okay about themselves
- Explore one's beliefs and views on cases related to the structure and function of the sexual and reproductive system and the diversity in it.

Case 1

Presenting concerns:
A couple Ayaan (35 yrs) and Mala (37 yrs) came into counselling and reported feeling distraught and conflicted as their new born baby was described by the doctor to be an intersex child. They are being pressured by their family and relatives to give up the child as they are considered to be "abnormal". The parents while being disappointed by the child's sex are horrified by the thought of giving them up. The doctor recommended that a feminizing surgical procedure be performed on the child to avoid the shame that they might face in the future and their family agrees. The couple stated being confused and are seeking help and advice on their next course of action.

- What are your thoughts about the intersex variation in people and the reasons it occurs?
- What may be the possible challenges intersex people face in their lives, that makes their caregivers anxious and worried?
- What kind of information can you give them as a counsellor to help them make a better decision regarding the well-being of their child?

Session Notes:
After an initial period of shock and the doctor's recommendation to raise them as a girl, Ayaan and Mala decided to learn more about the intersex variation in people. A friend referred them to another couple - parents of a child with intersex variation - who recommended against any sex assigning surgery for the child, for various reasons including the fact that the child would have no say in what is done to their body. So they decided to wait for the right time during which they got a lot of backlash from their family and doctors. People close them them suggested that they were being emotionally abusive towards their child by subjecting it to a life of torture and difficulties. They stated feeling very guilty and isolated. They were unsure of what to do and felt guilty that they weren't able to love the child and care for it unconditionally.

- What do you think is in the best interests of the child and why? Would you propose that to the couple?
- Why is the couple unable to love their child unconditionally? What might be their belief systems that hinders them?
- What can help the couple resist the societal pressures and do what is best for the child?

History:

The couple had a love marriage and were distantly related to each other. They were not in a hurry to have a child. After a few years, in their early 30s, when they felt ready to become parents they reported having trouble conceiving and had to go for IVF treatment. The pregnancy was very difficult and they now had this niggling feeling that because of all these factors, the child was born with an intersex variation. They felt very guilty that they may have wronged their child and should have not been in such haste or desperation to conceive a child .

- What were some of the predisposing factors for the challenges that the couple was going through?
- What are the societal beliefs that compounded the distress for the couple?
- What could help them become more assured of themselves and their actions and decisions?

Case 2:

Rajani is a 20 year old who is worried that her genitals are rather ugly. Her friends often discuss about how the labia minora have to be of a certain colour and size to not look repulsive, and that men now a days are very particular about these things. Rajani feels that she is not very good looking either and coupled with the shape o her genitals she will be rejected by her partner. She is considering going for plastic surgery to set things right but is afraid of hospitals and clinics as such.

- How would you approach this case?
- Is surgery is good option?
- What would you say to Rajani?

Chapter 3: Diversity in Gender Identity and Sexual Orientation

Chapter 4. Development of Gender Identity and Sexual Orientation

Objectives

1. Reflect on our understanding of the diversities in sex, gender and sexuality - what may be existing beliefs about what is 'normal' or not and how we feel about it
2. How to support those who have been impacted by the cultural, social and individual biases against queer people

Case 1

Presenting concerns: Bharat is a 25 years old male from a Sindhi family who reported that he was sent to therapy by his family when he came out to them as a homosexual person. He said that he doesn't need therapy or need to be "converted" into a heterosexual person and just wants to get over the session. He stated being comfortable in his sexual orientation and being in a stable relationship at the current time.

- What are your thoughts and beliefs regarding homosexuality and how would they impact your exploration of the client's concern?

Session notes:
The client stated that he had known about his sexuality since he was a teenager but didn't want to come out to his family as he was worried about not being accepted by them. He longed to feel loved by his family, but was also very angry with them. Even at school, he had difficult experiences when his classmates observed or got to know about his orientation. He described an incident from his childhood, when he had a crush on another boy and when he told the boy about his feelings, they were horrified and disgusted by the knowledge. He reported being bullied by them for the rest of the year until they went to a different section the following year. On further probing, he stated that his current relationship is going strong and his partner's family knew about them and accepted them. He still struggled though, to be open about his relationship with his friends and family, for the fear of being shamed and this sometimes caused rifts between him and his partner. This fear intensified when he mustered the courage to tell his family about his sexuality and they were horrified by this information and called him immoral. He stated that even though he had been expecting this reaction, he still felt betrayed by them and felt like he might not be able to ever trust them.

- How might your client's early experience in school have impacted him and his sexual well being?
- How important is it to reveal one's orientation to one's family and close friends and why?

History:
The client's family was very religious and considered homosexuality to be abnormal and against the will of God. He had a strict upbringing which caused him to rebel against his family and he felt he never fit into the family. He has a strained relationship with his parents. He tried to gain their acceptance initially but struggled with it and eventually gave up. His relationship with his

family deteriorated even more once they found out about his sexual orientation and want to "cure" him as soon as possible.

- In what ways did the client's family and their beliefs regarding his sexuality have an impact on his self-esteem and his sexuality?
- What might be the client's beliefs about himself and his sexuality?
- What do you think about his rift with his family and whether he needs to make more efforts to patch up with them or not?

Case 2

Presenting concerns:
A 30 year old male came seeking counselling, wearing a saree. He stated that he liked and was comfortable wearing sarees which also helped him stay in touch with his feelings. This attracted the criticism of his family and people around him. He felt deeply distressed, helpless and conflicted as he didn't know what to make of the rejection and ridicule from the community which was in conflict with what he felt about himself and what he was comfortable with.

- What are your thoughts and feelings about what the client stated?
- What more could you explore about the client's gender identity and expression?
- What might be the reasons for this client to have developed this way of feeling?

Session notes:
The client stated that he used to drape his mother's sarees as a kid and enjoyed the feel of it. He also felt like he related more to her when he wore her clothes. He showed an interest in playing with dolls and doing princess themed role-plays. As a kid, all the adults around him enjoyed it and didn't pay too much attention to it. Growing up he discovered that he likes to be in touch with his feminine side as well and wearing a saree did that to him. He reported no body dysphoria and was comfortable being assigned the male gender. He just disliked the tough male image that he was expected to conform to. He said that he tried to wear male clothes and did wear them from time to time, but he felt uncomfortable and unhappy in them. While he felt happy in a saree, he struggled to come to terms with the judging looks and disgusted faces of those around him. He stated feeling hopeless and helpless - he felt he was going to be unhappy no matter what he chose. He also had suicidal thoughts which he had put to plan. Before taking that action though, he thought that he could seek counselling as a last resort to see if it helps.

- Why do you think the client can't manage the situation by just dressing differently on different occasions (in women's clothes in private and men's clothes in public)?
- Does every form of gender expression need a label?
- What is causing the suicidal thoughts and how serious is it?
- What does the client wish to change through the counselling engagement?

History:
The client revealed that he came from a family which enjoyed a high socioeconomic status, which was well-known and respected in the community. He shared a good relationship with his

parents and they were supportive of him on most occasions. He stated that they were also struggling to accept his desire to wear what he wants and they thought something was wrong with him. He felt guilty about causing their dilemma and the shame they might face in their community. What made him more anxious was that he identified as a homosexual but didn't have the courage to talk to his parents about this, because he was sure it would add to their distress.

- What are some predisposing, precipitating, perpetuating and protective factors in this case?
- What might be the way forward to help this client reduce his feelings of hopelessness and guilt?

Case 3

Presenting concerns:
A 30 year old man sought counselling to deal with severe anxiety and his struggles with his identity. He opened up about being an intersex person who identified as male and being sexually attracted to women. He had a congenital degenerative disorder affecting his vision and his doctors had given him the prognosis that it will lead to eventual blindness. He had also been advised surgery to remove his undescended testicles as it increased his chances of developing cancer. One of his doctors had recommended surgery to affirm his sex as a female, so he could marry a man and would have some support and social security in the eventuality of his blindness. He sought information on what may be the implications of a sex affirming surgery - whether he will begin to feel more like a female, whether he will start being attracted to men and what other changes might happen to him. He was tired of living life with this uncertainty where everyone wanted to assign a sex to him. It seemed like if he conformed to the binary world through surgery and other treatments, he might have a chance at a better life. He was very unsure though and very disturbed by the decisions he had to make.

- What do you feel about the doctor's advice that considered the practical aspects of survival for the client?
- Do you think having a sex affirming surgery can make anyone feel differently about their gender identity?

History:
At the time of birth nobody acknowledged that he was an intersex child even though his family knew his body was different. He was brought up as a girl and it was not until he was 19 years old that he learned about the intersex variation in sex and that his sexual identity might be of an intersex person. This enabled him to understand himself better, why he always felt like he did not fit in his social roles or relate to his assigned gender. He had been aware that he was attracted to women from his early adolescence.

- How prepared do you feel about working with a client on issues related to their sexual orientation or gender identity? What topics do you feel underprepared to work with?

- If a client came to you with a deep faith in conversion therapies, hoping to get over their own sexual orientation, how would you work with the client?

Queer Affirmative Counselling Practice (QACP)

This section is written after researching and reading material on Queer Affirmative Counselling Practices by Mariwala Health Initiative which strives to make mental health accessible to everyone, especially marginalised people and communities. Queer affirmative counselling or therapy is the approach that embraces and aims to empower individuals belonging to the LGBTQAI+ community who are adversely impacted by the standards and expectations of the heteronormative culture we live in. While QACP is viewed as a specialised area of expertise, it is vital that a mental health professional is competent in providing effective counselling to the LGBTQAI+ community because, firstly, it is assumed that heteronormativity is the default and that everyone is heterosexual or fall in the gender binary category, causing members of the LGBTQAI+ community to feel confused, ashamed and disturbed about their identity and sexual orientation. Secondly, being gay, lesbian, bisexual, transgender is still seen as a pathology rather than a nautral way of being. QACP aims to promote a positive perspective towards the LGBTQAI+ community while addressing the impact of homophobia and transphobia on them.

Life stressors of members of the LGBTQAI+ community are:

1. Difficulty with accepting oneself and one's sexual identity if they belong to a gender or sexual minority which is regarded as not normal in a heteronormative world.
2. Unlike for heteronormative people who do not usually get asked about their gender or sexual orientation, individuals belonging to sexual minorities feel the pressure to 'come out' and reveal their gender and sexual identity
3. Discrimination in the form of withholding privileges or equal rights once their gender and sexual identity is discovered.
    a. Entry barriers to education/ employment opportunities - through things like forcing a binary choice in entry forms for sex/ gender, denial of gender-neutral washrooms, denial of promotions etc. Lack of safe educational and work spaces often leads to many dropping out of school and work
    b. Access to Housing: Societies often refuse to sell or rent housing to queer people. In some spaces, this leads to ghettoization or the invisibilization of queer people to avoid any possible violence.
    c. Access to Health: Very little of the physical and mental health care available is queer informed, let alone queer affirmative. Lack of queer affirmative healthcare also means that queer individuals do not seek medical help as easily as others do, for fear of being misgendered or humiliated and denied treatment.
4. Microaggressions: Queer people are routinely subjected to name-calling, bullying, misgendering, excessive staring, "joking," passing rude comments etc.
5. Violence in the name of healthcare: These include sex imposition on intersex infants and children through surgeries that are not really necessary for their physical health, but done at the behest of parents or others; "treatment" in the name of "conversion," as if there was something wrong about being LGBTQIA+; use of unscientific, useless and traumatizing procedures in the name of trying to "heterosexualize" them.

Conversion Therapy: It is the practice of trying to change the sexual orientation of an individual using unscientific means whichharm the person physically and psychologically. While there is no evidence that one's sexual orientation can be changed, many practitioners continue to practice it. On the contrary, there are studies that indicate that such therapies may even be harmful to the persons who are subject to it. Individuals who underwent conversion therapy have been known to be prone to anxiety, depression, substance abuse and suicidality. Counsellors play an important role in creating awareness regarding the harmful effects of conversion therapy. It is a counsellor's responsibility to talk about the harmful impacts of conversion therapy to the individual, the family and community and create an understanding that any form of gender expression or sexual orientation is natural.

Counsellors' role in making therapy queer affirmative

1. Using queer affirmative language and refraining from using words which are considered derogatory to the LGBTQAI+ community.
   Examples of affirmative language here:
   a. Asking for the pronouns that the person uses, and not assuming based on appearance or name
   b. Using "common" instead of "normal" or "natural"
   c. Not using the name a person used before their transition (deadnaming)
   d. Asking about client's "partner" instead of husband or wife
   e. Updating intake forms to be more inclusive and respectful (and not limited to Male/ Female/ Married/ Divorced/ Widow/ Mr/ Mrs/ Miss)
   f. Not using derogatory terms like "homo", "lesbo", "faggot", "it" (instead of their pronoun)
2. Create a queer-friendly counselling environment. It could be done by having magazines and posters that indicate that people of all gender and sexual identities are welcome, letting people know that they deal with issues regarding sexuality, training staff to be friendly towards everyone and not making people uncomfortable.

