

A Clinical Case Report on Psychotherapy for emotional problems in an abused child.

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Abstract:

Introduction: Psychotherapeutic management strategies for curbing psychopathology and its sequel in abused young children and their parents, has been scarcely reported by clinicians or caretakers, in hospital setups in India. Classical clinical evidences and international guidelines for holistic psychotherapeutic management of such cases recommends, 'short-term cognitive behavioral approach' works well in handling and releasing the abused child and their caretakers from the emotional impact of the abuse.

The objective: The present case report aims to document and disseminate the treatment outcomes of the usefulness of Trauma-Focused Cognitive Behavioral Therapy for Children in emotional problems in a reported case of a sexually abused pre-schooler and her parents.

The Design: A brief clinical single case based report on the clinical manifestation, psychological assessments, therapeutic formulation and psychotherapeutic account of a 5 year old, abused girl child, diagnosed as per ICD-10, DCR, with 'other unspecified behavioral and emotional disorders with onset usually occurring in childhood and adolescence', referred to the Clinical psychologists for management.

The Method: Based on a comprehensive psychiatric history taking, psychological assessment and therapeutic formulation, a Trauma-Focused Cognitive Behavioral Therapy for Children Affected by Sexual Abuse (Cohen, Mannarino, Deblinger, 2012) was offered by 2 trained licensed Clinical psychologists, to both the index patient and the parents, with a total of 19, 90minutes, bi-weekly individual sessions, followed by 3 conjoint parent-child-therapist sessions and a follow-up of 3 months. Symptoms were monitored for change by the therapist on the 2 outcome measures: Daily behavior checklist, and child sexual behavior inventory (Friederich, 1992), & by the parents after each session on daily basis.

Statistical Analysis: Clinically significant changes (50% and above) based on pre- and post-therapy data scores on outcome measures were used to assess the efficacy of the therapeutic intervention.

Results and Discussion: Results indicate the intervention was effective. The challenges faced by the clinician, in terms of management of the complex psychopathology, sensitive socio-cultural and developmental history of the index patient, are discussed below.

Key words: Emotional problems, abused children, psychopathology, psychotherapy, case report, India

I. Introduction

Child abuse is the physical or psychological maltreatment of a child, can be differentiated into four major categories, physical abuse, emotional abuse, neglect and worst of all; the sexual abuse. Child sexual abuse (CSA) is defined as the misuse of power and authority, combined with force or coercion, which leads to the exploitation of children in situations where adults, or children sufficiently older than the victim to have greater strength and power, seek sexual gratification through those who are developmentally immature, and where, as a result, consent from the victim is a non-concept. Such gratification can involve explicit sexual acts, or may involve invasive and inappropriate actions not directly involving contact (Miller et al., 2007). Child sexual exploitation can involve the following: possession, manufacture and distribution of child pornography, online enticement of children for sexual acts, child prostitution, child sex tourism, and child sexual molestation, involving them in digital or object penetration, anal or vaginal penetration, oral sexual acts, offending touch, and subjecting them to other paraphalic activities. As per recent epidemiological estimates of the national study conducted by Ministry of Women and Child Development (2007) in India, it is estimated that our country has the second largest child population in the world, with a reported prevalence of sexual abuse being 53.22% in innocent young children. Moreover, among them 52.94% are boys and 47.06% girls, 21.90% of children face severe forms of sexual abuse. Furthermore, the later study also points out that, In India, 5-12 year's age group of children face higher levels of abuse, that largely goes unreported; and that 50% of times, the sexual offenders were known to the victim who were in positions of trust (family member, close relative, friend or neighbour).

What happens after a child has been sexually abused is critical as it has a profound influence on the child's psyche and future. Child Maltreatment in any form thwarts the normal developmental path of growth and maturation of the child. Subsequently, it has marked socio-cultural implications for the child as an individual within the matrix of self, family and society. Further, timely addressing and acknowledgement of abuse by the caretakers, clinicians, and family, is critical, not only for the child's recovery and return to normal developmental trajectory, but also for prevention of future series of maltreatment/neglect/ abuse to the victim. Reviews (**Human Right Watch, 2013**) suggests that post the abuse, when the child reports these incidences to non-offending parents/caretakers, very often the children's complaints are completely dismissed or curbed, not just by parents, family members or persons in positions of authority, but also by the police, medical staff, and others. Additionally, instead of supporting them with empathetic reintegration, victims are re-traumatized once they make their abuse known. Studies from India and abroad unanimously support that consequent to abuse, such children may endure significant psychopathology, emotional and behaviour problems of anxiety, fear, post-traumatic stress, guilt, depression, conduct problems, lifelong psychological disturbances like relational difficulties, psychiatric disorders, spiritual concerns(**Lanktree, Briere, Zaidi, 1991, McLeer, Deblinger, Henry, Orvaschel, 1992, Deb, 2005, 2006, Deb and Mukherjee 2009; Kacker and Kumar 2008; Priyabadini 2007**). In addition to this, rarely reported are incidences where children develop inappropriate sexualized behavior, consequent to contact or non-contact abuse. In such cases the victimized child unknowingly later on, tends to internalize or act out similar abusive behaviors with other children. Furthermore, seldom, caretakers may seek help from a clinical psychologist or a psychiatrist, with concerns of acute onset of emotional problems like fear, mood liability, irritability, social withdrawal, and disinterest, conduct issues along with age-inappropriate, unusual, risky, and socially offensive and sexual behaviors in abused children. Indian researches lack identification and documentation of such sexual behavior problems that emerge in abused children, as an unusual sequel to abuse. Lacunae in existing literature in India, also exists, in terms of psychotherapeutic management of such unique cases. Theoretically, in works abroad, such cases have been identified and known as 'sexually reactive children', 'sexual offenders', 'children- who- molest', and 'child perpetrators', have been recently renamed in literature in a more de-stigmatized manner as, 'Sexual Behavior Problems', in sexually abused children.

