CASE REPORT

DIALECTICAL BEHAVIOUR THERAPY FOR CSA-RELATED PTSD AMONG YOUNG ADOLESCENTS: A SINGLE CASE STUDY

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Childhood sexual abuse (CSA) is a pervasive and traumatic experience that can lead to long-lasting and profound psychological costs, especially post-traumatic stress disorder (PTSD) among young adolescents. This single case study explores the application of Dialectical Behaviour Therapy (DBT) as ground-breaking therapeutic approach for the treatment of child sexual abuse related PTSD in this vulnerable population. DBT found to be effective in treating CSA related PTSD, according to a growing body of research. This case study presents the course of treatment of 13 years old girl with CSA-related PTSD who received Dialectical Behaviour Therapy as treatment. In this instance, the client reacted to the therapy and displayed positive changes. Following the treatment, the client's PTSD criteria were no longer met, evidenced by substantial drops on the scale used for evaluation. The article discusses the treatment implications of DBT and how well it treats children with PTSD related to CSA.

Keywords: Dialectical behaviour, therapy, Child sexual abuse (CSA), post-traumatic stress disorder (PTSD).

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INTRODUCTION

A nation's direction is shaped by the way we raise our children, who are the greatest resource in our society. Many issues affect today's kids, including child labour and verbal, physical, and sexual abuse. The most catastrophic of these problems is probably sexual abuse, which is illegal and rarely given the attention deserves in Pakistani legal or social circles. Due to particular religious and cultural sensitivities, there is a muted air surrounding in this subject.[1] CSA is an alarming matter in Pakistan[2], which can have adverse impacts on one's mental and physical well-being[3]. The emotional and mental development of children and teenagers is greatly influenced by their early experiences.[4] A child's physical, psychological, emotional, and social development can be profoundly impacted by adverse childhood events, such as abuse and neglect, causing lifelong wounds on their psyche.[5]

Child sexual abuse (CSA) is an unwanted sexual doing, with perpetrators using supremacy, threatening or abuse of victims not able to give assent [6].CSA is classified into non-contact sexual abuse for example incident exposure and sexual harassment, contact sexual abuse without penetration, involving non-genital caressing, kissing, and contact sexual abuse with penetration, with the most severe being anal, oral, or vaginal intercourse.[7]

It is prevailing however lately accepted social problem in Pakistan. On different types of Child abuse and neglect, no official data is available in Pakistan. Unofficial report shows that 15–25% of Pakistani children are sexually abused. Another study estimated 88.7% of school children reported physical abuse in Karachi; out of 300 school children in Rawalpindi/Islamabad disclosed being sexually abused (1 in 7 girls and 1 in 5 boys), and 72% of the abused victims or survivors were younger than 13 years old.[8]

Post-traumatic stress disorder is sturdily related to child sexual abuse.[9] Early developmental years are crucial for healthy growth but exposure to abuse can lead to long-term psychiatric illnesses.[10] Study indicated 20–40% patients of with psychiatric illnesses lug with them a history and liability of CSA.[11]

Dialectical Behaviour Therapy is an auspicious treatment for trauma-related disorders in children and adolescents, modified to address unique needs and appraise its efficacy in posttraumatic stress disorder (PTSD)-afflicted sexually abused children. Dialectical Behaviour Therapy is denoted by DBT. It is a particular sort of cognitive-behavioural psychotherapy (CBT). Marsha Linehan, Ph.D., an American Psychologist designed this in 1980. Research findings indicated that DBT is effective irrespective of age, sexual role identity, sexual orientation, and race/ethnicity of a person.[12] DBT may be effective for sexually abused children with PTSD, anxiety, and depression, but further research is needed to develop tailored treatments.

MATERIAL AND METHOD

Dialectical behaviour therapy was explored as a potential treatment for CSA-related PTSD in a 13-year-old survivor of sexual abuse using a single-case study research methodology. Case studies provide interpretive and idiographic insights into emotional and behavioural issues in clinical settings, offering a comprehensive analysis of an individual's life.[13] Therefore, a single outcome was required to evaluate the therapy's effectiveness and serve as a benchmark for further research and treatment.

CASE INTRODUCTION

The present case study refers to the treatment of a 13-year-old child. The client was a Pakistani, Muslim girl who came to Ayub teaching hospital due to irritation, sleep disturbances, loss of interest in daily activities, flashbacks, and avoidance behaviour. The client was a student in grade 8 and resides in Abbottabad with her nuclear family. The client was from Hazara, Hinko-speaking, a second-born child of five siblings and a lower middle socioeconomic background. The clinical psychologist took 12 sessions with the client on average lasting for 45 minutes. Considering the client's handiness, sessions were conducted in Urdu language.