3. Become aware of myths and biases existing around the LGBTQAI+ community and avoid making the same assumptions.

a. Take an educative stance in counselling when faced with people with lack of information or misinformation about their gender or sexual identity. This could also mean having data of resources and referrals to provide the clients/ directing them to queer friendly/ affirmative professionals
b. Encourage self-acceptance. Clients having grown-up surrounded by heteronormativity may have internalized homophobia and homo-negativity and may struggle with self-acceptance.
   1. Show unconditional positive regard, empathy and genuineness. Make the client feel validated and show them that they are people worthy of dignity and respect.
   2. Help them see their values, qualities and strengths
   3. Engage in conversations around shame and guilt. It is the result of the society's beliefs and assumptions.

c. Enable access to queer friendly resources like books, films, websites, NGOs, support groups, forums working on queer issues, helplines providing services to queer group.

d. Maintain confidentiality. While confidentiality is an inherent part of therapy, taking extra care to make sure that the privacy of the individual is maintained and that effort is communicated to the client, is necessary.

e. Become aware of one's own biases and prejudices towards sexual and gender minorities

Chapter 5: Gender Bias

Objectives

- Understanding the role of gender bias in the formation of identity, beliefs and values
- Understanding the role of gender bias, toxic masculinity and its impact on men
- Becoming aware of one's own biases with respect to different genders and its role in the therapeutic process/relationship
- Developing a treatment plan that empowers the client and promotes development of healthy self-esteem

Case 1

Presenting concerns:
A 55 year old woman reported feeling depressed and unmotivated since her children had moved out and settled in their own careers and lives. She felt a lack of purpose as she was used to her children being dependent on her for the past ~ 25 years and now didn't know what to do with her life. As a young adult, she had completed B.Com and wanted to study further (and do a course in financial accounting) but she was married off by then and her husband and in-laws did not encourage her. After the kids were born she also felt that her family had to be her priority and not higher studies. But now that her responsibilities had reduced, she reported feeling lost and lacking a sense of direction. She also reported episodes of breathlessness and excessive sweating when she reflected on her life and her current situation

- Do you think this is a common issue among women in our society? If yes, what are the factors that make them vulnerable to this struggle in their middle age?
- Would completing her higher education have made her feel more confident, independent and self-assured? Could she take up further studies or skill development now?

Session notes
The client discussed in detail how she had tried to talk about this with her family but they were quite dismissive of her situation and had suggested that she could take up some voluntary work to keep herself occupied. She barely had any friends anymore - whenever she had tried to spend time with her friends, her husband complained that she was ignoring him and made her feel guilty. She reported facing body-image issues, being shamed for her skin colour and for gaining weight over the years of successive pregnancies and managing household duties. She was resentful that her husband had managed to remain fit and sometimes suggested that she was overweight because she was lazy. She held herself responsible for their sex life getting impacted - they hadn't had sex for the past 5 years.

- Why do you think the client had taken such a passive, submissive role in her family?
- What skills can you use to help the client identify her own self-defeating patterns and beliefs and the source of these beliefs?

History:

The client came from a highly religious, authoritarian family. Her family often suggested that she was overthinking things and needed to be more adjusting - that she had had such a good life and was being ungrateful by complaining and feeling restless. Brought up with strict religious values, she was conditioned to think that her purpose in life was to be a 'good' daughter, wife and daughter-in-law and she feared being judged on those counts - so she rarely complained, she worked very hard at pleasing her family members and tolerated all their demands on her. She also reported that her mother-in-law used to harass her physically - pinching her when she was angry, making her do strenuous work for long hours, sometimes even when she was unwell. Her husband seldom stood up for her since he couldn't be assertive with his mother.

- What can make the client feel that it is ok to take care of herself, to focus on her health and well being?
- What might happen if the client resists or confronts the ways in which her family treated her? Would it be ok in a counselling relationship, to support a client who wants to assert herself - which might potentially cause rifts in the family?

Case 2

Presenting concerns:
A 35 years old male reported difficulty finding a suitable partner, often experiencing anxiety and associated physical symptoms when he thought about it. He was keen to get married and have children, but worried that with his income he would not find a woman of his liking who would be agreeable to marry him. He sought counselling to get over his anxiety, to figure out what he could do to find a good partner so that he could feel more motivated and positive about his life.

- What are your thoughts about marriage, the right age to marry and what one should look for in a life partner?
- What do you think about your client's goals for counselling?

Session Notes:
The client seemed extremely angry about what he thought was the unfair advantage that men with money had, who according to him found it easier to find a marriage partner. He seemed resentful towards women because of this and reported being violent towards the women in his close circles or women who were confident and assertive. He wanted to develop self-control lest he end up in legal trouble. He had been in a couple of relationships in the past, which ended bitterly with the women walking out on him or threatening to call the cops on him for his violent behavior. While he tried to apologise and explain himself, the women did not seem to have the patience anymore, to give him more chances to mend. He thought of this as arrogance on their part - something that he didn't feel he deserved. All they seemed to want is a luxurious life, for which he was expected to slog his days off.

- What are the client's belief systems that perpetuate his behavior towards women?
- How might he be supported to cope with another such failed relationship if it did occur another time (while he is in therapy)?

History:

The client reported being sexually abused by his aunt as a child. He had been unable to form a relationship with his mother as she was uninvolved and suffered from depression due to his father's demise when he was 4 years old. His memories of childhood were of stealing money to buy food, financial struggles and an unavailable, unstable parent. He grew up learning not to trust anyone, believing that he had only himself to depend on, and continually wary of getting caught for his petty crimes. Though he received support and help occasionally from his extended family on his mother's side, he rejected it because he was angry with his mother. He eventually distanced himself from his mother and felt resentful towards her for being an irresponsible parent.

- Does the client's circumstances justify how he feels about women?
- What could be done to help him learn to trust more and to become more aware of his biased views about women and himself?
- What in the counselling relationship can be useful to help the client learn how to connect to people with trust and authenticity?

Case 3

Presenting concerns:
A 30 year old male was sent to counselling as a part of an Employee Assistance Program in his office. He stated that had only come because his manager forced him to. His manager had suggested that he should work on his anger issues so that he is seen as more of a team player. Currently he admitted that many of his colleagues seemed unhappy with him. While no one could fault his work, they also preferred not to work with him because of his behavior. Their feedback was that he could be quite a task master, with little consideration for people and their needs or circumstances, often lashing out at them when he was dissatisfied with their work. They had also raised the issue that he played favourites - more accommodating and less abrasive with male colleagues who were similar to him and tough and dismissive of the women in his team and the men who were less aggressive and outspoken. According to him, that was because work only got done by people like him while the others tended to be slow and indecisive.

- How would you connect with a client who seems reluctant to be counselled, who believes that he is misunderstood and that it is the others who are the problem?
- Do you believe that everyone should learn to be nice and polite and only then can they grow in their profession? Explain your answer

Session notes:
It took several sessions before the client opened up about himself. Even when he did, he was guarded and only spoke vaguely - requiring the counsellor to pause, let him stay with his emotions and probe only when he was ready. Over several sessions he admitted that he struggled to get a hold on his emotions and also that he got violent at times. While he wanted to control it, he couldn't and regretted it later. His partners from earlier relationships had told him that he was like a closed book and they found it difficult to connect with him. He also stated being attracted to males at times, but tried to hide these feelings and instead became overly rude to them as he

felt ashamed and disgusted with himself regarding these feelings. He reported having many one-night stands with women, to get over these feelings but wasn't very successful.

- What could help understand the client's closed, inexpressive nature - what aspects of his life would you want to explore further?
- What kind of skills and techniques can you teach the client to process and deal with his emotions in a healthy manner?

History:
The client spoke about his parents who were mostly unavailable because they were away travelling on work. He was raised by his maternal grandparents for most part of his childhood. The grandparents used punishment liberally, as a way to toughen him up and make him a man. They had little patience with his longing for his parents - telling him that he should be brave and strong and that big boys should not be so clingy about parents. They also frequently praised and compared him to their grandson from their son (client's uncle) - who was treated quite gently and with a lot of affection when he visited them. The client had little love for his grandparents and had to tolerate them because he had no choice. At 14 he was molested by his neighbour who groped and fondled him on several occasions. He expressly mentioned that he wasn't traumatized by it because the experience was not violent and he even might have enjoyed it. He sometimes wondered if he was a 'corrupted' person because of how he felt about his grandparents, his parents having no interest in him and how he attracted abusive people to him.

- How will you help the client rid himself of the thoughts that he was inherently an unworthy person who harbored bad thoughts?
- What are the predisposing and precipitating factors in this case?
- How will you explore whether the early experience of sexual abuse had an impact on his current presenting concern and whether it needed to be explored further?

Counsellor's role

1. To bring a focus on gender related factors that may have shaped the client: their thought processes, their values and behaviours, how others viewed and interacted with them and the coping mechanisms they developed. It may be that the presenting concern is rather different from these issues to start with - but with skilled probing and authentic connection, some of these underlying issues may be arrived at.

2. View clients from an intersectional and gender sensitive lens to have a better understanding of the client's presenting issues. The counsellor should avoid letting their own biases interfere in the process of therapy. (Mainstream counselling interventions were criticised for their Androcentric, Gendercentric, Ethnocentric, Heterosexist, Intra-psychic and Deterministic bias (Worell & Remer, 2003). Many feminist counsellors thought of traditional methods of therapy like cognitive behavioural therapy, psychodynamic therapy and family therapy to be sexist). Counsellors should approach therapy with a more mindful gender sensitive, non-judgemental lens that allows clients - irrespective of their gender - to acknowledge their vulnerabilities and work on it

3. Maintain an egalitarian perspective where the counsellor values and respects the client's opinion and worldview rather than assuming the role of an expert, to be able to ultimately empower them (Joshi, 2015). Counsellors should help clients identify their internal thoughts and belief patterns from a gender-sensitive lens and support them in understanding that their beliefs may be rooted in gendered messages they are receiving from society.

Case 4

Rights and laws in the context of discrimination and violence

Objectives :

- Provide awareness to the client on how to access legal protection and recourse in different situations of abuse.
- To draw attention to Human Rights and how these create gender and sexual equity.
- Develop an understanding of when a counsellor may ask their client to seek legal advice

Presenting concern:
A 20 year old woman came for counselling regarding the physical abuse she was suffering at the hands of her husband and in-laws. This had been so for a year since the time she had conceived and they had made her go through a sex determination test (illegally) - since the fetus was reported to be of a baby girl, they forced her to abort. She reported being more troubled more by the psychological/ emotional trauma of how she was being treated and of losing her baby than the physical violence against her.

Session notes:
The client stated that her in-laws were very nice to her in the early years but she had always had challenges in her relationship with her husband. He was very forceful in his demand for sex and would threaten to leave her if she did not accede. She never enjoyed sex with her husband, but learnt to tolerate it. She stated that his behaviour improved when she got pregnant, but became worse after her abortion. She felt severely distressed and was unable to go about her routine due to this. Her parents noticed this which was when they persuaded her to seek counselling to help resolve these issues. They expected that counselling would help make her more tolerant and accepting of her situation. They had expressly discouraged her from thinking about a divorce - they thought the problem was more in her mind than the actual situation itself. She did not want to rock the boat and leave her husband - it was a big change, would hurt her parents and she had no confidence in herself. However, she was also afraid of going back to her husband/ inlaws' place because of the harassment which was increasing by the day

History:
The client came from a traditional upper-class family and shared a good bond with her parents. She stated that while she was able to communicate anything with them and they encouraged her to do whatever she wanted to do, they drew a line at letting her go out to work as they felt that she shouldn't bother herself with these things and wanted her to have a life where she could be

comfortable. And while she wanted to become a chartered accountant, she didn't argue about it with her parents as no woman in her family had studied that much.

Notes

Apart from the general counselling skills in cases like the one mentioned above or other situations where the safety of the client is at stake, the counsellor's role involves providing the client information regarding their rights and laws where they can take required action if desired. Often, clients facing such severe trauma develop learned helplessness where they feel a loss of control because of being in the same situation for a long time. Providing them with information about laws that could protect them may give them a sense of control. Though some clients might be skeptical regarding the law, explaining to them the procedures involved in a factual manner and giving them the time to process information can bring back some confidence. Even if they decide not to take legal action, knowing that they have certain rights and laws may give them confidence to take necessary steps to get out of the situation. So information and psychoeducation are important aspects in these cases. And apart from providing them with the information, it is recommended to have certain legal referrals in place in case the client asks for such advice.

Cycle of abuse

Helping the clients understand the cycle of abuse also helps them see patterns and ways to get out when necessary. They are:

1. **Tension building**: increased tension followed by a break in communication which leads to the victim feeling fearful and trying to placate the abuser.
2. **Incident:** leading to verbal, emotional, physical or sexual abuse. Includes anger, blaming, threats and intimidation.
3. **Reconciliation**: the abuser apologizes, gives excuses, blames the victim, denies the abuse occurred or claims that it wasn't as bad as the victim claims.
4. **Calm:** The incident is "forgotten". No abuse is taking place. The honeymoon phase.

The cycle then repeats as the underlying toxicity in the relationship has not been addressed. Very often, the victim feels compelled to 'forgive' the partner who seems very remorseful and promises not to let that repeat. Any further mention of the violent incident is used to shame the victim as someone who does not let go of the past, who wants to use a 'small' incident to score a point and so on. Sometimes, the victim is also so convinced with the stories that the abuser uses to explain their misbehavior and believes that the abuser is helpless against their own violent tendencies. These along with the victim's own insecurities and learned helplessness keeps them stuck in the cycle of violence perpetrated on them

Chapter 6. Self-esteem and Body Image

Objectives:

- To determine the impact of body-image and self-esteem on people of all identities.

- To recognize the development of shame in relation to body image and its impact on one's self-esteem

Case 1

Presenting concerns
Anushika, a 30 year old entrepreneur running an interior designing firm, sought counselling for her high levels of anxiety and fluctuating sense of self confidence that seemed to impact her business. She reported binge eating several times a day and then purging later on, this pattern often accompanied by stomach aches. She knew this was unhealthy and had consulted a dietician about how to change her dietary habits. She was fairly disciplined with her exercise regime. She shared that after divorcing from her husband 2 years ago, of late she has been thinking of dating again. However, she experienced anxiety at this thought, because the main reason for the breakdown of her marriage had been her husband's constant put downs about how unattractive she was and how he was not sexually satisfied with her.