Sexual behavior problems in children has been defined by **Hall, Mathews, Pearce, Sarlo-McGarvey, & Gavin (1996)**, as when they (a) occur at a greater frequency or at a much earlier age than would be developmentally expected; (b) interferes with children's development; (c) occurs with the use of coercion, intimidation, or force; (d) is associated with emotional distress ; and/ or (e) reoccur in secrecy after intervention by caregivers. In the current conceptualization, experts have highlighted that sexual behavior problems in children 'do not represent a specific diagnosable disorder, but rather a set of behaviors that fall well outside acceptable societal limits and puts the child at a critical developmental risk of adult psychopathology'(**Association for the Treatment of Sexual Abusers, 2006**).Furthermore, evidences from popular research on etiology of children with such problems have pointed out that, they may have developmental histories with lack of substantial evidence of sexual abuse, single incident of contact or non-contact abuse, physical abuse, inter-parental violence, with parental neglect, and other familial risk factors in child-caretaking environment (**Silovsky, Niec, 2002 and Kellogg 2009**). In the view of management of such cases, many health professionals opt for psychoanalytic/ psychodynamic psychotherapy as treatment of choice for such cases. In support of a more holistic management of such cases, classical works of **Cohen** and his colleagues (**1991, 1994, 1996, 1997, 2006**) support that nearly 68% of anxiety and 41% of depressive symptoms, 36% of inappropriate sexual and 31% of regressive behaviors in abused pre-schoolers, are responsive to short term tailored behavioral interventions, that in co-operate structured play and behavior therapy for the child, and parallel parent management training sessions for the primary caretakers. However, as per the recent evidence based trends, the Trauma-Focused Cognitive Behavioral Therapy, have been developed and tested to their effectiveness in remediation of naïve children, who undergo abuse and traumatization. (**Macdonald, 2012 & Cohen, Mannarino, Deblinger, 2012**). The rationale of the present clinical case report is, to provide descriptions of the assessment and psychological treatment of infrequently reported child abuse cases, for trained mental health clinicians, in clinical setups, with preliminary information on the effects and usefulness of the Trauma-Focused Cognitive Behavioral Therapy, in India.

Patient identification information and reason for referral: The index case was a 5 and a half years old, girl, second born of two siblings, studying in nursery, from middle socio economic status, residing in an sub-urban nuclear conservative family setup with parents, referred by a psychiatrist to the clinical psychologist, for emotional and behavioral problems consequent to abuse. The patient was accompanied and brought to treatment, by her parents who were seeking the physician's, psychiatrist's and psychologist's consultations for the 1st time, respectively, with concerns of odd age in-appropriate sexual and masturbatory activities noticed in the child since the past one and a half year.

II. Clinical Case History & Summary

The index case was a second born, pre-schooler, girl child, with a normal birth and developmental history; normal socio-adaptive skills. She was brought with a history of significant sexual behavioral and emotional disturbances in her, since the past one and a half year. The chief complains of the caretakers were, the insidious onset and persistent course of inappropriate sexual behavior in child, characterized by frequent masturbatory activities of child (in play activities at home and in public places like in classroom, in play ground with other children and in social situations), and recent fear of being reprimanded by parents.