Presenting Complaints

Client stated that she was experiencing recurrent intrusive symptoms in the form of "unwanted memories" "flashbacks", as well as intense psychological strain, "avoidance of stimuli" connected to the trauma, "hyper-arousal" and "suicidal ideation and self-harm". She experienced "irritability" and difficulty "initiating" sleep.

History

Female child "A" 13 years old, was living in the joint family system. She was abused by her paternal cousin who was 22 years old. He raped her for two months whenever he had the chance. The client reported that her cousin used to visit her home daily. Child "A" seemed anxious and sad. She was troubled with flashbacks of traumatic events, nightmares, feeling numb and panic attacks, a shattered self-image and difficulties setting personal boundaries. She tried to forget her painful traumatic experiences but began having flashbacks. She experienced violent nightmares.

In an attempt to blend in, "A" cut herself apart from both her surroundings and herself. She claimed that having experienced sexual assault at such a young age from a close relative had a terrible impact on her and that she found it difficult to set boundaries for herself and other people. Her boundaries grew hazy. Body pain, sleeping problems. She was having suicidal ideation, attempted suicide once and was rescued by her mother. She had the feeling of shame and guilt. "A" was very attached to her mother but still she couldn't disclose the sexual abuse trauma to her mother because of fear of the abuser. She was a very obedient child and a very bright student in school. After abuse her performance declined. She became isolated. She started avoiding family gatherings and refused to visit any of her relative's homes.

Assessment

The client exhibits symptoms that are suggestive of posttraumatic stress disorder (PTSD), outlined in DSM-5 (F43.10). These symptoms include fatigue, recurring nightmares, flashbacks, sleep disturbances, aggression, thoughts of self-harm, avoidance, and hyper-arousal in anticipation of trauma-related stimuli. The client's daily functioning has been significantly impaired due to symptoms such as depression, crying, diminished interest, despair, pessimistic views, guilt, and alienation, which have persisted for three months. Borderline personality disorder was taken into consideration in the differential diagnosis due to the self-injuring behaviour, the unstable self-image, and the affective instability, although the requirements were not entirely met. Thus, it appears that the client experienced PTSD and that she currently fulfils diagnostic criteria. Using the CPSS -V- SR PTSD scale, the client was evaluated.

Child PTSD Symptom Scale for DSM-V (CPSS-V-SR),

The CPSS-SR-5 is a revised form of the Child PTSD Symptom Scale self-report (CPSS-SR) for DSM-5. Five-point ratings range from 0 (not at all) to 4 (severe; six or more times per week) for the twenty symptoms of PTSD. The seven functioning items are valued on yes/no. Child PTSD Symptom Scale (CPSS) is a useful tool that has an 84% sensitivity and a 72% specificity [14].

Case conceptualization

In accordance with the underlying concept of DBT[12] a hierarchical, structured approach based on the following therapy goals was planned:

- Building a therapeutic relationship and motivating the child for change
- Psychoeducation regarding the onset of PTSD, /attaining basic capacities
- Skills development for regulating emotions
- Lessening of PTSD symptoms
- Improvement of emotional regulation and acceptance and change
- self-esteem and life goals
- Steadiness of therapeutic gains and relapse prevention

Course of Treatment and Progress

For 3 months, the client had a total of 12 appointments of individual therapy, lasting an average of forty-five minutes each.

Course of Treatment:

Session 1. Developing a relationship with the client and learning about their environment was the first aim of treatment. During the first sessions, the client was also given psychoeducation on the issue and the value of following the prescribed course of action. The client, seeking psychiatric assistance for the first time, was informed about the treatment plan, collaborative method, psycho-intervention process, and the required time for medication effects to be ad the brief period needed before the effects of medicine could be seen. A thorough safety plan was established, a non-suicide contract was created and signed, and the client was urged to record any suicidal thoughts in writing. All of these measures were taken in response to a single suicide attempt. The client was advised to follow prescribed medication and collaborate with their psychiatrist for effective treatment integration, while also examining their emotional state and destructive behaviour.

2 to 4 Session

The client filled out a tracking sheet to keep note of both helpful and harmful behaviours during treatment. Moreover, behavioural analyses were done to identify the variables influencing self-harm. Regular mindfulness activities were conducted at the beginning and end of the session. She demonstrated a strong interest in mindfulness and as a result, she used to practice mindfulness extensively on her own as a homework assignment. Eventually, the client and the therapist took turns giving instructions for the exercises. Emotion management skills were taught to foster emotional awareness and raise distress tolerance[12]. The client was able to stop her problem behaviour after just a few sessions and pay closer attention to how she perceived, processed, and controlled her thoughts and feelings.