- How important is sexual satisfaction in a marriage and how dependent is it on the partner's looks?
- What are some of the factors that can impact sexual intimacy and its experience in a relationship?

Session Notes
As a teenager, Anushika's family discouraged her from feeling any romantic attraction. This made her constantly worried that her parents might believe the rumours about her having a boyfriend (which her classmates kept teasing her about) and this caused her to be wary of any romantic attractions she felt. When she was in the 10th grade, she was sexually abused by one of her seniors and when she gathered the courage to share this with her mother, she was blamed for it and was told never to speak about it again. Because of all this, she developed a sense of dressing that was 'modest' - mostly loose, dull colored clothes so she didn't attract any attention. This along with being called chubby and overweight, made her dislike her body and feel unattractive. She began to purge during her high school years and this continued into her 20s when she was often described as 'thin'. She felt in control of her body though and it helped her deal with her environment with minimal stress. When she was out of her purging phase, she binge ate with the hope of gaining some weight and then the cycle repeated - all the while trying to meet some ideal standard of body weight. Tired of this back and forth, she hoped counselling would help her reconcile with the internal conflict so she could begin to focus on other important things in life.

- What may be the messages that Anushika has internalized about herself - that is causing her so much self-doubt?
- How differently might Anushika feel and behave if she was more confident and self-assured?

History
The client grew up with strict, authoritarian parents. She had little to no communication with her father. Her mother was always worried about her safety and what the community might say- so

Anushika wasn't allowed to explore new things, or to go out with friends or on overnight school trips. Her parents even decided her choice of what college and which course she would attend. This created a pattern of helplessness and thoughts of incompetence and shame. She married her hotel management classmate, when she was 22 yrs old. However, she had some inhibitions about sex, struggled with conflicting emotions about physical intimacy and this caused a rift between them. Meanwhile he had an extra marital affair and justified it by telling her she was sexually unattractive and frigid. She felt betrayed, but also believed that she was partly responsible for her husband's actions. She filed for divorce despite her parents' advice against it - for the first time in her life, she took an independent decision and took charge of her life

- Do you feel that Anushika was overreacting to the incidents in her life? Should she have tried to reconcile with her husband first - and forgiven him the indiscretion?
- Why was Anushika dealing with the same issues for so many years despite seemingly having moved on in life?

Notes
Body-image is strongly linked to an individual's feelings of self-worth. When a client reports dissatisfaction with their body, the counsellor can do a deeper exploration of their body-image, what they believe about their bodies and what has caused it.

To start with, it might help to connect with the body-function. The counsellor could start with exploring what the client wishes to experience in and with their body, to elicit more personal connections with themselves. This could be through open-ended questions like:

- What does your body enable for you?
- What do you wish to enjoy through your body?

Through the responses, the counsellor might be able to connect the client with the functionality they seek in their body, and get a perspective on whether their body enables such functions and meets those expectations.

The counsellor could go on to explore what is their specific definition/ parameters of "ideal figure" and what it means for them. This could be done by asking questions like:

- What would being thinner mean for you?
- How would your life and relationships be different once you have achieved your ideal body-type?
- How would your view of yourself change after you have achieved your target weight?

These questions will bring clarity to the counsellor about the client's motivations and struggles and will also provide a space for the client to introspect and understand how their sense of self is related to their body-image. After the exploration, the counsellor can help the client identify where and how they developed this idea of an ideal body and whether it is practical or even healthy to go after such an ideal. This can be done by asking the following questions:

- What kind of messages do people around you give you about the way you look?
- What are the body types you aspire to achieve and why do you feel those are better than yours?
- What would it take to pursue this ideal and at what cost?

The counsellors can help the client identify negative self-talk, challenge it and change it with a more positive talk. An example of it is:

Negative Self-talk	**Challenging thought**	**Altered positive self-talk**
"I am fat and do not deserve respect"	"Can my being fat take away my right to be treated with respect?" "By what or whose standards am I fat? Does that also always mean I am unhealthy?"	"I am a human being worthy of respect irrespective of my looks." "People need to treat each other with respect - irrespective of their looks, body size or shape. I too can respect myself whatever be the condition of my body"
"I am unattractive. Nobody will find me sexy."	"Is feeling sexy about how one looks? Are all sexy people good looking by current standards?"	"I can be comfortable in my body whatever its shape and size. Being at ease with one's body makes people attractive." "There is no one ideal body standard. Everyone has a unique body and this diversity adds to what makes a person interesting." "There are all kinds of sexiness."
"I will not get opportunities unless I look and act in a certain way."	"Let me look closely at the successful people in my industry and see if they are all looking the same."	"People's skills and abilities are independent of their looks. I can get many opportunities that are not solely/ not at all dependent on a person's looks" "My success is based on what I make of the opportunities I get or the opportunities I make for myself."

When the counsellor acknowledges the worthiness of the client and connects to them at a personal level, when the client experiences unconditional regard and respect with the counsellor,

they develop a healthier sense of self and are able to challenge the messages they get from various other sources regarding their body-image. They also learn to treat their body and mind with respect, and become aware of their enjoyable experiences with their bodies - balancing the negative self-defeating thoughts that they have internalized from years about their own bodies.

Chapter 7. Attitude towards sexual health and issues with reproductive health

Objectives

- Promoting an understanding about basic issues with sexual health, the stigma associated with these issues that limits people's ability to speak about it or seek care.
- Exploring the role of counsellors in reducing shame and stigma in clients about their sexual health
- Understanding when to seek medical support in therapy and how to liaison with individuals

Case 1

Presenting concerns:
The client was a 28 year old female who recently got married and reported having sexual issues with her partner. She was unable to have penetrative sex with her partner. Every time they tried, she felt intense pain, even though she felt emotionally ready and her partner was patient and supportive. She stated feeling guilty about letting her partner down and didn't know what to do.

- What might be wrong about the client - is it likely to be physical problems or psychological ones?
- Is the guilt that she feels normal and justified?

Session notes:
The client and her partner had not been able to consummate their marriage. She stated that while this was an arranged marriage and she was initially wary of her partner, she now felt comfortable and even attracted to him as she got to know him better. Her apprehension about having sex had emerged right at the prospect of getting married - as she had never had a relationship and no sexual experience. She reported feeling conflicting emotions - excitement, pleasure, guilt and even shame - when they got physically intimate. She was not sure what that was about, but willed herself to ignore the unpleasant emotions and let her husband lead her through the sexual act. It was at the moment of penetration that she reported feeling extreme pain and discomfort - to an extent that they had to stop.

Upon exploration of her feelings she reported feeling extremely conscious and uncomfortable about exposing her body and letting another person touch her intimately. She believed that she was overweight and therefore unattractive and wondered if her husband might be faking his attraction towards her . She shied from sharing her inhibitions and doubts with her partner lest their relationship deteriorate any further. She secretly consulted a doctor who ruled out any physical cause for the pain.

- How do you imagine one's body weight impacts their sexual satisfaction with their partner?
- What might be the other reasons that the client is facing this stuckness?

History:

The client came from an upper-middle class conservative joint family where it was taboo to talk about romance and sex. She described an incident when she was 18 and for the first time, watched a pornographic movie out of curiosity. Her father found out and called her characterless and a shame on their family. He took away her phone privileges for an entire year and refused to talk to her normally, avoiding any eye contact with her for a long time. She stated feeling extremely guilty for the same.

- What does this incident have to do with her current concern? How is it even related?
- What are your views about women watching pornography?
- What might be a plan to help her overcome her stuckness - help her relax and learn to enjoy sexual contact instead of being afraid of it?

Case 2

Presenting concerns:
Jai (50) and Mariam (39) had been married for 15 years and sought counselling to help make a decision about their unplanned and untimely pregnancy. A week before the counselling session, they had found out that Mariam was 6 weeks pregnant. They were struggling to come to terms with the information as they feel conflicted regarding having a child at this point in their lives. They stated that they had wanted a child 10 years ago but as they were unable to conceive for a long time, they stopped trying. They had somewhat gotten over the feelings of hope and then disappointment that they had felt frequently. Currently they stated feeling anxious about having a child at this age as they felt they were not ready for the responsibility at this age. They were also struggling with guilt at the thought of terminating the pregnancy.

- What are your thoughts and beliefs regarding the concern of the clients?
- How can you explore this issue a little further without bringing in your own beliefs or ideas regarding the matter? What questions could you ask them, to explore their concern further?
- How can you know if the concern is shared by both of them or just one of them?

Session notes: They stated that this is one decision that has caused a deep conflict between them and they are at loggerheads at this point. Jai wanted a child as he feels they can handle the responsibility. Mariam stated that while she wished she had a child earlier when she was more flexible in her career, now she has successfully settled in her work and is focused on growing in her job, does not want to jeopardize all that she has earned for herself. They usually sorted out their conflicts amicably as they were used to facing hurdles in their relationship - facing the pressures of marrying outside their communities and then the anxiety of not being able to conceive. But this is the first time that they had such differing opinions which was causing them to drift apart. Jai feels that their families were finally happy and were thrilled when they learnt about the pregnancy. He believes that Mariam will be happy once they have the baby, but Mariam is skeptical. She states that while she is glad to finally reconnect with their family, she has now accepted her life the way it is and doesn't want her work or body to change. Jai stated that while he really wants a child, he doesn't want Mariam to be unhappy.

- Whose point of view aligns more with your thinking?
- What judgements crossed your mind as you read the scenario? What part of it can you relate to, from your own personal life - if at all?
- What might make it difficult to maintain a neutral stance without taking sides or expressing what you feel is best for the couple?

History:
They got married 15 years ago against both their families' wishes. Jai came from a traditional family which was against him marrying a muslim girl. Mariam's parents were not too happy about how Jai's family treated Mariam and they were not in favour of this alliance. When they couldn't conceive, they faced a lot of backlash from both their families, some members even suggesting that they were never meant to be. Mariam also stated that she had a miscarriage 10 years ago which impacted her deeply and she said she wouldn't want to go through that again. Even though the doctor stated that there were no complications, she was firm on not wanting a child at this point. When they discussed the conflict with their families, both families were enthusiastic that they should go through with the pregnancy. Mariam began to feel cornered and Jai reported feeling extremely guilty for the same as now he is torn between wanting to be there for his partner and his longing to have a child of his own

- What is your assessment of the core issue for this couple?
- When they are so caring towards each other, why is this couple unable to sort out this issue like many others they have?
- What are some predisposing, precipitating, perpetuating and protective factors in this case?

Notes
In cases in this section, along with the therapeutic skills of listening and attending, it would be helpful for the counsellor to provide certain information to the client to help them make better decisions or refer them to the right expert to help them with the information - for eg - information regarding becoming a parent at an 'advanced age' or about abortions. Keep in mind that the information is given in a manner that is in sync with the goals of the therapy and not coming from a place of our own biases.

The counsellor needs to mindfully keep the focus on what common decision the couple can arrive at and not influence the couple towards any particular decision that the counsellor thinks is the best - this may mean helping the individuals articulate their concerns in a way that the other empathizes with/ understands, finding common ground and bringing them to a space where alternatives are discussed, facilitating discussions where they can talk about their vulnerabilities without fear of being judged adversely and an understanding of how they will support each other during these difficult times and so on.

Case 3

Presenting concerns:
A male 55 years old, reported feeling distressed and conflicted on learning that his son was recently diagnosed as being HIV+ve. He was also angry, embarrassed and disappointed with his

son who came out to them as being a homosexual person. He wondered what he had done wrong in the upbringing of his son and blamed himself for not having noticed that there was something different about his son. Maybe if he had noticed it early enough, he could have done something to protect his son from his homosexual 'tendencies'.

- What is the key concern for this client that you could identify as the counselling goal?
- How would you feel about this client and would you be able to relate to him and his concerns?

Session notes:
The client stated that he had shared a good rapport with his son before finding out about his condition and sexual orientation. He encouraged his son to move out of their house, because he could not bear to see him everyday and not get angered by his sexuality. Having done that, he felt guilty and agitated because he couldn't stop loving his son, especially at a time like this when he was suffering from a terminal illness. He struggled with guilt, worry and some repulsion whenever he thought about this son. He was not sure he knew his son at all and was also hurt that his son just left home without trying to patch up with his parents. With time, he had reconciled to the current situation and wished he could undo his actions of the past. He wanted to help his son but he didn't know how. He also hoped to get his son back on the path of 'morality' if he could.

- Do you feel that this situation can be redeemed? Is the client's goal of wanting to 'help' his son realistic?
- How do you feel about the fluctuating emotions of the client towards his son?
- What could be done to calm the distress of the client?

History:
The client had an authoritarian parenting style. Because he had had a strained relationship with his own father who used to physically abuse him, he had vowed to be kinder to his children. He came from a deeply religious family where they had instilled ideas about how to avoid committing sins, how to live a life of morality, in the service of mankind so as to achieve liberation after death. He strongly believed this and wanted to pass this on to his children and was devastated to realize that his son was not treading the path that his religion preached.

- What do you think about the client's readiness to be in counselling and change?
- What might be challenges in the counselling journey and how could you and the client overcome those?
- Are there any of your own values and belief systems that are getting challenged by the details of this case? How can you attend to the dissonance that this case may be causing in you, and not let it affect your work with this client?