Past history: The problem behavior in the child was apparently notice first by the parents, about 1.5 years back, when they noted the child's unusual interaction with a new driver, who used to pick and drop the child to her preparatory school on daily basis. During one of the occasions, it was reported that the driver brought the child very late while bringing her back to home from the school. On reaching home, it was observed that the child's clothes were wet, soiled with mud. Subsequently, on inquiring with the driver, it was reported by him that on the way back, while sitting in car, she had accidentally fallen in a pond, next to the school gates and so clothes got spoiled and they also got late. Accordingly, as the suspicion of the parents elevated, they inspected the child for any injuries and inquired about the same with the child. However, as the child's and driver's version of the incident were corroborative, the parents decided to leave the issue, believing the story narrated by both of them. The parents reported that they became significantly worried after another similar incident that occurred within a few weeks later, subsequent to which they removed the driver from the job as the child started expressing her hesitancy to sit with the driver in the car, refused to be talk to him, and to be dropped to school by him, and was noticed running to hid herself under the bed, whenever she would meet him. The child also started resisting the touch of her own mother while taking bath, or dressing her, and would occasionally ended up in wetting her bed in sleep at night and rubbing her abdomen against her mother's thighs at night. It was reported that the some of above behaviors gradually disappeared after they changed their driver. However, the only exception to the latter was that, the child continued to resist being touched on naked body while the mother gave her a bath. Also a new behavior was noted by the parents. As per the parent's reports, the patient would be spotted carrying out masturbatory behaviors at home, like inserting her finger, pen, pencil, crayons and paper in her vagina. It was also reported by the parents that over the past 1 year, ever since the child had started going to preparatory school, her school teacher also reported incidences when the child would rub her abdomen and legs against the edges of furniture in the class. The teachers also compliant that the child was noted kissing her bench mates on cheeks and hugging other children in play activities. In order to manage the increasing problem behavior, the parents of the child reported that they started nagging and scolding the child whenever they would spot her engaging in any of the above behaviors. Once she started being scolded for it, the patient was seen to be get upset excessively after the scolding, and would hid under the bed or dining table or hours together. They also noticed that she began to lie or hide if she got bad remarks in her school notebooks, and would not report about daily events of class at home out of a fear of being scolded. Parents also reported that the child has acquired an age inappropriate sexual knowledge and inquisitiveness to watch and ask intimate scenes on T.V., in magazines and insist on wearing exposing dresses. With the above mentioned complains, patient was referred to seek consultation from a psychologist by a general physician and a psychiatrist. They felt the need to consult was urgent there as they felt they might be embarrassed if the child continues to publically engage in the later mentioned inappropriate behaviors.

On Mental Status Examinations, the patient was reluctant to interact with the examiner, was shy, manner of relating was reserved. Rapport was established with difficulty as the child was mostly quit and responded nonverbally. Once the child was engaged in art work, she started interacting appropriately, in a friendly manner, in monosyllables. Clinically the child appeared to be of above average intellect, was a multilingual, with a slow to warm temperament. There was no history suggestive of any organicity, genital discomfort or any other physical complaint/perceptual deceptions /persistent low mood, crying spells, disinterest in daily activities, specific fears/anxiety, disturbances in circadian rhythms .In order to evaluate the presenting problems, a detailed behavior analysis and child diagnostic psychometry, Child Sexual Behavior Inventory was administered.

III. Psychological Assessment Strategies

The following assessments were planned for the patient:

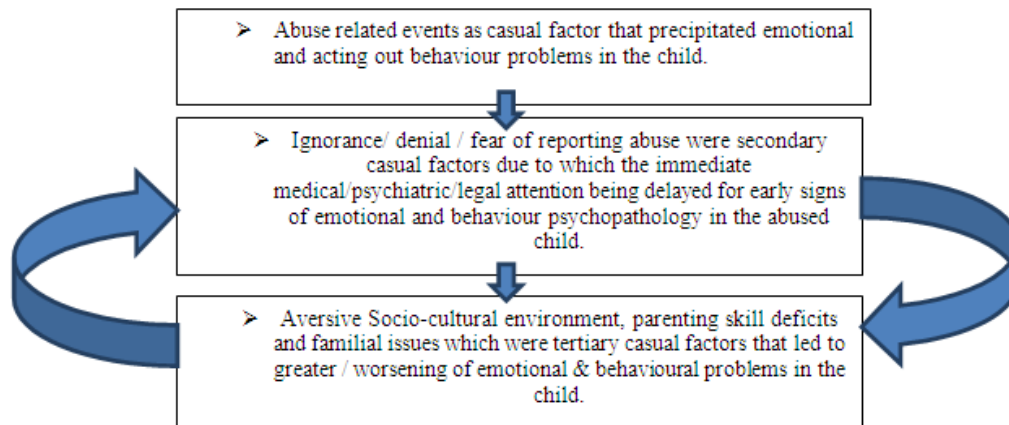
- a. Diagnostic psychometry conducted on the child: The Raven's controlled projective test (and the Children's Apperception Test, Indian version (**Choudhary,1960**) was selected to gauge into unconscious aspects of the patient's mind and to tap the interpersonal dynamics and patterns of needs, difficulties and conflicts existing between the child and the environment.

- b. Detailed Behavior Analysis of child, conducted with parents: The behavioral analysis performed (**Kanfer and Saslow, 1965**) was used in order to conduct a detailed analysis of the patient's present behavioral problems.
- c. Child Sexual Behavior Inventory –II (**Friedrich,1992**) about the child, was conducted with parents.

a) Finding on the detailed behavior analysis and child diagnostic psychometry.

