Case Report

Trauma focused cognitive behavior therapy in a traumatized female child

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Summary

Children and adolescents of this era are experiencing more traumatic events than earlier, resulting in more diagnosed cases of post traumatic stress disorder. One such case is discussed here following exposure to molestation. After assessment and case formulation, an extensive psychological management (Trauma Focused Cognitive Behavior Therapy) was done which is presented through the report. Mentionable improvement was acknowledged by client who paves the way for future evidence-based work.

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Introduction

Study shows that children in our community experienced many indirect traumatic events in their lifetime, where the at-risk children are more prone to direct trauma.[1] Some of them might develop post traumatic stress disorder (PTSD). For treating post traumatic stress disorder (PTSD), cognitive behavior therapy (CBT), trauma focused cognitive behavior therapy (TF-CBT), Eye-movement desensitization and reprocessing (EMDR), group delivered cognitive behavior therapy (GD-CBT), behavioral therapies, critical incident stress debriefing and psychodynamic treatments are usually being applied, where TF-CBT has strongest empirical support.[2,3] TF-CBT was developed by Dr. Anthony Mannarino, Judith Cohen and Esther Deblinger during the 1990's,[4] which is a manualized treatment. It is designed to address the unique needs of children and adolescents who have trauma-related symptoms such as PTSD, behavioral problems, sexualized behaviors, maladaptive or unhelpful beliefs and mental health disorders related to traumatic life experiences.

Case study

Suborna (pseudonym), a 12-year-old Muslim girl from urban background with lower-middle socio-economic class was referred from the Psychiatry Outpatient Department (OPD) of National Institute of Mental Health for psychotherapy. She was afraid to be alone at home, i.e. bathroom & bedroom, experiencing frequent nightmares, sleep disturbances, irritated mood, anger outbursts, frequent crying and low mood. From history it was explored that Suborna was molested by her cousin brother several times in past. She complained about the event to her parents and her paternal aunt, but they suggested to keep it secret and took no steps to ensure her safety. Suborna felt insecured and her symptoms manifested in course of time which was noticed by her maternal family members. She got consultation from National Institute of Mental Health and diagnosed as having Post Traumatic Stress Disorder (PTSD). Suborna's father was a service holder and mother was house wife. She was the second child of her parents. Her elder brother was died from suicide around 1 year ago, who was close to her. Her mother had intellectual disability and could not take care of her children including Suborna properly. Relationship among her parents was not good and they became separated few months back. In assessment, Beck Youth Inventories (BYI),[5] and Children's Revised Impact of Events Scale (CRIES-8)[6] Bangla Version,[7] was administered. Intelligence (IQ), adaptive skills and mental state examinations were done.

The case is formulated according to the relevant information and presented in Figure 1.