Chapter 8. Sexual Development in Children and Adolescents

Objectives:
- Normalising the developmental psychosexual stages and behaviors among children as they grow and learn from their environment

- Understanding psychosexual needs of the elderly and the social stigma and shame associated with its expression
- Becoming aware of one's own biases while dealing with such cases
- Developing a plan that promotes healthy sexual growth and expression among children and the elderly
- Developing awareness among adults about their role in the development of a child's sexual identity and expression

Case 1

Presenting concerns

The class teacher brings two children of grade 1, Neha and Amit, to meet the counsellor who volunteers in the school once a week. The teacher complains that Neha and Amit have been seen showing each other their genitals while in class. They are usually seated at the back and she has seen Neha lift up her skirt and ask Amit to pull down his pants on multiple occasions. The teacher continues and says that this has happened twice this week and when she has asked Neha what is going on, she usually does not say much. The teacher has scolded both of them and conveyed that such things are not good.

- If you were the school counsellor, what might be the immediate thoughts you have and what do you have to consider?
- Who all need to be involved in the discussions and 'counselling' sessions and what might be the objectives of these conversations?

Session Notes:

While discussing body parts and safe and unsafe touch with the children separately, Neha seemed to think that showing her vulva to others was a sign of love since she had seen her mother do it multiple times. She wanted to play with Amit and this was her way of initiating play. Asking the other person to show their private parts was also something Neha had seen at home and asked Amit to do so. In sessions with Amit, it was found that he did not know why the teacher was scolding him but he felt bad and cried whenever the teacher reprimanded him. He saw it as playing along with Neha and was interested in finding out why her private parts were different from his own.

- What are some of the angles you might want to probe when presented with this information?
- What are the outcomes you might want to consider, for these counselling sessions with the children?
- What can you do about the curiosity that the children have displayed - do you need to do anything, who can do this, when and how?

History

Neha's parents were called in for a discussion and they admitted that since their socio-economic condition did not afford them separate rooms and they all slept in the same room, it was quite likely that Neha had seen her parents engaging in sexual activities multiple times. In Amit's case, the concept of private body parts or safe/unsafe touch were not yet introduced to him since they

thought he was too young for all that, and he was quite unperturbed by this exploration of bodies since he didn't attach any particular importance to it.

- Do you feel there was something 'wrong' with the way the children had been raised? If so, which set of parents needed to change and in what ways?
- What might be a plan to change these behaviors in the children, without making them feel guilty or ashamed of what they were doing? How can the idea of socio-sexual play in a private setting like a home vs soci-sexual play in a public place like a classroom be explained to children?
- What do you think about this kind of socio-sexual play among children? Should adults make space for such play or stop it whenever it comes to their notice? How might these courses of action affect sexual development in children?
- How can children be taught personal safety with the idea of empowering children to report perpetrators of sexual abuse? How can such education also make space for socio-sexual play among peers of 3-7 years of age?
- What might be your inhibitions or apprehensions about talking about these matters with i) the children ii) their parents iii) the teacher?

Case 2

Presenting concerns
10 year old Adnan came for counselling and reported feeling distressed as Adnan was confused about being the 'boy' he was supposed to be. Adnan stated a preference for 'girly' things like dressing up in pink frocks for fun and playing with toys made for girls. Adnan reported learning about the transgender identity in one of the classes at school and wondered if that was what Adnan was feeling. While going through this struggle, Adnan was also teased by classmates about being too girly and a 'sissy' and felt all alone and misunderstood
.

- How will you address Adnan during your conversations? What pronouns will you use?
- What might be signs you will look for that will confirm what Adnan's gender is and why? Is it important that every child or adolescent know and determine their gender identity?

Session notes
On further probing Adnan revealed being okay considered as a boy, with just a preference to play with girls or dress as one. Adnan, for whatever reasons, was withdrawn and had not found anyone with whom to confide in and often felt unwanted by others. Sometimes Adnan wondered if there was any truth in all that others said and if there was something wrong in Adnan's body. Adnan was conflicted about what to play, and with whom and how it might be interpreted by friends and family. Even Adnan's closeness with another boy in class was twisted and interpreted as them being more than just friends - at which point Adnan's friend distanced himself from Adnan and pretended that he didn't like Adnan at all.
.

- Do you need to apply any 'corrective' strategies to help Adnan - if yes, what might those be and how will they be used? If not, explain why
- What could you tell Adnan about the difficulty in making and keeping friends?

History

Adnan's home environment seemed safe and healthy, with parents willing to talk about sensitive matters and the struggles of an adolescent. Yes, Adnan felt anxious bringing up this topic because Adnan felt the parents weren't entirely open or knowledgeable about these matters. Occasionally Adnan had been told to be tough like a boy and not weak or sensitive like a girl, or that behaving in a feminine manner and socializing mostly with girls might cause Adnan to be excluded by other boys and Adnan might end up friendless. Adnan was worried that if they got to know their child's preferences, they might be shocked and feel let down and ashamed of their child.

- What messages can help Adnan see beyond the parents' beliefs and thinking about their child's sexuality?
- What might you say/ do to allay Adnan's fears about the self?
- What might be the resistance that Adnan may face in the social environment that might complicate the counselling and healing process?

Notes

Counsellors working with children deal with various developmental issues and the exploration of their sexuality and gender identity is one of them. The common belief is that curiosity about sex and sexuality is only appropriate (if at all) in teenagers and adults. There is therefore a lot of discomfort and embarrassment and shame that caregivers feel, when younger children show signs of expressing their sexuality. With a possibly gender-variant pre-pubescent child, the counsellor might want to talk about

- diversity in gender and sexuality - and that there is no hurry to take on a label.
- bullying and safety
- body-safety rules
- potentially safe contacts outside of family,
- And address anxiety around difference from peers

Parents and teachers and other adult caregivers are important influences in the child's environment and need to be counselled about the healthy development of a child's sexuality - to help them be more supportive and non-judgemental about the developmental journey of the child. They could be supported to answer any questions that their child poses, in an appropriate manner.

If the counsellor is working in a school environment they should also handle confidentiality in an appropriate manner since the lines of confidentiality could get blurred when the child is referred by a teacher and other children begin to speculate about the reason the child was taken to a counsellor. The counsellor needs to navigate contracts of confidentiality between oneself and the child, oneself and the school and oneself and the parents - in a manner where the child's well being is prioritized. It is recommended that the child's consent be taken before sharing any specific details with the school or parents - unless there are issues of self and others' harm, in which case other ethical considerations to mitigate the harm will supersede.

Chapter 9. Attitudes towards sexuality

Objectives:

- Facilitating an understanding of various forms of sexual expressions and explorations; and client's attitudes towards the same
- Understanding counsellor's role in promoting healthy sexuality among clients with various psychosexual concerns
- Exploring one's attitudes towards commercial sex work and reflecting on how to support those who engage in it

Case 1

Presenting concerns:
A 24 year old male of Indian origin, living in the USA reported struggling with dependence and addiction to watching porn and masturbating to it. He felt guilty about it and had made a couple of attempts to end the addiction. After a brief period of abstaining, he would succumb to it again. He had consciously abstained from having sex with another person because he feared that once he experiences it, he might become excessively dependent on sexual encounters. He was also worried that if his future partner discovers this, they might reject him.

- How do you feel about the client's odds of overcoming his addiction given that his previous attempts to get over the addiction were unsuccessful? What is the scope of work possible with this client in a counselling format?

Session notes:
The client reported that while this has not yet impacted his work, he was struggling with feelings of guilt and shame. His dependence on porn was also compounded by his reluctance to go out and meet people. He had no close friends in the US and felt isolated and lonely. He had tried online dating but was too scared to meet anyone in person. He imagined that no one would be interested in having sex with him once they learnt about his addiction. His notions about sex were also only those he got from movies and porn - he was often anxious that he might not be able to satisfy his partner the way the people in the movies did.

- What do you feel about the client and his ideas about sex and sexual relationships? How comfortable would you be engaging in discussions on pornography and sexual addictions with this client?

History:
The client came from a conversative family and had a strained relationship with his father who had separated from his mother and lived separately. He never received any kind of appreciation or acknowledgement from his father and his mother tried hard to make up for that by showering him with ideas about what a good son he was. He developed a conflicting idea about himself owing to the disparate messages he got from his parents. He struggled with self-doubt and worried he might become like his father - who had cheated on his mother and had had multiple affairs while married to his mother.

- What may be the protective factors in this case for this client?
- Do you believe that he might also turn out to be like his father eventually? Explain your answer
- What messages could make him believe that he is in charge of his own life and that he is not a slave to his parents' conduct in their lives?

Case 2

Presenting concerns:
A heterosexual, married couple Albert and Riya sought counselling to deal with a breakdown in their sexual life. The couple, aged 75 and 74 years, were struggling with their sexual needs and urges which had changed over the years and they reported an inability to experience a satisfying sex life. In the past few years, they admitted feeling an increasing amount of shame for desiring to have sex and guilt when either of them found that they were not able to get aroused or arouse the other. There also seemed to be a lack of communication with each other.

- What may be the changes they experience with age - w.r.t their sexuality? What do you think may be appropriate or not?
- Do you think it is possible to explore each other's bodies and experience sexual attraction and intimacy after one goes through menopause and when old age begins to slow one down?

Session details
The couple shared that till the ages of 50-55 years, they had an active sex life and were able to experience satisfying sexual intimacy without any concerns. In the last few years however, they found that it takes them longer to get aroused, with the husband complaining that his wife is not able to experience arousal in the same manner as before. They struggled with decreasing stamina, and both had qualitatively different yet similar anxieties about not being able to please the other. They refrained from talking about it with their age-mates as they were not sure what others would think of their need for sex at this age. They also wondered whether it was normal to have such desires at their age and whether they should just stop trying so hard.

- Since they seem to seek validation from the counsellor, of their sexual needs at their age, how willing do you feel, to support them in fulfilling their needs?
- Do you think what they are experiencing is to be expected and that they should reconcile to it? What information can you share with them that might help them feel more at ease?

History
The couple had been married for 45 years and had a healthy marital and sexual relationship for most of those years. After Riya underwent hysterectomy when she was 55 years old, she had experienced a decrease in her sexual arousal and Albert wondered if she was losing interest in him. He stopped initiating any sexual contact with her after multiple denials from her. Neither spoke about it with the other worried that the truth might be hurtful.

- What factors make it difficult for Albert and Riya to speak to each other openly about this crisis in their relationship? As a counsellor, what topics might you need to broach more sensitively and when?
- What are some predisposing, precipitating, perpetuating and protective factors in this case?

Notes
The idea of sex and sexuality has commonly been associated only with the youth and middle aged adults. The idea that old people might have sexual needs and desires is ignored and even ridiculed - since the perception is that the primary role of the elderly is to be in service of younger people in their lives, and they should slow down and settle for lesser and lesser in preparation for their end. Those who do express their sexual needs are looked at as aberrations and characterless or perverted, selfish people who haven't wisened up with age. Because sex in general is met with a lot of shame and uneasiness, the sexual concerns, especially in elderly people is shrouded in shame and secrecy. This means that the elderly who experience sexual concerns might not have the space to discuss and seek help for it. Also, sex is equated only with penetrative sex. Most people are not aware of how the whole body can participate in sexual activity and that genital organs remain sensitive to touch and orgasm can be experienced till the end of one's life. People also tend to compare and judge their experiences with their past experiences, rather than be present in the moment, just experience and enjoy!

- What can help the couple feel at ease with their own sexuality? What might be information you could share with them, that could put matters into perspective?
- How might the expression and experience of sexuality be different from what the couple experienced as younger adults? How can they savour what is present?
- How could you help the couple deal with their apprehensions about societal opinions? So that they are able to express their sexuality more openly, appropriately and in a fulfilling manner?

Case 3

Presenting concerns:
The client is a 30 year old commercial sex worker (CSW), who reported facing distress and severe anxiety after recently coming out to her family about her profession. She was having anxiety attacks from then and was unable to continue with her work - her profession was of her choice and not something she was forced into. She sought counselling help while she struggled with the rejection from her family (though she had expected it) and a close friend and wanted to decide if she should continue with her chosen profession or quit it now. She had no other work experience and quitting meant starting all over again in a new field - and she was quite at a loss about what to pursue

- How prepared do you feel to connect with this client and her dilemma? Reflect on whether you may have any biases or judgements about her chosen way of life
- What might be the focus of the counselling - her struggle with her anxiety attacks or the decision she needs to make about her profession? Explain your answer

Session notes:
The client became sexually active when she was 16 and realised that she enjoyed sexual activities of different kinds. She began exploring sexual experiences with different partners while she also studied for her bachelor's degree in psychology. She discussed her sexual experiences with a handful of friends who were non-judgemental about it. That was when she was approached by a friend who was involved in sex-for-pay engagements who convinced her to give it a try. She tried it out warily and realized it was safer than she expected, she enjoyed her trysts with different people and many of her clients reported that they felt very validated and confident in their sessions with her. She was aware that most people around her would be critical of her life choices and think of her as immoral and wayward. She was mostly unperturbed by it until she met a guy she really liked, who would not commit to her because of her chosen way of life. It was then she began to evaluate what she wants to do next.

- Do you feel the client is capable of altering her desires and committing to spending her life with one partner?
- What about this case might challenge you in being there for the client with unconditional regard?
- What might be the insights that will help the client in making the decisions she seeks?

History:
The client came from a liberal middle class family, with parents who were supportive of her during her growing up years. The family environment was quite open to the extent that matters related to sex and sexuality were never shrouded with secrecy. She went from a small town to a metropolitan city for her undergraduation and here she was exposed to more sex-positive attitudes and she also understood the concept of agency and consent as she navigated her way through the years. While her parents were not too disturbed by her occasional boyfriend and short-lived relationships during college, that changed when they got to know that she was in it for the money. They couldn't reconcile with the idea that went against their values. They chose not to talk about it with her after the initial shock of learning about her preference.