Detailed behavior analysis carried out with the parents of the child revealed that the child's behavior was characterized by persistent, age-inappropriate:

- **Antecedents of problem behavior:** The emotional and behavioral problems in the child started consequent to the incidences of contact/non-contact sexual engagement or abuse that the child was subjected to by their driver. On elicitation with the parents and the child, the details of these events could not be fully revealed as the child was not able to disclose about the same to the parents/ therapists or could probably not remember, verbally put her experience into words, since the abuse happened 1.5 years back, when she was only 3.5 years of age.
- **Immediate consequents to child abuse were:** Behavioral excesses in form of acting out of pleasure seeking masturbatory behaviors carried out several times a day by the child, mostly self-soothing in nature, consequent to being alone/bored/in thrill/in play (like insertion of finger, pencil, crayon, paper in her vagina at home (sometimes in public, however mostly privately, during solitary play), was often seen rubbing her lower abdomen and thighs against furniture in classroom, was observed rubbing herself against her mother's thighs, pillows in bed; she was also observed reporting fear of being touched on naked body, when her mother would bathe or dress her. Additionally, caretakers were concerned over her age inappropriate sexual inquisitiveness, and sexual gestures like kissing other children at play.
- **The behavior was more eminent** in social situations when the child was not with elders and was with other children of her own age like in classrooms, in play grounds, and at cousin's place.
- **The motivational analysis** revealed that the post the incidences of abuse that triggered the emotional-behavioral problems in the victimized child, **the maintaining factors** for these behavior problems were, firstly the child's internalized conflicts post-abuse, secondly the child's over-inquisitiveness and pleasure seeking interest which the child derived in continuing the masturbatory activities.
- **Deteriorating reinforcing factors of problem behavior:** The probable reasons why these behaviors deteriorated over the past few months were firstly, the parent's conservative attitude and unyielding efforts due to accept that the child was maltreated/abused, secondly acknowledging the emotional consequences that the child was undergoing, thirdly denial, minimizing the reality of abuse and that the child required immediate medical & psychiatric attention, fourthly keeping the issues under secrecy for long, and lastly trying harsh parenting methods to curb the problems like over-reprimanding the child.
- **Additionally, aversive factors in socio-cultural and family environment which lead to increase in problem behavior** was, the fear in parents in revealing abused-related history to doctors/reporting the same to the police as it would damage the family esteem, perception that the child was not the sufferer and with time as she grows older she would rather, overgrow behavior problems and forget the 'minor incidence of abuse', Also, parental skill deficits and errors in their attributions were evident in the caretakers, due to which they ignored the real impact of abuse on the child, blamed the child for her inappropriate social conduct and causing embarrassment to them and the family, were unable to cope with the complex impact of sexual abuse in the victimized child.
- **Secondary consequences of aversive factors in socio-cultural and family environment were: The Behavioral deficits** that recently emerged in the child, like concealing day to day events, lying over minor mistakes, unusual resistance to talk to parents, out of the fear of being scolded, as reported by her(consequent to antecedents like parental scolding, blame reprimands, complains of teachers and cousins for masturbatory activities carried out by the child).
- **The situational analysis of problem behavior revealed a vicious cycle:** (PTO)



- **Positive prognostic factors:** The analysis of the present social relationships in the patient's environment revealed positive prognostic factors used in psychotherapeutic management of the case. These were the child's responsiveness to activity reinforcers (like, going to park, drawing, colouring), verbal reinforcers (like, praise from other people), and material reinforcers, likes, sweets, chocolates, fruits. Parenting factors, like to intimacy to both the parents, who were identified as not abusers in this case. Also, her proximity with the mother who was relatively more emphatic for the child, has a high motivation to seek cure, and was willing to involve herself in treatment process.

b) The Diagnostic psychometry findings (The Raven's controlled projective test and The Children's Apperception Test): Indicated that the protocols presented by her were original, creative, with simple themes, warranting a diagnostic level of interpretation. The findings did not reveal any particular likes or dislikes, fear or worries perceived by the child. The findings depicted that the child had a close bond with parents, who she perceived to be like her friendly play companions. Additionally, a need for close playmates was revealed by her with whom she could share, talk and play with. On the stories projected by her the hero in most of the stories were of same age and sex as that of patient, characterized by traits of submissiveness, with main needs of secureness, autonomy, and affiliation. The conception of the home environment was friendly, happy; although her conception of the world outside her home was threatening, cruel, dangerous. Anxiety in the context of adult authority figures was prominent on particular stories; also, fear of environmental catastrophes, of being bullied or punishment by dominant figures was present. The conflicts revealed by her were for need of autonomy versus a press of aggression. Most of the stories had happy endings in which the patient ultimately manages to escape the environmental adversities.

c) On the child' sexual behavior checklist, the parents of the child reported that she used to carry out the following behaviors with high frequency (of once in 2-3 days) :-Masturbation with hand and object, rubs body against people or furniture, inserts or tries to insert objects in vagina or anus, tries to look at pictures of nude or partially dressed people (in catalogs, in T.V.),kisses other children they do not know well, seems very interested in opposite sex, touches or tries to touch mother's private parts, talks about wanting to be the opposite sex, in play activities, draws elaborate and emphasized sex parts of men and women and their hands, palms, fingers, when drawing pictures of people, and other inappropriate sexual behaviors summarized in the detailed behavior analysis.