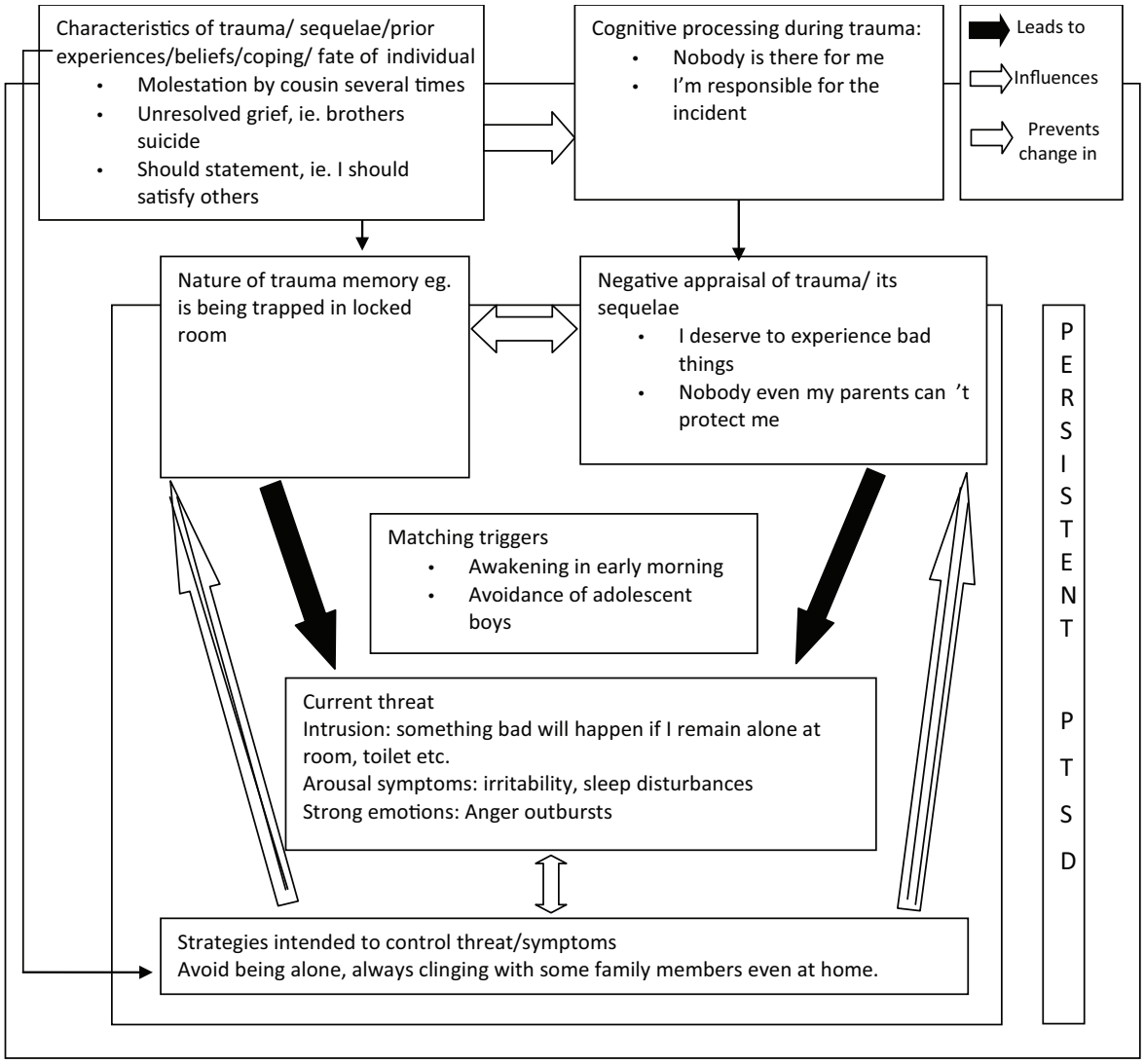

Figure 1: Cognitive model of PTSD[8]

Fourteen psychotherapy sessions were given within three and half months followed by three subsequent follow-up sessions in next seven months. Medication was provided by psychiatrists. Following psychological interventions were administered:

Psycho-education on trauma and child abuse, parenting training for behavioral management and effective communication and progressive muscular relaxation was taught.

As part of affective expression and regulation technique, management of emotional reactions and improved ability to identify and express emotions, and participation in self-soothing activities was taught.

As part of cognitive coping and processing, the connection between thoughts, feelings, and behaviors were taught and modifications of inaccurate attributions were done with the client.

As part of trauma narrative and processing, gradual exposure exercises of abusive events and processing of unhelpful thoughts were done.

In vivo exposure to fearful stimuli was done with the help of family members.

Family works were done in conjoint parent/child sessions to enhance communication and to ensure opportunities to boost up the client.

As part of enhancement of personal safety and future growth, education and training on personal safety skills, interpersonal relationships, healthy sexuality and use of new skills in future stressors and ways to cope with trauma reminders were taught to the client.

Flash cards were used as part of anger management where coping techniques was written and instruction was written that the client should follow during anger outbursts.

Pie chart was done to reduce feeling of guilt.

Outcome of the therapy is given in following tables (Table 1 and Table 2).

Table 1: Obtained score in Beck Youth Inventories in consecutive sessions

	1st session	6th session	12th session
Beck self-concept inventory for Youth (BSCI-Y)	24 (much lower than average)*	53 (average)	50 (average)
Beck anxiety inventory for Youth (BANI-Y)	63 (Moderately elevated)*	57 (mildly elevated)*	49 (average)
Beck depression inventory for Youth (BDI-Y)	55 (Mildly elevated)*	49 (average)	38 (average)
Beck anger inventory for Youth (BAI-Y)	67 (Moderately elevated)*	37 (average)	37 (average)
Beck disruptive behavior inventory for Youth (BDBI-Y)	37 (Average)	37 (average)	31 (average)

*Indicates that obtained score indicated problem to some extent

Table 2: Obtained score in Children's Revised Impact of Events Scale (CRIES-8)

	Session 1	Session 5	Session 11
Subtests	Obtained score	Obtained score	Obtained score
Total	18*	21*	11

*Total score of 17 or more denotes that probability is high that the child will obtain a diagnosis of PTSD

Discussion

Bangladesh has natural and man-made disasters and there is possibility that prevalence rate of PTSD might be comparatively high for both children and adults. Usually both pharmacological and psychological management are done in earlier cases of PTSD.[9] For the current case TF-CBT was applied. TF-CBT is already proved as gold standard for PTSD in developed countries.[10] Though TF-CBT was given to current client, there were some limitations as well. Father was not available in therapy session and mother had intellectual disability, which made family work limited to some extent. Still then, favorable outcome was achieved throughout the therapy session. In seven months follow up, it was found that the client started school again, living with both parents and her symptoms were also under control which indicated good improvement. It should be noted that current client got psychiatric medicine along with psychotherapy. So, good outcome was the combined effect of drug and TF-CBT.

Conclusion

Bangladesh is a disaster-prone country with possible large number of PTSD cases. TF-CBT might work well and add new dimension in clinical practice. It is new in Bangladesh and proved to be effective in current case study. We can apply it in large scale along with psychiatric medicine and can support trauma cases effectively. Future efficacy studies need to be done on this type of psychotherapy using improved research design and representative sample.

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