- What do you feel about her liberal upbringing and the values around sex and relationships that she imbibed?
- Is your client's lifestyle a responsible one? Would you support her decision to continue working as a CSW?

Notes
The themes of guilt and shame are present in both the cases mentioned above to some extent. A lot of it has to do with the sex negative attitude where people are led to believe that one's sexuality (esp. when it is not heteronormative) is something to be ashamed of. The World Health Organization mentions that sexual intimacy, orientation, and eroticism can enhance an individual's self esteem, how they communicate, and experience love (2006)[2]. The counsellor's role here is to help clients identify their internalised sex-negative attitudes and beliefs (if they

[2] Burnes, T. R., Singh, A. A., & Witherspoon, R. G. (2017). Sex positivity and counseling psychology: An introduction to the major contribution. *The Counseling Psychologist*, *45*(4), 470-486.

have any) and develop a more positive and rights based attitude towards sex and sexuality. It is to help clients cope with the sex-negative attitudes they have to deal with, in their everyday life.

Sex positivity is the idea that all forms of sexual experience and expression are positive as long as they are healthy, explicitly consensual and do not violate the rights of others. It assumes that there is nothing shameful or 'bad' about one's orientations and desires, even if some of these may be frowned upon by society owing to heteronormative ideals. Sex positivity is the attitude of valuing sex and sexual pleasure for its own sake and not just from a reproductive lens or pitched against morally constraining, unforgiving religious/ faith-based value systems which are often reflected in our laws as well.

Mental health professionals can play an important role in raising awareness about sex positive atttitudes. Developing a sex positive attitude can provide resilience against **erotophobia** which is an irrational or intense fear towards anything erotic. Erotophobia along with developing a sex negative attitude impacts the self-esteem of a person and understandably so since sex and sexuality is such an important aspect playing a role in how the people live and behave.

The counsellor needs to be open to do self-work to accept their own sexuality and develop a sex positive attitude themselves since a large part of accepting the clients and providing them empathy and validating their experiences is by being genuine as a counsellor and a person. Since counselling requires a practitioner to be self-aware and self-accepting before promoting the same in their clients, it is vital that counsellors either seek guidance or take measures to become aware of their own biases first. The counsellor too is a product of the same society as the client - and may have internalized sex negativity, erotophobia and other disempowering beliefs.

Chapter 10. Sexuality and Disability

Objectives:

- Understand the impact of disability on sexuality and the sexual identity of an individual
- Facilitate counsellor's awareness of own biases, if any, to sexual expression among people with disability
- Understand the counsellor's role in promoting healthy sexuality among clients with disability

Case 1

Presenting concerns:

The client is a 38 year old woman who reported feeling anxious and distressed in being physically intimate with her girlfriend and this was causing a rift in their relationship. She reported that she had always been socially awkward and struggled with being touched in any way by friends or by sexual partners. She had recently got more clarity about what may have caused her discomfort, when she was diagnosed with autism. She had started taking treatment for the same. While she had been able to accept herself better and build deeper and stronger relationships, she has continued to struggle with physical intimacy and reported feeling dread and anxiety thinking about the moment. Through counselling, she wanted to become more

comfortable being in sexual contact with another, and to allay her fears and discomforts while doing so.

- What might be the link between autism and the presenting concern of the client?
- What goal might you set with this client and how would you know that any change or shift has happened?

Session Notes:
The client stated that while she was comfortable with her sexual orientation and was aware of it since she was 15, she struggled to getacceptance from her family and society for the same. She was constantly bullied by her peers for her orientation and for being upfront about it. She mentioned being sexually assaulted by one of her seniors in college - which he explained was his way to make her understand what "normal" relationships are like. She struggled with coming to terms with it for a long time but what scarred her the most was the reaction of those around her who either didn't believe her or said that she deserved it. This was her first relationship since then and she stated being really happy and wanting to take things forward. However, every time they got intimate she would get tense and when her partner touched her genitals, she would feel disgusted and terrified. Though her girlfriend had been patient and willing to take things slow, the client reported that they were having more fights and her girlfriend was feeling frustrated about not being able to have sex with her. The client wanted to get over her anxiety and fear and give her best shot to this relationship

- Was the incident of sexual assault an added reason for the client's inhibition towards sex?
- Would supporting the client to manage the anxieties related to the autism condition help in this scenario?

History:
The client came from a middle class punjabi family and she stated that she always struggled to fit in. While her family members loved her, there was always a lack of connection she felt with them. They couldn't understand her reclusiveness and her agitation when things didn't go her way. The parents and siblings were quite expressive and boisterous in their ways and often felt hurt when she rejected their physical expressions of affection or when she refused to be part of their frequent celebrations and get togethers. Her sexual orientation was also seen as an aberration that the family chose to avoid acknowledging and pretend didn't exist.

- What about the family environment may have contributed to the client's current distress?
- What might explain the disconnect she felt with her family and could that be remedied through counselling?

Case 2

Presenting concerns:
The client was a 30 year old man with cerebral palsy who was wheelchair bound because of it. He reported being in frequent conflict with his parents since he refused to feel disadvantaged and live on the pity and sympathy of others. His philosophy was to experience life as he desired, to

go after what he wanted and to refuse to feel like a victim. He traveled a bit, joined a book club, enjoyed musical performances and events, went out with friends to movies and pubs and such. He had a good support system of friends he could depend on when he needed assistance for things like doctor visits, travel and the occasional outdoor drive or hike.

He reported feeling suffocated and burdened though by his family's and society's expectations to behave and live a certain way just because of his disability. He was all the more upset that his family had found a girl from a lower socioeconomic class, who was willing to marry him. He was angry and disgusted at his parents who were willing to take advantage of a girl's circumstances and incentivize her to marry their son - and their assumption that that was the only way he would find a life partner. The reason he sought counselling was to stay resilient and stand his ground on this matter and also to explore the idea of marriage and whether he wanted to pursue it or not

- How do you feel about the client's circumstances and the quality of his life as an independent, single person?
- Are his family's concerns valid and reasonable or are they overreacting and just wanting to palm off their responsibilities to the future spouse?

Session notes:
The client stated he didn't want to be tied down with a commitment like marriage and also that he was bisexual. His family didn't seem to understand his sexual orientation and assumed it was just a phase of confusion he was going through. He had an active sexual life once he began to explore his desires - early experiences were with college mates and then with commercial sex workers. He was comfortable with paying for sex whenever required and didn't want to narrow his options to just one partner after marriage. He also stated that having sexual relations with him is not easy and requires his partners to be open to atypical sexual experiences, very patient, caring and reliable; and he cannot get attached to someone without knowing if he can trust them.

- What do you feel about the client's outlook on sex and commitment?
- Do you think the client is avoiding commitment because of apprehensions about the intentions of prospective partners or is he clear that he wants a greater variety of sexual experiences that a committed relationship would not allow for?

History:
The client came from a financially well off business family. He had a healthy childhood and was close to his parents but felt he was overly protected during those years. This made him rebel against them and seek independence. It also made him feel somewhat less confident about himself - he was not sure if he would be able to manage without the support of his parents. So he challenged himself to take up and do things that made him feel competent, and showed them that he can manage himself fairly well. He was aware of his privileged family background and conscious that others with disability often did not have the opportunities and agency that he had. This prompted him to stand up for disabled persons, to fight for their basic rights, to educate the public about how to engage with them respectfully and such. His parents wanted him to quit all that, and assist with the family business

- What made the client feel vulnerable when faced with the wishes of his family (that he should get married)?
- Given that he was quite assertive about claiming his rights and clear about his needs, why do you think the client felt that he needed counselling?
- What might be the role of the counsellor in this case?

Additional Reflections - If the client was a female, how would you take forward the therapy? Do you feel equipped to answer these questions? When you read the case, do you sympathize with any of the people? If yes, would this come in the way of developing empathy for the client and family?

Notes

While a person's disability does not form their complete identity, it impacts every area of their lives and quite significantly, their sexual experiences and expression. Existing stereotypes and myths about people with disabilities are that they lack sexual urges, that they cannot engage in sexual acts, that their sexual needs are abnormal and even that they should not desire sexual satifaction given their specific disabilities. They are usually not provided any education or information about how to manage their sexual needs, how to stay safe and how to find ways for healthy sexual expression. This not only impacts their self-worth and quality of life, but also leaves them vulnerable to various sexually transmitted diseases and sexual abuse. Counsellors can help create awareness and provide guidance on sexual matters to clients with disabilities and their families/ caregivers and help them develop sex-positive values and sensibilities.

Counsellors need to explore their own biases regarding sexuality and disability before working with the client to avoid giving inappropriate, ineffective or harmful interventions, improper diagnosis of the presenting concern and retraumatizing the clients

Chapter 11. Sexual Relationships

Objectives

- Facilitate an understanding of different sexual and romantic relationships and explore client's attitudes towards the same
- Understand the counsellor's role in promoting clarity and awareness among clients about their relationship preferences and how to engage in a respectful, consensual way
- Facilitate an understanding of the changing and evolving nature of one's sexual needs and preferences and its impact on relationships and sexual experiences

Case 1

Presenting concerns:
A couple (wife 55, husband 59) who had been married for 30 years, reported having a strained emotional and sexual relationship. This seemed to have started 3 years back when the woman was diagnosed with breast cancer and had to have one breast removed. It took her some time to recover physically and mentally - to accept the 'disfigurement' to her body and to get over the idea that she was no longer attractive. The husband also seemed unsure of how to engage with his wife after her surgery. His behavior seemed to suggest that he was repelled by her post-surgery body though he didn't say anything openly. They stated not being sexually active for the last one year. They sought counselling help to resolve their issues and revive the sexual energy in the relationship

- What do you think about a long term relationship that could be in crisis because of a physical condition of one of the partners?

Session notes:
The couple stated that they had a love marriage and had a healthy sexual relationship in the early years of their marriage. As they aged, there were signs of some stress and tension when the husband could not get aroused and have erections as often as he used to. He began to feel anxious and inadequate in bed. This concern was exacerbated by the fact that he was a functioning alcoholic and struggling with anxiety and taking medicines for the same. The wife on the other hand was worried and reluctant to have sex since being diagnosed with breast cancer and having one of her breasts removed. She felt unattractive and was scared that her husband would feel the same. She was beset with worry that he would leave her for someone else because of her condition. They struggled to discuss these issues with the other for fear of putting them off. Despite the lack of sexual connection, they lived amicably as a couple, and conducted themselves as if everything between them was normal.

- What do you think are challenges to communication between the couple?
- What may be the protective factors that could stand this couple in good stead as they tried to work out their concerns?

History:

When they courted each other and got married, the couple was hailed by friends and family as a very ‘good looking’ couple, made-for-each-other and they seemed like a perfect match. The wife was very particular about her grooming and looks and took good care of herself so that she aged gracefully. It was particularly distressing for her to face the prospect of losing a breast and she couldn’t bear to look at her post-surgery self without cringing. The husband on the other hand, like the stereotypical man of the house was supposed to do, chased after his career determinedly, enjoyed significant success as a result of his hard work but also let himself go in his pursuit of a successful career. He was often stressed out, had niggling health problems regularly, looked tired and aged and had begun to take his wife for granted - proud to show her off to his colleagues, proud about her skills as a hostess, assured that she would be there to satisfy his sexual needs and believed that she was also happy with the life he had provided her.

- What may be unhealthy patterns in the couple’s relationship?
- Is it realistic to work towards a goal of reviving their sexual relationship, given their respective physical conditions?
- What might be the insights that each could have, that will help them engage with each other more respectfully and confidently?

Case 2

Presenting concerns:
A 48 years old married woman sought help in resolving the distress and complicated emotions she felt due to her ongoing sexual relationship with a neighbour’s son. The man was 24 years old and a physiotherapist. Initially he used to come over to her house to help treat her back pain but that soon led to a sexual relationship that the client quite enjoyed, but also felt guilty about. He convinced her that it was ok for her to explore her sexual desires outside of marriage since she was quite dissatisfied with her husband anyway.

- What do you feel about the client’s extra marital relationship? Do they sit well with your values or go against them?
- What do you feel about the age difference between the client and the guy - and do you think it has/ will have any impact on their relationship?
- What might be the reasons the client is feeling guilty about being in an enjoyable relationship?

Session notes:
The client said she had been dissatisfied with the sexual relationship with her husband as he was unwilling to explore and experiment with different acts and he would rarely respond when she initiated sex. She also reported that he constantly disrespected her and ridiculed her weight publicly and showed no interest in her other than for sexual purposes. On the other hand, she felt valued and cherished in her relationship with the physiotherapist. When her neighbour found out about her relationship and confronted her, she felt ashamed and conflicted. The neighbour’s son openly stated to his mother that he really loved her and was willing to commit to a relationship if she came out of her marriage. The client however felt that would be a big step to take and she was not sure she was ready to upheave her current life. She was worried that her daughter and husband might come to know about the relationship and that her husband would leave her and

leave her to fend for herself. Her neighbour (the physiotherapist's mother) had given her an ultimatum that she should stop seeing her son otherwise she would feel compelled to reveal everything to the client's family. The guy had convinced her to not do so and to give them some time to sort this out.

- What do you feel about the way the physiotherapist's mother is reacting to the situation? Is she right in interfering with her son's personal matters?
- What will you explore with the client that will help her get clarity on the best course of action for her?