IV. Clinical Case Formulation

In light of therapeutic formulation, a working diagnosis of 'Other unspecified behavioral and emotional disorders with onset usually occurring in childhood and adolescence (F 98.8)', was made. It was urged that etiological factors that could have contributed to the origins of the problem behavior were the incidences of sexual engagement/abuse of the child, about 1.5 years back. Predisposing factors like the child's slow to warm temperament; conservative home atmosphere might have led to either inability for the child to report the incidence of abuse to parents or parental denial, ignorance, guilt of neglect and/or of acceptance of the abuse. The maintaining factors of the problem behavior were the gratification that the child's unresolved trauma and due to which she started acting out, seeking pleasure from masturbatory activities and parental mal-attributions and skill deficits to manage and cope with the problem. Also additionally, reinforcers like, socio cultural and familial issues of minimization, shame, guilt, secrecy and reluctance to seek help for the sexual behavior problem in their child at an early stage, led to worsening of the unresolved trauma of the child. The problem behavior deteriorated over the past 6 months, as the parents started excessively scolding and intrusively checking

to check the sexual self-stimulatory behaviors/gestures of the child, that were reported by others (teachers, neighbours, relatives), for their socially offensive nature. Thereon, new emotional and behavioral issues appeared in the already victimized child, like hiding for long hours after being scolded, lying and concealing daily school, academic and peer related events, out of a fear of being scolded. As all of these emerged in the child, overall it in turn led to vicious cycle of re-traumatization for child and increasing parental worries, frustration, and inability curtail the dynamics of the situation for which they finally sort psychotherapeutic management.

Choice of Psychological Treatment for the present case Trauma-focused cognitive behavioral therapy (TF-CBT) is an evidence-based treatment approach shown to help children, adolescents, and their caregivers overcome trauma-related difficulties. It is designed to reduce negative emotional and behavioral responses following child sexual abuse, domestic violence, traumatic loss, and other traumatic events. It is a short-term treatment, provided in 12 to 18 sessions of 50 to 90 minutes, depending on treatment needs. The intervention is usually provided in outpatient mental health facilities, used in hospital, group home, school, community, residential, and in-home settings. The treatment involves individual sessions with the child and parent (or caregiver) separately and joint sessions with the child and parent together. Each individual session is designed to build the therapeutic relationship while providing education, skills, and a safe environment in which to address and process traumatic memories. Joint parent-child sessions are designed to help parents and children practice and use the skills they learned and for the child to express his/her trauma narrative while also fostering more effective parent-child communication about the abuse and related issues. Recent research findings suggest that TF-CBT is more effective than nondirective or client-centered treatment approaches for children who have a history of multiple traumas (e.g., sexual abuse, exposure to domestic violence, physical abuse, as well as other traumas) and those with high levels of depression prior to treatment (Deblinger, Mannarino, Cohen, & Steer, 2006). In view of evidence based trends in Psychotherapy, treatment was planned in the present case, in keeping with the behavioral analysis of psychopathology, socio-cultural background of the case and the caretakers and factors like child's cognitive capacity, and interest in drawing, play and parental motivation.

V. Treatment Implementation

A total of with a total of 19 , 90minutes , bi-weekly, individual sessions with the child & parents, and 3 extra conjoint parent-child-therapist sessions, conducted over 2 months, by 2 trained Clinical Psychologists, were conducted with the following broad goals, content and techniques.		
Broad goals	Content of the clinical sessions	Therapeutic techniques
<p>Short term Goals: Individual sessions with parents focussed on enabling them to express their concerns, sexual behavior problems in abused children and psycho-educating them about the treatment rationale .</p> <p>In Sessions with the child, the goal was to build rapport , empathetic validating bond, and secure attachment with therapist to help the child later on openly express traumatic memories or feelings.</p>	<p>Sessions with parents : Helping the parents empathetically explore , realize the reality of abuse, addressing their courage to seek help and aid them, working over their expressed emotions, reactions towards the child, issues of re-victimization of child (all within the background of socio-cultural milieu).Also, advised to halt the use of ineffective parenting strategies of excessive scolding /reprimands/name-calling for problem behaviors.</p> <p>Sessions with child: Play & Art therapy aimed to use play as a mode for building foundations of therapy and trust in therapist, exploring child's concepts of body-image and past experience of same.</p>	<p>Sessions with parents :Using CBT psycho-educational methods, flow charts of A-B-C charts, viscous cycle of problem behaviors of parent-child following the abuse. Daily monitoring dairy prescribed to parents for charting problem behaviors.</p> <p>Sessions with child:Use of stories, doll house, art and craft, paintings, drawings, games to form alliance. And explore past memories , aid in catharsis and build atmosphere for nurturing play and re-enactment play.</p>
<p>Middle session goals :</p> <p>With the parent : Affective expression, resolution. Building effective parental skills for greater warmth, appropriate control and communication skills for parenting, addressing sexual issues at different ages, and learning skills to curb mild behavior problems.</p> <p>With the child: Trauma narrative and processing and improve their ability for affective expression with memories of abuse ,behavior modification.</p>	<p>With the parent : Resolving memories of guilt, shame, etc in connection with the abuse. Parent management training to deal with issues of sexuality, secrecy, developing a medium of comfort with child, rebuilding attachment skills, and skill training the parents and child to comfortably communicate on sexual/ intimacy issues, and use of therapist and skills learnt to reduce milder problem behaviors.</p> <p>With the child: Expression of trauma, personal concepts of body touch and boundary. Decreasing milder behavior problems and building new concepts of body touch and boundary on contingency contacting.</p>	<p>With the parent: CBT techniques of event-thought-emotion viscious cycle, and parent management training, using and teaching parents –child contingency management effectively.</p> <p>With the child: Play techniques like hide & seek feeling exercise (Kenney-Noziska,2008)to express hidden emotions, bodies and boundaries (Fortino, 1999) to learn new body concepts and following contingency management</p>
Final goals for parents & child: Reducing sexual behavior problems,	With the parents: Building effective parenting skills, using behavioral parenting skills to tackle the stronger-sexual behavior problem in child, effective communication and abuse	