5 to 7 Session

First, self-accusations ("I could have screamed, run away, or bitten him") were addressed to address the client's feelings of humiliation and guilt. With constructive questions like "Why did you behave like this at that moment?" and a thorough analysis of the client's actions and thought processes during the traumatic experience, dysfunctional cognitions were examined, and the client was able to objectively detach herself from her guilt by answering to question (For example, "Who really ought to feel ashamed?"). It was realized to a child that it was a shame for the abuser, not the victim. The client questioned religious and legal aspects which were also discussed in detail.

8 to 9 Session

The client was assisted in effectively distancing herself from her fears by having her worries and anxieties about the exposure phase investigated and questioned. There were initially two double sessions per week of the exposure. Sexual trauma causing the most discomfort was identified as the trauma by the client and the therapist. The client kept her eyes open and spoke about her first memory of being sexually abused in the present tense. She was asked to prepare an expressive report of her experience of trauma, confronting herself, as a home assignment and in the session, she was instructed to revise the summary of the recently taken session once a day in between appointments. She reported a rapid decline in distress. Using recently obtained in-depth information about the traumatic incident, dysfunctional thoughts and beliefs were altered. Client "A" noted a noteworthy decrease in post-traumatic symptoms as a consequence. After the exposure period, she was able to accept the memories of the trauma as a part of her past. This writing provided Creative Avenue for CSA survivors to use in their recovery.

10 to 12 sessions

The session focused on problem behaviour identification and modification, using a cost-benefit worksheet. The client learned coping strategies and accepted trauma, reducing pain and promoting self-acceptance. It was reminded to the client that acceptance will help the client to think less often about trauma, and even when they think about it situation will have less power on her and will trigger fewer emotions with less intensity. The client reported that accepting reality helped her to move on. The client realized that accepting reality frees up the energy that can be put into solving the problem in the present situation.

The client learned Skills for being effective in life goal setting through the goal setting sheet. The client was found to have positive emotions and reported dealing with her agony a little easier. The client reported that she had made an effort to keep her actions unaffected by the dysfunctional self-beliefs that had been developed at the start of the session. She also succeeded in managing her behaviour, accepting days of lower productivity and scheduling self-care activities. The therapist and client observed positive emotional, cognitive, and behavioural changes at the end of treatment, addressing the issue of re-victimization. Finally, this case study demonstrates that DBT can be used to treat CSA-related PTSD in young adolescents commendably.

Assessment

The client's PTSD symptoms improved with treatment, dropping from 66 to 15 (figure, 2). She showed increased acceptance and motivation, completed responsibilities, and gained assertiveness, contributing to better family coping.

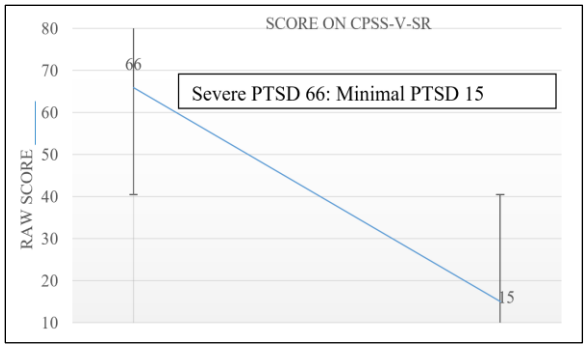

Figure-1: Score on CPSS-V-SR

Complicating Factors

The client initially hesitated to disclose trauma to her mother but after a second session, she was ready to share her information, reassured about confidentiality.

Access and Challenges to Care

Living in a joint family occasionally made the client's appointment challenging on given date, rearranging the session resolved the issue.

Treatment Implications

The case study demonstrates that DBT is a beneficial treatment for children with PTSD linked to CSA, leading to significant behavioural and thought shifts in a shorter time.

RECOMMENDATIONS

DBT is a successful treatment for trauma-related disorders in children and adolescents, particularly PTSD-afflicted sexually abused children. It improves behaviour, and emotion regulation, and reduces suffering, regardless of age, gender, sexual orientation, or race.[12] In a country like Pakistan, where mental health awareness is insubstantial, clients' turn-out rate for therapy is low.[15] However, with use of a therapy focusing on CSA victims' satisfaction level and motivation for therapy, will encourage clients to come for therapy.

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