History:
The client came from a conventional middle class family with strict and authoritarian parenting. She had met her husband for the first time on the day of their engagement and wasn't given a choice in the matter. When she began facing difficulties in her marriage and shared it with her parents, they asked her to adjust and try harder to make the marriage work because they felt that it was the woman's responsibility to do so. Besides, they said, the husband was just being a typical man - he was not abusing her or depriving her of any comforts and she should learn to be happy about what she had. When the client tried to explore different sexual acts with her husband, he found it respulsive - he retorted that instead of doing all that, she should just get in shape and learn to groom herself so he feels attracted to her. She gave up her desires and had also convinced herself that she had too high expectations and her needs were abnormal.

- Is the husband's opinion about sexual acts healthy and right?
- How would you help the client resolve this difference in sexual needs between the couple, IF she said she wanted to improve the sex life with her husband?
- What could you do about the impact of body shape and weight on the sexual health of the couple?

Chapter 12. Sexual Preferences and Practices

Objectives

- Use a sex-positive, rights-based approach to support clients with concerns around sexual practices. Empower them to experience and value sexual pleasure responsibly with themselves and others.
- Understand different types of sexual preferences from a rights-based sex-positive perspective.
- Explain the concept of enthusiasm in informed consent and how it can help distinguish abuse from different sexual practices

Case 1

Presenting concerns:
Reema is a 35 years old woman who recently began exploring her sexual preferences after getting divorced 2 years ago. She was introduced to BDSM (Bondage, Dominance, Submission, Control) communities and found herself intrigued and wanting to experience such sexual acts further. She worried though, that exploring this lifestyle would make her a bad mother and role model to her two children. She was also worried that if her ex-husband finds out about her sexual interests, he might use it to try and gain custody of her children.

- What do you feel may be the misconceptions about BDSM that it can be used to suggest that one is a bad parent?

Session Notes:
Reema had an unhappy marriage where her sexual needs were disregarded and her husband reprimanded her and called her a slut and a whore whenever she suggested that they should do new things. She reported feeling extremely ashamed about her sexual desires while also never really enjoying sex with her husband but having to pretend that she did. She was taken by surprise and anxiety when her husband suddenly filed for a divorce. Though initially Reema felt lonely and terrified about being left to fend for herself, she was also relieved to regain her freedom. She began a successful career when she put her management degree to use and started an online company on pet products. While setting up her business, she met a 25 year old man Gideon who was helping her design her website. They became great friends almost immediately and it soon turned into a romantic relationship. She felt more confident with him and discovered her interest in BDSM which he gradually introduced her to. She was still affected by her ex-husband's accusations that she was immoral and a nymphomaniac for enjoying sex so much and for wanting more. She wanted to understand if her needs and desires are okay.

- How would you address the client's need - to know if her sexual desires are okay and normal? What are your opinions about the BDSM practices that she found exciting and desirable?

History:
Reema came from a conservative family which always considered her a rebellious kid for not following rules and constantly getting into trouble. She was ridiculed for being "too modern" and

disrespecting societal traditions and told that she would turn out no good as an adult if she continued like that. She got into a relationship with a boy in 11th grade and when it was discovered by her father, he restricted her from going anywhere but school and got her boyfriend rusticated on the premise that the boy had taken advantage of his daughter. From then, every time things went wrong with her relationships with friends or family, she was blamed for bringing bad luck to them and ruining them. The same was said when her husband divorced her. As an adult she was still occasionally struck by the worry and guilt that she brought bad luck to people and could cause them ruin - and she was worried that would happen with her children too.

- What are the perpetuating factors in this case?
- How would you address her belief about herself as bringing bad luck to others? Is there any connection that may have with her interest in BDSM or any other sexual practice?

Case 2

Presenting concerns:
A heterosexual couple sought relationship counselling as they were facing a crisis in their relationship, much having to do with a break down in sexual relationships. They wanted help to arrive at a decision and move forward in a direction that worked for both of them. Their sexual experiences were highly dissatisfying and it seemed like they no longer felt the same attraction to each other, that they once did. They had considered experimenting with an open relationship but were not sure how it might impact their relationship and their future together. They also considered inviting another couple to have sexual relationships with - but were not sure how to go about it.

- What would be your thoughts as you hear out the needs of this couple? Is this a matter requiring counselling? If yes, what might be your counselling contract with them?

Session notes:
The couple (both 32 years old) stated that they had been dating for 2 years and then got married after pressure from their families to get married. They only became aware of the many differences in their expectations and sexual needs after they got married. The wife was sexually more adventurous and had explored sexual practices of BDSM (Bondage, Dominance, Submission, Control) prior to their marriage. The husband was uncomfortable trying out anything which was an unconventional heteronormative sexual act. Things became worse when the husband found out that his wife was having an affair and he retaliated by getting back with his girlfriend from the past. When things blew up, they admitted to each other that they regretted their indiscretions, and wanted to give their relationship another chance. In the session, the wife also expressed that she would like her husband to be open to more kinds of sexual practices since she got bored of the same routine and frequency of their sexual acts. The husband seemed very unsure of how he might be able to reconcile some of the suggestions she made - they seemed to go against his values about relationships and commitments.

- How would you stay objective and be neutral while understanding the needs of the couple? Who has your support more than the other - and why? Can a counsellor be neutral and not partial to one person during couples counselling?
- What are your views about BDSM and its impact on a married relationship?

History:
The husbandboy belonged to an upper socio-economic class, fairly devout family and he was taught that the virtuous thing to do was to have sexual relations only with the one he married. Sexual acts that were non-normative were often discussed with dersion - as something that people with corrupted values do. He was a martial arts trainer and was trained to be disciplined, to control one's actions and impulses, and to respect tradition and societal values. The girl also belonged to the upper socio-economic class and her family had quite radical views about relationships and sexuality. They did not consider sex a taboo topic and raised their daughter also to think of it as not a big deal, but something that people engaged in for the purpose of pleasure and recreation. The wife had trained to be a counsellor - to have an open mind, to be non-judgemental, to respect people with diverse belief and values systems even if it did not agree with her own.

- What is the impact of each of their training on how they thought of themselves in their relationship?
- What might be the values on which the couple might find common ground in order to work through the crisis in the relationship?
- Could the solution to this matter be that they proceed with experimenting with their sexual preferences till they figure out what works for them both? What may be other options they could consider?

Notes
BDSM and other sexual kinks are not well understood in our society, given the taboo on discussing sexual acts and desires, and the fact that only certain sexual acts and behaviors are approved while others are often cast as immoral, sinful or abnormal. Counsellors have to reflect on their own beliefs around sexual preferences and practices and be mindful of whether those beliefs may interfere with the work that they do with the client. A sex-positive, rights-based approach to counselling will mean being able to respect that people have different sexual preferences which are all valid, that they have the right to engage in sexual acts for the purpose of experiencing pleasure, as long as the rights of all persons involved have been respected and there is no harm to anyone in the process. It is to go beyond what one is conditioned to think of as okay or not, and explore the socio-cultural, patriarchal belief systems that control or influence one's sexuality and its expression and experience

Apart from this, the counsellor seeing clients with alternative sexual preferences can:

1. Emphasize the confidentiality contract and explore all concerns related to it
2. (Where possible) Provide psychoeducation about the alternative sexual preference the client has concerns about, clarify their understanding and direct them to resources that can help them get clarity. Where the counsellor is not very well informed about the

particular topic, they could admit to it while still holding space for the client to share their distress and sound off their conflicts.

3. Take efforts to learn more, listen to people from the LGBTQIA+ communities, read opinion pieces and studies about the psycho-social issues related to gender and sexual minorities
4. Find a queer-affirmative supervisor who can help process and guide the counselling process whenever the counsellor may be unsure or unclear about their interventions or quality of their presence in the therapeutic relationship

Chapter 13. Pedophilia

Objectives:

- Understand how pedophilia presents and the difference between pedophiles and child sexual abusers
- Reflect on preconceived notions of what one has been told about pedophiles and the pedophilic disorder
- Help counsellors reflect on own reactions to people with this diagnosis and consider if one is ready to work with a client presenting with this concern
- Understand ways in which to hold the concerns of the client and enable them to manage their sexual needs in safe, appropriate ways

Case 1

Presenting concerns:
A 32 year old male reported feeling extremely distressed and ashamed of his sexual urges that involve prepubertal children. He was addicted to porn and preferred to watch those involving young children. Apart from adversely affecting his work productivity, he felt extremely guilty that he was indulging in an unethical practice, he was disgusted about how his desires violated his values, but he just couldn't seem to help himself. He didn't know what to do and was seeking guidance.

- What are your opinions about this client and their presenting concern?
- What do you think is the work to be done, to help this client develop some sense of okayness about himself?

Session Notes:
The client reported a long term addiction to porn that began in his teens and his current goal of getting over the dependence. About his sexual attraction to prepubescent children, he stated that he has never acted on his urges and just to be on the safe side, he kept a distance from children in general. He was conscious that they were vulnerable to being influenced and he did not want to be in a position where he impulsively misused his power as an adult. He had tried to date women and explored his sexual urges with men, but that did not change his attraction to children. Recently his current partner caught him masturbating to pornographic videos of children and they had a showdown with the partner giving him an ultimatum and time to work out his problems. They were currently on a break. He was not sure anymore what he could do and was feeling helpless.

- What do you think about the act of masturbating to pronographic videos of children - was it a healthy outlet to his urges, was it harmful, if yes, to whom and why?
- Do you feel there was any hope for him in finding satisfaction in his sexual life - if yes, how might he need to change, what kind of partners should he choose, what help might he need to get there?

History:

The client was an only child and was adored by his parents. He grew up in a fairly open environment where he could talk about all his growing up issues with his parents. At the age of 13 though, because of his parents' highly demanding jobs, he was sent to a boys residential school which was a very controlled and restrictive environment. He had just about started understanding about attractions and relationships when this happened. For the next few years, he had little opportunity to explore his own sexuality, his worries about himself or what he heard around him - about senior boys in his school who were sexually active with each other, rumours about teachers who had abused students, about teachers who were in relationships outside their marriage and such. These were discussed in such scandalous ways that he feared becoming a victim of such intentions of others and was always on his guard. He was glad to graduate from that school and be back home. After his graduation, he pursued his interest in expressive arts and currently worked as a choreographer.

- How is his history relevant to what he was currently going through? Do you think there were any causative factors in his history?
- What about his history gives you clues about the nature and severity of his anxiety?

Notes

As portrayed in the above case, not all individuals who experience sexual attraction towards minors act on their urges. Since this is a stigmatised concept that has socio-legal repercussions, people with such attractions are not able to talk about this much less seek help. Even mental health professionals struggle to help an individual holistically. It involves having a plan for the treatment process, doing a risk assessment for the client, setting up support systems that the client can rely on when in need (apart from just the counsellor), engaging with experts in the field (psychiatrists for eg) and getting the client's commitment to the agreed course of action and decision making when in moments of crisis. Counsellors must also be fairly well versed with the legal provisions and requirements that surround an act of sexual contact of an adult with a child.

Pornographic material involving children is referred to as Child Sexual Abuse Material as the child is being subjected to sexual abuse during the making of such pornographic material.

Confidentiality vs Reporting

Another important aspect of working with clients struggling with attractions towards minors is telling the client clearly and explicitly about confidentiality and its limitations that may compel the counsellor to report the client if there is sexual abuse of a child or a vulnerable adult. This communicated objectively and without judgement is an important aspect of therapy as it helps in developing an open relationship with the client while also balancing the client's and the counsellor's rights and responsibilities.

Therapeutic process

Some points to keep in mind when working with a person with a diagnosis of pedophilia are:

1. Treating the client with respect while communicating the understanding that any form of sexual contact with an individual under 18 or anyone else without consent is against the law.

2. Being mindful of the language used and avoiding use of labels and diagnoses like paedophilia (unless the client uses it themselves), child abuser, cradle snatcher and other derogatory ones. One way to do it would be to ask the client what term they are comfortable with about their struggle.
3. Learning to challenge the thoughts and beliefs of the client while also not making assumptions. An example of this is: “In what way has your attraction to children impacted your life and daily activities” or “What are some triggers that make it more difficult for you to deal with your concern?”
4. Providing information on pedophilia and the development of sexuality. It can help the client understand the reasons behind their attraction and provide clarity.
5. Exploring any possible childhood trauma.
6. Talking about the client’s feelings on not being able to fully and openly express themselves sexually and unable to experience sexual satisfaction and contentment.
7. Discussing factors that exacerbate their sexual urges towards children and how these could be managed.
8. Discussing stress management - as a person under stress is more likely to lose self control and give into their urges.
9. Developing an effective treatment plan which could include: self-acceptance, reducing shame, managing stress, avoiding situations that may make it easier to act on their urges, identifying and changing any narrative that justifies abusing a child, and helping them develop skills to develop a healthy social circle and support group.

Chapter 14. Intersectionality

Objectives:

- To help counsellors become mindful of different intersectional identities and their impact on a particular client's presenting concerns.
- To develop awareness of and observe one's thoughts, emotions and behaviours with respect to various intersectional identities and its impact on the therapeutic process/relationship.

Case 1

Presenting concerns:
Alex, is a 42 year old Caucasian, German man settled in India for the past 7 years, with his Tamilian wife. He first came for counselling with concerns regarding change in appetite, sleep dysregulation and a constant worry about everything. He started feeling like being 'on edge' all the time and felt restless throughout the day with no understandable cause. He reported frequent conflicts between him and his wife, with him 'snapping' quickly. He was preoccupied with thoughts about his perceived inadequacies, instability in employment, and his role as a husband and he felt like an outsider in the country. He loved his wife and was happy with the marriage, but recently had started to doubt whether they were a good match and whether he really deserved her.