reinforcing pro-social behavioral replacement skills, concepts of body privacy & good-touch skills, & prevention of further sexual victimization and abuse.	prevention skills. With the child: Play techniques used to consolidate new body and touch concepts, coping skills training for child 'ok to say No' (Crisci, Lay, Lowenstein, 1998) to prevent & report abuse in future, & lastly following contingency chart with parents for unlearning the inappropriate sexual behavior. Conjoint parent/child sessions for Enhancing personal safety and future -Family work to enhance communication and create opportunities for prevention of abuse.
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VI. Detailed Description Of TF-CBT Sessions

- i. **Short term goals of initial sessions of therapy** with parents were, ensuring that the child is not being sexually abused or abusing others presently, psycho-education of the parents (about sexual development, normal sexual play and exploration, genuine emotional distress, management), and along with the same, parallel insight-oriented sessions for parents to work over their expressed emotions. With the child, the immediate goal was to use play as a mode for attachment, trust, exploring child's concepts of body image/touch and rapport building and founding a safe accepting environment for further therapeutic work. In Brief therapeutic account the Initial Sessions (1 to 5) comprised of accomplishing the later, with the use of various integrative CBT techniques. The parents were also prescribed a daily monitoring dairy and charting of undesirable behaviors at home.
- ii. **Intermediate goals of middle therapy sessions**, were to help child openly express her memories, of personal victimization, personal concepts of body touch and boundary. In brief therapeutic account, in keeping with the child's age/capacity/history of abuse, play therapy techniques were used to help recollect, express, release and relieve experiences of any past trauma and memories of contact /noncontact abuse. Subsequently, therapy aimed to help build corrective emotional experiences (by reconstruction and resolution of trauma); and lastly imparting learning of and practicing of basic, simple rules about sexual behavior and physical boundaries, differences "between good touch and bad touch". Using play and behavior techniques, the child was taught sexual boundary and contact rules (with emphasis on which behaviors are acceptable with whom and distinguish these from which behaviors are volitional to self/others). Therapy aimed at decreasing undesirable behaviors and increasing the desirable behavior through operant techniques and contingency management. The middle sessions also incorporated parallel parent management training to deal with issues of sexuality, secrecy, developing a medium of comfort with child, rebuilding attachment skills, and skill training the parents and child to comfortably communicate with each other on neutral and age-appropriate sexuality related issues. Also, Sessions 6-9 implemented contingency management for milder forms of behavior problems (like sharing school events, sharing any details of play sessions with the mother and activities with mother, lying, not using bad language, and not hiding under bed/table). The progress of the therapy was good and done on daily monitoring charting of contingency behaviors by parent at home. Moreover sessions 10-13 focused on behavior modification of difficult self-stimulatory behaviors in child.
- iii. **Long term goals of end therapy sessions** were extending the play based teaching interventions used to consolidate pro-social behavioral replacement skills, body privacy & good touch skills, prevent further sexual victimization and sexual abuse prevention with acquisition of safety skills. Parental skill training emphasized on accepting the problem, building effective communication ability with the child in matters of sex, supervising and monitoring skills to prevent abuse, use of attachment rebuilding skills with child, and effective use of operant procedures in child rearing. End sessions (14 to 19 and extra 3 conjoint parent-child sessions) focused on combined behavior skill training and behavior experiments for the child in controlled situations to reinforce skills of body privacy, and build up the assertive behaviors to prevent sexual victimization. Also in further joint sessions, the therapist helped the patient and her parents to practise effective communication skills, to build secure attachment, promote timely and adequate reporting of the abuse in future. The therapy was terminated on complete resolution of problem behaviors.
- iv. **Post psychotherapy termination**, the contingency management plan was prescribed to be continued by parent at home, to generalize therapeutic gains. Outcomes of the therapy were that in nearly 19 parallel sessions and 3 combined sessions of psychotherapy, the index patient and caretaker, were corrected with complete remission of sexually problem behaviors, in emotional behavior, parent-child interactional problems. Additionally the child maintained well after termination of psychotherapy and was asymptomatic on follow up after 3months, and so contingency charting of behaviors was faded out.
- v. **Therapist-related factors:** Both the therapists participated in all the sessions consistently, were between the age ranges of 25-30 years old, female psychologists, trained professionals and licensed as clinical psychologists, in cognitive behavior therapy, with 2-3 years of clinical experience in working with children, in out-patient and in-patient units of psychiatric units, in tertiary hospital setups. For this particular case management, the therapist followed the treatment guidelines prescribed by evidenced based works of **Child Welfare Information Gateway,2012, Macdonald, 2012 &Cohen, Mannarino, Deblinger,2012**.In sessions with the child, the therapeutic pace was slow, language was much simplified, play and story based and activity