- How do you think you might be able to relate to this client given that he is from a culture and race that you are not very familiar with?
- List the cultural considerations to be made while dealing with this client

Session notes:
Having been in India for the past 7 years, he had found it difficult to build a career for himself. With only a high school diploma, he found that there were no jobs that would fit his experience and age and that even with 10+ years of experience in a management role, no reputed company would hire a high school graduate for a decent salary. He felt disappointed and over time when he faced many rejections, it took a toll on his confidence and his sense of self-worth. His wife, a prominent lawyer in a private firm, worked full time and was the breadwinner while he looked after the house. He was annoyed with strangers who would ask him about his salary or about how he felt as a house-husband. Their assumptions and hints that his marriage was on the rocks because of his unemployment resulted in the client over-thinking about his life, whether he would ever get a job, whether his wife would stay with him now that he didn't have a job. These thoughts were often accompanied with feelings of worthlessness, shame and extreme anxiety. He confirmed that his wife had never explicitly expressed any negative feelings about him staying at home and these were just his fears.

He expressed feelings of isolation and thought that he could not share these difficulties with anyone, especially as he did not have family or even friends in the country who would understand him. The language barrier increased this sense of not belonging and isolation. He eventually stopped trying to share and distanced himself from everyone including his wife.

- What are some of the beliefs impacting the client's self-esteem and emotional state?
- What were the dimensions of his identity that made him feel inadequate?
- What role does the gender of the client have to play in his current circumstances?

History

Past history revealed that the client had grown up in foster care since birth as his mother passed away during delivery and his father was unable to take care of him. At foster care, he was sexually abused for many years by older kids and his caretaker, and his complaints were not taken seriously. He tried to seek help from other children in the home who ridiculed him by saying that he was lucky to have such sexual experiences and he should just enjoy them. He experienced physical violence in foster care as well as in school, with older children beating the younger ones frequently. He also in turn physically abused younger kids when he was older, and abused animals as well - either killing or maiming them. He started drinking at the age of 13, and struggled with alcohol dependence in his later years.

He met his wife when she was posted to Germany on work and they decided to return to India when her posting ended because she had a full time employment based in India and he was a freelancer and was ready to move his work location. Things were okay for the first 2 years. Slowly though, Alex started becoming anxious about what he was doing with himself (or not doing). In India, he was the only man in his friend circles, who didn't have a full time job. This would trigger thoughts about how he was dependent on his wife instead of the other way around and increase his sense of shame. In an attempt to prove himself he invested in businesses in Dubai which failed after 5-6 months, with the client incurring major financial losses. His belief about his incompetence increased and he began to experience major anxiety and stress. For the past 8 months, he reported an inability to look and apply for jobs and feelings of shame because of that. He reported frequent marital conflicts and feared that his wife had lost interest in him and that she did not love him anymore.

- Do you think this current turn of events was because the client was not responsible enough and overestimated his capabilities? Explain your answer

Notes:

Every client has a unique background and having an intersectional understanding of the client's identity is important for a counsellor to provide culturally competent counselling and therapy (Ali & Lee, 2019). No matter how similar the concerns of the individual might seem to a counsellor at times, the client's varied social identities and worldviews change the way they might approach and are impacted by the issue.

In the above case for example, the counsellor might routinely deal with cases regarding marital conflict and be aware of some recurring dynamics that cause such conflicts. But because this client comes from a different culture, his approach, thoughts and experiences will vary from that of someone who has been married within the same culture. There are many interlinked concerns which need to be understood and addressed, to be able to support him - eg. his struggle to adapt to a new culture, his dilemma regarding employment, his educational qualifications, his wife's

successful career, his marriage, how people around him react to his situation. How he interacts with and responds to these identities will play a role in how he copes with the issue. As a counsellor, it is vital to be able to understand every individual's point of view to be able to empathise with them and support them as they resolve their issues.

The first step in conceptualizing the case is to acknowledge the presence of these multiple intersectional identities, to explore how the client has been impacted and how the client responded to the situation.

Like the clients, counsellors also have their own intersectional identities which impact the way they view the clients, their concerns, and how they approach the work with the client. It would be helpful to regularly reflect on

- One's own position and identities and how they might impact a client who has a different set of intersecting identities
- One's own values, assumptions and biases that might get challenged by the client's worldview

Reflective activity:

1. How have your various intersectional identities like your gender, sexuality, religion, ethnicity, class, caste, marital status, educational qualifications impacted your life and worldview? (It can be a Positionality statement)
2. What are the areas which give you power and privilege and areas where you do not have the power you would like to have?

- **Examination of one's reactions to new or different identities:** Exploring one's own defensive thoughts and responses, blocks, anxieties, preconceived notions, fears and guilt also impact the therapeutic journey. While some counsellors may deny showing any kind of biases towards their clients, as humans it is quite natural for one to have an opinion on things which might not always match with that of the client's. So, it would be helpful to acknowledge the differences in the thoughts, beliefs and assumptions and work to make space for them.

  For example, in the above case study, some counsellors may be uncomfortable that the client is consuming alcohol as a coping mechanism, or they may experience discomfort after discovering the client's history of being physically abusive towards others, or they may be derisive of his insecurity just because he does not earn as much as his wife.

  - Which aspects of the client's history or behaviour made you feel uncomfortable after reading the case?

- **Addressing differences and privileges in the session:** When the counsellor comes from an open space of addressing their own privileges with the client, they make room for open and honest communication and a collaborative approach to the counselling

relationship. It also shows the client that the counsellor is interested to learn about the client's experiences without any judgements.

- **Forming a healthy therapeutic relationship in awareness with the intersectional identities:** While it is understandable that the counsellor might not be aware of all the intersectional identities and worldviews existing, the idea is to have a beginner's mindset where they come from a place of not knowing and acknowledging that they do not know anything about this person. This can help the counsellor do a deeper exploration and become aware of their own biases while still showing empathy and respect to the client.

Whatever therapeutic approach a counsellor decides to use in therapy, what really builds a healthy counselling relationship is when the counsellor is aware of their own identity, beliefs and values while also being interested in and respectful of the client's identity, beliefs and values. For example, in the above case scenario, the counsellor can ask the client various questions to understand him and his experiences better. Such as: "It seems like you might feel suffocated at times. What are your beliefs regarding marriage or a steady relationship and the roles of each partner in keeping the relationship alive?"

Chapter 15. Sexual Violence against Adults

Case 1

Presenting concerns:
The client was a 40 year old female who reported a great deal of agitation and distress when she found out that her 16 year old daughter was dating someone. She said that she was furious and took away her daughter's phone and internet privileges which escalated the conflicts between them. The client was very sure that she would not permit her daughter to have any romantic relationships at her age - she considered her too young to know what is safe or not and to conduct herself responsibly. She was afraid that boys or men would take advantage of her daughter if she wasn't careful and if anything went wrong, everyone would blame the mother for not taking care of her daughter

- How do you feel about the client's diktat for her daughter? Is the daughter at an age where she can responsibly be in a relationship without getting into any trouble?
- What do you think about the way in which the client enforced the restrictions on her daughter?

Session notes:
The client broke down in conversation with the counsellor, stating that she doesn't trust teenage boys who, according to her, only wanted to sexually exploit girls. She had tried explaining her concerns to her daughter who brushed them off as boring advice. In the first couple of sessions, she had hinted that as a teenager she had also taken some risks and fallen into trouble with boys and had learnt to be more careful. In one particular session with the counsellor, she revealed that she had been raped by a boy she had a crush on, when she went out to a party (having lied to her parents that she was at a friend's place studying). When her parents found out about the incident, they were furious and shattered. They asked her not to reveal anything to anyone and blamed her entirely for it. After this incident they curtailed all her freedom and got her married as soon as she graduated. She stated that more than the event itself, it was her parents reaction that broke her. And though she would be 100% supportive of her daughter no matter what, she didn't want her to go through something like this.

- Do you think the client was partly to blame for the incident of rape?
- What about the client's circumstances egged her to take the risks she did? Was she not capable of rational thought and sound decision making at that age?

History:
The client came from a wealthy family who, in the elite circles, had the reputation of being benevolent, gracious people who represented the best of society. She was always in the spotlight because of this and could not afford any scandals or controversies that would reflect on the family. This was rather suffocating to her as a growing up girl. The incident of rape was a shock to the whole family and all they could think of was how to cover it up so news does not leak out. So she put the experience behind her, learnt to submit to her family's wishes and never spoke about it till she met the counsellor. She had not even shared it with her husband who she trusted

immensely. That incident continued to be a skeleton in her cupboard that frequently caused her deep distress which she had learnt to deal with on her own.

- What did the client infer from her own experience of sexual assault and the circumstances that led to it? How objective are those inferences?
- Do you think it is important to share everything about oneself with one's spouse? Esp. things of a significant nature that have impacted one's outlook on life?
- What support does the client need that can help her reduce her anxiety regarding her daughter and overcome her distress caused by the sexual abuse she had suffered? What might be a plan to help the client overcome her distress?

Case 2

Presenting concerns:
Pratham was a 28 year old man who came from a small town in Karnataka, who reported experiencing high levels of panic and chronic insomnia after being sexually assaulted by a cab driver on a business trip to Mumbai. He had barely been able to come to terms with what happened to him and felt suffocated and breathless every time he remembered it. He had not spoken about it with anyone - he could not think of anyone among his friends who would believe him or even understand such a thing. Besides, he felt repulsed at the prospect of even recounting the incident - which was also why he did not lodge any complaint with the police. He sought counselling to help calm himself down and to get a grip on himself so he can get on with his life.

- Why did Pratham think that no one would believe him?
- What might have caused him to feel extreme reactions of suffocation and repulsion at the memory of the incident?

Session notes:
Pratham haltingly explained how he had gotten to know this driver who helped him commute across the city over a couple of days of work. On the day of his return, he asked the driver to drop him off at the airport and dozed off in the car during the commute. He woke up in the dead of the night to realize that the car had stopped and the driver had begun undressing himself. Pratham felt disoriented at what was happening and couldn't believe himself. He just froze in fear and confusion while the driver tied him up and sexually assaulted him - he couldn't muster up enough strength to fight back his assaulter back and lost consciousness after being brutally assaulted. As morning dawned some people found him hurt and barely able to move and helped him to a hospital where he received some first aid care. He just told them at the hospital that he had been mugged and robbed and he returned on the next flight back home.

Back home, he struggled to make sense of it all - continually asking himself 'why me?' and believing that something about him caused the driver to abuse him. He felt disgusted with himself, weak and powerless and he feared having to go back to work lest he be asked to travel again on work. He had begun to cut his wrists to distract himself from the pain of the trauma. He came into counselling because he couldn't bear to be alone with his thoughts.

- What are your thoughts about men who are sexually assaulted by other men? What makes them vulnerable and what kind of people are the abusers?
- What may be the messages Pratham has internalized that are making him scared and anxious?
- What are useful perspectives that could help Pratham overcome his distress and maintain sex positivity despite his experience?

History:
Pratham came from a conservative, middle class family, accustomed to and conditioned by life in a small city. He had two younger sisters and an aging mother. He had to take up responsibility for his family early in his life after his father passed away from cancer. He had always thought of himself as resourceful and capable of facing all the troubles that life might send his way. This incident though, shook that belief. Pratham had always been the one who advised his sisters and the women in his family to be careful, not take risks, who took extra care to accompany them to and from their places of visit and such. The family looked up to him for assurance and confidence during times of crisis. And now, they were puzzled at what they saw - a defeated, distressed man who seemed to struggle to manage his own tasks and seemed disoriented for most of the day.

- How might the environment around Pratham affect his healing process? What may be protective factors in this case?
- How important is the counsellor's presence in this relationship and what can it add to the counselling process and the client's journey through the crisis?

Case 3

Presenting concerns:
Annie was a 41 years old woman with an intellectual disability. Her brother brought her to the counsellor after she communicated to him in disjoined ways, that their landlord had sexually assaulted her one day when she was alone at home. She stated feeling extremely scared since then and also complained of experiencing mild pains in her pelvic region. She recounted having shouted at the abuser and having tried to fight him off, but was unsuccessful. After the incident, she had become dull and distant. She stayed with her brother and sister-in-law who both cared for her deeply and were incensed to know what had happened. They had filed a case with the police and had moved out of the house within that week.

- Do persons with intellectual disabilities have to be taken greater care of? Should they have a greater number of safety measures that will keep them safe?
- Do you think Annie's disability made her an easy target for sexual abuse? Would this impact her confidence in herself significantly and is yes - what could you do about it?

Session notes:
Annie needed her brother to help communicate to the counsellor - to translate what she was trying to say in a coherent way and help clarify her messages. She conveyed how she had always been a little scared of the man - and on that day, he seized the opportunity to check when her

brother and SIL will be back and when assured that they will be gone a while, he forced himself on her. He seemed quite undisturbed at being found out because he had told her that no one will believe her and that he will deny all her claims if she spoke about it. Annie reported feeling frustrated and helpless and somewhat guilty for bringing this on the family - she wished she had been smarter, had known better what to do, had been able to call her brother on the phone - but none of it occurred to her while the assault seemed imminent. She blamed herself, she cried for being so vulnerable and apologized to her brother several times.

- How would your approach be different in Annie's case than if the client was neurotypical without any intellectual disability?
- What could you share with Annie about personal safety that could alleviate her distress at this time?

History:
The client came from a family which was quite supportive of her challenges as a disabled person. They had instilled confidence in her and raised to be independent with basic job-related skills. She had moved in with her brother and SIL when she got a job near their residence. During the pandemic though, she had lost her job and took over the care of the house and the family while she waited for other opportunities to turn up. She was grateful to her brother and SIL for having her with them. Her parents had not been informed about this incident because they would be heartbroken - her brother suggested that they keep it from them and she agreed. She was just sad that she had caused so much pain in the family

- List the protective factors that could help Annie through her healing process?
- What are her beliefs that have to change, for her to feel confident and free from distress?