oriented expression and coping skill learning was adopted to meet the developmental age and needs of the child. Measures of adherence involved counting of missing appointments, homework compliance, involvement in sessions.80% adherence and compliance was noted in the present case by the child and the parents, within the therapeutic structure of a total of 19 , 90minutes , bi-weekly, individual sessions with the child & parents, and 3 extra conjoint parent-child-therapist sessions, conducted over 2 months. Written therapeutic record, reassessments and tracking of homework monitoring done by parents of the case, was monitored by both the therapists from time to time. **Ethical issues:** The Participant consent for therapy and research was provided by the child and the child’s caregivers. Privacy, and confidentiality for disclosure of personal information(like name, place, relationships, background, etc) was maintained all throughout the case management and reporting.

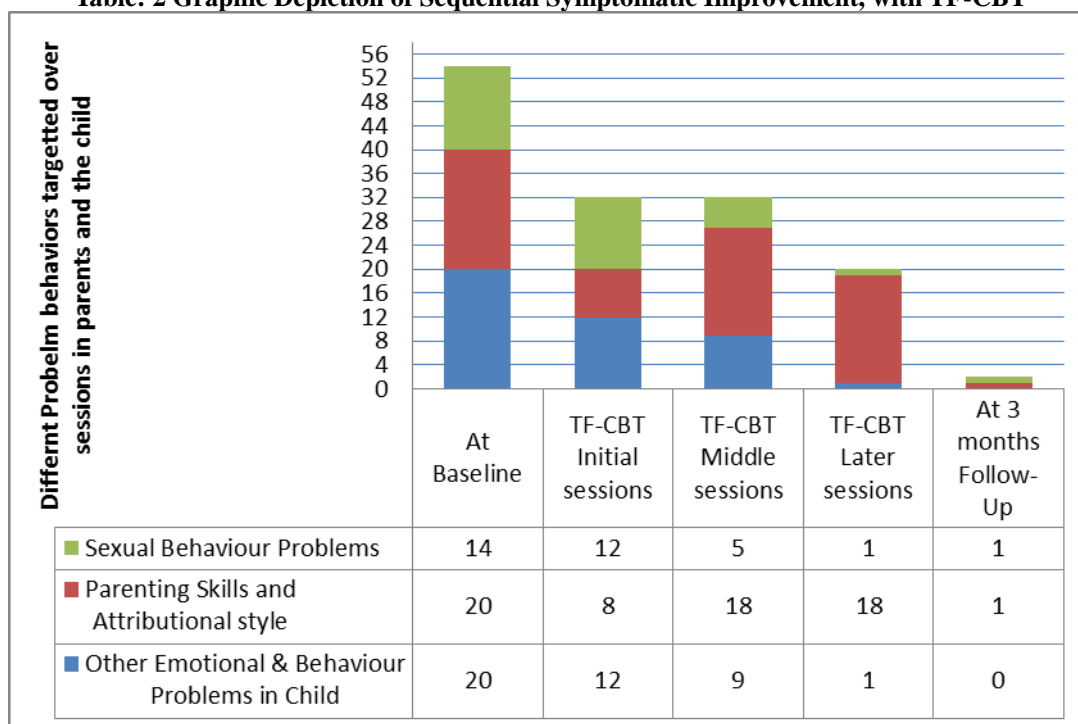
VII. Results Of Psychotherapy

Table 1 & 2 presented below summarize the pre-post therapy assessment results on various outcome measures as indices of improvement and the graphic depiction of sequential symptomatic improvement, with TF-CBT, in the management of the present case. (PTO)

Table: 1 TF-CBT Pre-Post assessment results on various outcome measures of improvement

Outcome measures	Pre-Psychotherapy scores on total problem behaviors	Post –Psychotherapy scores on total problem behaviors	Improvement Percentage From pre-post TF-CBT
Daily checklist of Behavioral problems as per detailed behavior analysis Performa	20	1	95%
Child sexual Behavior inventory	14	1	93%