Notes
As a counsellor, counselling clients who have gone through sexual abuse or any other kind of trauma can typically be a long process depending on the impact it had on the client. The counsellor can use various treatment options to help the healing process. Before that it is required to do an assessment of the risk (whether ongoing, impending or past) and its impact so that necessary other interventions (medical/ legal/ social) may be used to keep the client safe. Some areas that a counsellor can assess are:

- The physical safety of the client: The process of emotional healing can begin, if the client is physically safe first. As a counsellor you can check for any necessary medical interventions that the client might need and have a list of referrals to help out the client with the same.
- Any ongoing threat or assault from the abuser or perpetrator: In case of ongoing child sexual abuse or sexual abuse of a vulnerable adult (disabled), the counsellor is required to take legal action to make sure that necessary steps are taken to stop the abuse. In case of an ongoing sexual assault of an adult the counsellor can help them understand their options and guide them in a way they can take action if they want to. Here it is necessary to understand what support and services that person might need.

What not to do?

- Do not lecture, criticise, preach or blame clients for the actions they took to cope with the abuse.
- Do not get overwhelmed - stay calm
- Don't make promises that you cannot keep
- Don't leave the client emotionally unsafe
- Don't miss checking for suicidal ideation
- Do not use a 'one size fits all' or 'ready-made' treatment approach with all the clients
- Do not be impatient with the client's progress. Let them decide the pace

Keeping the above points in mind the counsellor can begin the counselling to help the client process the impact of the abuse on them. Because different people react to events differently, the treatment process will also vary with every client. There is a basic process that counsellors can follow to help the client process the abuse fully. This process is loosely adopted by "The Courage to Heal Workbook" by Laura Davis who spoke about dealing with sexual assault.

The first step is to encourage the clients to talk about the instance which is called the trauma narrative. As a lot of people do not want to revisit the past trauma, they might not have gotten the space to explore and openly discuss the event and their feelings and perceptions about it. Sometimes just talking about an event gives a lot of clarity to people and puts in perspective for them their views of the assault. This can be done by paraphrasing as it gives the client the assurance that someone is actively listening and encourages them to open up further. Also using open ended questions which typically begins with "What" as they usually lead to facts and information and facilitates exploration. "How" questions help in digging deeper into an individual's state of mind. "When" questions address the timing of the concern. "Where" reveals the place that the event took place in and "Why" questions help in the understanding the reasons and motivations. The counsellors should use caution while asking "Why" questions as they might sound accusatory.

Next, the counsellors can help the clients recognise the impact it had on them. This is the place where it might get worse before it gets better as it involves the clients learning about the extent of impact it had on their personality and relationships. This process takes time to understand and process for the clients and it is necessary for the counsellors to be patient and let the client set their own pace with the insights rather than making them see all their patterns at once.

Helping the clients recognize and respect their coping styles they used to survive or deal with the trauma is another important aspect as shame and blame are very common in these situations. This can be done by psychoeducating them about basic human and bodily responses (typically fight, flight or freeze response) during the trauma and coping process that were adopted for self-preservation. Some ways in which the clients cope emotionally with the instance are:

- Minimizing: stating that the event that happened wasn't really that bad or traumatic
- Rationalizing: trying to explain the abuse like stating "they were too drunk and hence couldn't help it" "it just happened once" etc.
- Denying: This involves the client pretending that the abuse never happened
- Forgetting: also known as repressing or motivated forgetting where the memory of the event is pushed from the conscious into the unconscious. This is the brain's way of controlling the full impact of the trauma until the individual is ready to process it.

There are many other coping styles which might help the client at that moment to deal with the abuse, most of them become maladaptive in the long run as they have served their purpose and a counsellor's role is to help the client is recognizing and letting go of these patterns by helping them develop newer and healthier ones like writing or expressing their feelings in some concrete form, opening up to someone, acknowledging the impact of trauma and the strength they developed in the process. Movement based therapies and body work could also support individuals in moving forward.

While there are different ways for the clients to go through the healing process, the counsellor can understand and help them in the journey. The stages of healing are:

1. Making the decision to heal
2. The emergency stage where the individual begins to remember the memories of the events and their suppressed feelings regarding the same.
3. Believing it happened and learning to trust their perception of the event.
4. Breaking silence and talking about it. It could be with a trusted person or with a counsellor or with their own self.
5. Understanding and accepting that it wasn't their fault
6. Begin inner child healing and feel compassion for self
7. Helping them trust themselves and developing inner voice, acknowledging feelings. This can be done by encouraging them and doing a positive asset search
8. Grieving and mourning: the loss of a part of themself. Talking to them about the stages of grief
9. Owning and accepting difficult feelings like anger
10. Confrontation: real or metaphorical. Writing a letter, empty chair technique, etc.
11. Instilling hope and self-belief
12. Resolution and moving on

While the stages might happen in a different order for different people or some clients might not go through some stages, it is helpful for the counsellors to understand these stages as it could help them in exploration and insight of the issue.

Chapter 16. Sexual Violence against Children

Case 1

Presenting concerns:
The client was a 15 year old boy who was brought into counselling by his teacher who reported seeing a drastic change in his behaviour in the past few months. She stated that he had become aggressive and was underperforming in academics. He was initially very reticent and unwilling to talk about anything with the counsellor. After several sessions of just getting acquainted, he shared that when he was 5 years old, he had been sexually abused by a relative and this person was scheduled to visit his home soon and stay over for a few days in the coming month.

- What about the boy's situation needs immediate attention and in what ways?
- Would you trust a child's memory from 10 years ago, when they were barely a toddler?

Session notes:
The client stated that he was terrified at the thought of meeting his relative again as all the memories were coming back and he was unable to concentrate on anything else. He strongly felt the urge to scream and cry but he couldn't do that because of what people around him might think. He did not dare reveal this to anyone else because this relative was his grandfather's age and was a very well-respected member of his family and their community. The client also stated feeling ashamed because when he first got to know about his relative visiting, he was so scared that night he wet his bed. Since then he reported not drinking water before bed and tried to minimize his sleep time because of the nightmares he had started having. He said that his parents had also begun to notice the change in his physical and emotional health and were asking him questions. And he didn't know what to do or say to them. A part of him wanted to tell them everything while another part was worried that his family might not believe him.

- The boy was a teenager now - why was he still so fearful about reporting his abuser? What dynamics were at play?
- What approach would you take to make the client feel safer and more confident about facing the relative when he came visiting?

History:
As a young boy, the client adored this elderly relative who used to play with him and teach him fun things to do. All this changed when the man sexually abused the client for the first time - the client though very young to know what was done to him, was very sure it was wrong and felt betrayed and scared. He was not able to stop the abuser from repeating the behavior though. He withdrew into a shell and had several health issues as a reaction to this experience. Doctor after doctor failed to diagnose the cause for this tummy aches, vomiting, high fever headaches, rashes and such. That phase continued to be spoken about in the family as the time when the client had some mysterious ailment and almost thought they had lost him. He hated listening to that story and would walk away when it was narrated. He gradually learnt to express the pain and fear through poems and short stories he'd write. His friends and family greatly appreciated his literary skills and encouraged him to publish them in his school journals and children's magazines but he just told them it was too private to him.

- There seemed to be so many signs of the client having a traumatic experience. Why do you think the adult caregivers missed them or downplayed them? Do you think the parents were negligent in this case?
- The client seemed to have a fairy loving family - what stopped him from reporting his abuse to any of them?

Case 2

Presenting concerns:
A 9 year old child was brought into counselling with complaints of resumed bed wetting and being socially withdrawn from the past one year. She was reserved and appeared scared initially and gave only one word answers. The parents sounded helpless about her condition - they had tried many techniques to make her stop the bed wetting, but there was no change. While she was usually silent and introverted, she hated being left alone by her parents and also disliked going to school - everyday morning would be a big fuss about getting ready to go to school. The parents often left her at a neighbour's house while they went out on work or were late getting back home. They were exasperated with the bed wetting which they assumed was because their daughter was lazy and just didn't want to get out of bed at night to pass urine.

- What does the bedwetting seem to suggest about the client's situation?
- What about the parents' assumptions may be incorrect?

Session notes:
The counsellor engaged with the child through play therapy to help her relax and feel safe to open up. Her play scenarios were often about a big character bullying a smaller character, an imaginary fight between them where the small character eventually won. Sometimes, she showed the big character cornering the smaller one and beating her up.

The girl slowly opened up to suggest how her babysitter neighbour did 'bad' things to her. She stated that the neighbour touched her inappropriately and would ask her to undress as a form of punishment for things like dropping a cup or not finishing food within the given time and such. She felt ashamed and even scared to tell her parents because they also beat her and punished her when she did not obey them. She was afraid that the neighbour may make up stories about her and convince them that she deserved more punishment. When the counsellor stated that they needed to talk to her parents about this she broke down and desperately begged the counsellor not to reveal any information. She said they would punish her for letting it happen to her and for keeping it a secret for a long time

- What was the vulnerability in the child that the abuser exploited?
- What do you think should be the goals of counselling for this child?

History:
The child reported that before the neighbours moved in 2 years back, things were all fine. When her mother started working, she was left under the care of the neighbour who took advantage of this. The father also traveled quite a lot and would be away from home for a few days each week.

When her mother got a job, there started to be tension between the parents and she knew that her mother was overly stressed trying to take care of home and the new job. She preferred to not add to her concerns.

- Do you see any gender bias acting out in this scenario? How does this impact a child's safety?
- What can you do to help the child feel okay about sharing her struggle with her parents?

Chapter 17. Restorative Practices

Objectives:

1. Explore whether some of the challenges described in the cases can be approached differently using restorative practices
2. Envision outcomes that help strengthen relationships among all parties involved and healing of the person (s) who may be harmed
3. Explore whether working with all impacted parties may enable the healing process as much as/ more than working with the client individually
4. Explore plans of how to engage with all parties involved

Case 1

(refer to chapter on diversity in sex for detailed case)

A couple Ayaan (35 yrs) and Mala (37 yrs) came into counselling and reported feeling distraught and conflicted as their new born baby was described by the doctor to be an intersex child. They are being pressured by their family and relatives to give up the child as they are considered to be "abnormal". The parents while being disappointed by the child's sex are horrified by the thought of giving them up. The doctor recommended that a feminizing surgical procedure be performed on the child to avoid the shame that they might face in the future and their family agrees. The couple stated being confused and are seeking help and advice on their next course of action.

- What is the conflict in this situation and who are the people who are adversely impacted by it?
- Do you feel like a restorative approach could help resolve some of the emotional distress in this case? If yes, who can it help and how?
- What might be the challenges and risks in this case, that the practitioners of the restorative approach has to keep in mind and pre-empt if possible?

Case 2

(refer to chapter on Attitude towards Sexuality for detailed case)

The client is a 30 year old commercial sex worker (CSW), who reported facing distress and severe anxiety after recently coming out to her family about her profession. She was having anxiety attacks from then and was unable to continue with her work - her profession was of her choice and not something she was forced into. She sought counselling help while she struggled with the rejection from her family (though she had expected it) and a close friend and wanted to decide if she should continue with her chosen profession or quit it now. She had no other work experience and quitting meant starting all over again in a new field - and she was quite at a loss about what to pursue

- How can a restorative approach help all those who are impacted in this case?
- What might be questions that could be posed for reflection if people impacted agreed to come together for a circle process?

- How will you watch out for the safety of all involved while this process is in progress?

Note: Please refer to the chapter on Restorative Practices in the Demystifying Sexuality Reference book, to clarify your understanding of this approach. Using a restorative approach will mean bringing together multiple people who may be impacted by a certain situation, ensuring a safe space for all who volunteer to do so and creating an environment where meaningful conversations can happen about the incident that transpired and how any harm that was caused can be repaired. This approach is different from a 1-1 counselling approach in that the onus of exploring reparative and meaning making actions rests with multiple members and not just the victim/ survivor or person harmed. While a traditional counselling approach is about enabling an individual or group to find agency and learn to cope or overcome difficulties and learn and grow in the process, the restorative approach focuses on finding and building support systems that ensure harm is curtailed and not repeated, that harm is repaired and that relationships between all involved are strengthened in order to make those happen.

References

1. Ali, S., & Lee, C. C. (2019). Using creativity to explore intersectionality in counseling. *Journal of Creativity in Mental Health*, *14*(4), 510-518.
2. Gatchel, R. J., Peng, Y. B., Peters, M. L., Fuchs, P. N., & Turk, D. C. (2007). The biopsychosocial approach to chronic pain: scientific advances and future directions. *Psychological bulletin*, *133*(4), 581.
3. Joshi, A. (2015). Need for gender sensitive counselling interventions in India. *Psychological Studies*, *60*(3), 346-355.
4. Worell, J., & Remer, P. (2002). *Feminist perspectives in therapy: Empowering diverse women*. John Wiley & Sons.

Back cover:

This Demystifying Sexuality Handbook is an accompanying document to the Demystifying Sexuality Reference Book. It has been developed by Enfold Proactive Health Trust for teachers and students of graduate, post graduate and special education courses, with the objective of reflecting on the real-life manifestations and applications of the concepts and ideas discussed in the Demystifying Sexuality program.

The handbook is a compilation of scenarios that aid the understanding of these concepts through discussions, role plays or reflection.

The handbook may be used as a guide by any teacher or facilitator trained in conducting the Demystifying Sexuality program, who may choose to use it as is, use parts of it or modify it to the specific needs of their learners. Students and practitioners of different disciplines may also use it to reflect on how they are applying these concepts in their interactions with people while in training, or in their professional capacity.