Table: 2 Graphic Depiction of Sequential Symptomatic Improvement, with TF-CBT



VIII. Data Analysis

Statistical analysis was carried out on the data obtained on the outcome measures used in the case report as a measure of the clinical significance of the results. Clinically significant changes (50% and above) based on pre- and post-therapy data (**Blanchard, Schwartz, 1998**) were used to assess the efficacy of the therapeutic intervention. Improvement percentage for therapeutic change on each of the measure was calculated on the basis of the following formula (**Blanchard, Schwartz, 1998**):-

Pre Score - Post Score x 100/Pre Score = Improvement percentage for Therapeutic Change

Using the above mentioned formula, the percentage of change between pre- and post-therapy points as summarized in **table 1** and graphically **depicted in table 2**, given above, is suggestive of 95% clinical

improvement in other emotional and behavioral problems evident in the abused child and 93% clinical improvement in Sexual behavior problems in the child, with the application of tailored TF-CBT as described in this case report.

IX. Discussion

Child sexual abuse may be referred to as an aversive sexual event, or series of events, in a child's life. Some children are victimised on a single occasion, but more often sexual abuse occurs over a period of time, sometimes years (**Davis 2002**). The duration of exposure to sexual abuse depends on a range of factors, including the perpetrator's ease of access to the child or young person and the steps taken to secure his or her silence, such as threats and coercion (**Elliot 1995; Kaufman 1998**). Except in communities ('sects' or 'cults') where social relationships may be formulated in ways that undermine or break down normal relationships within families, sexual abuse is usually hidden. Consequent to abuse, children are at risk of developing significant mental health problems. Cross-sectional studies have pointed to a number of factors that appear to influence the extent and severity of these effects, such as the age of the child, the frequency and duration of the abuse, the severity of the abuse and the relationship of the child to the perpetrator (**Friedrich, 1986**).

The rationale for interventions for children who have been sexually abused is that successful intervention may not only reduce the psychological and social impact of sexual abuse for a victim and their family, but also modify the impact on future generations, through improved functioning as a parent, and (if there is an association) by reducing the risk of future abuse by its victims. In the 1990s, two research teams, **Cohen and Mannarino (Cohen, 1991, Cohen, 1994)** and Deblinger and Heflin (**Deblinger 1996**), published manuals and established the effectiveness of a cognitive-behavioral treatment model for children who had been sexually abused. Deblinger and Heflin's original model has three core components, namely coping skills training and gradual exposure, cognitive and affective processing, and behavioral skills management. The later directed at helping parents manage the behavioral problems that can sometimes result from sexual abuse, including sexualised behaviors. In their model, Cohen and Mannarino integrate aspects of other theoretical frameworks of relevance to child sexual abuse, namely an emphasis on the meaning of the abuse ,the extent of a child's interpersonal trust and self-efficacy and how their abuse experiences, and in many cases that of their mothers, were reflected in relationships with others. These two teams later collaborated in developing a broad-based cognitive-behavioral model, designed to address the breadth of behavioral, physical and/or emotional difficulties that can be the direct result of traumatic experiences, including sexual abuse. They refer to this as trauma-focused CBT, which they define as "a components-based hybrid approach that integrates trauma-sensitive interventions, cognitive-behavioral principles, as well as aspects of attachment, developmental neurobiology, family, empowerment, and humanistic theoretical models in order to optimally address the needs of traumatised children and families"(**Cohen 2006**).

Presented above was an effective TF-CBT account tailored for young child with sexual behavior problems and emotional disturbances, in an aftermath of a possible licentious sexual engagement faced by her. Based on a comprehensive psychiatric history taking, psychological assessment and therapeutic formation, the treatment of choice for such a case was the evidenced based Trauma-Focused Cognitive Behavioral Therapy for Children affected by Sexual Abuse (**Cohen, Mannarino, Deblinger,2012**) which was offered by 2 trained licensed Clinical psychologists, to both the index patient and the parents, with a total of 19 , 90minutes , bi-weekly individual sessions, followed by 3 conjoint parent-child-therapist sessions. The gains of therapy were monitored at a follow-up of 3 months. Symptoms were monitored for change by the therapist on the 2 outcome measures: Daily behavior checklist of problem behaviors that were revealed after detailed analysis, and child sexual behavior inventory (**Friederich, 1992**).

Therapeutic factors of cure in the above case:

The Vital elements of cure were those that were suggested in the original model of TF-CBT(proposed by **Cohen, Mannarino, Deblinger,2012,**) that helped in case conceptualizing and application of specific techniques in the presented case report. Additionally, play therapy techniques integrated in the sessions, were invaluable, to help provide the tender aged child with a natural medium of expression, in reconstruction, working- through and in resolution of past trauma. Along with cognitive and behavioral techniques, play enabled the therapist to reach inside the child's mind, understand and help the client, express, address and overtly work on the hidden issues causing emotional distress. All essential therapeutic learning and coping skills training was imbibed via play therapy, within the frameworks of TF-CBT. Also, parental psycho-education, insight, skill and management training were important means by which parents got a chance to undo their hidden shame, guilt related to abuse, work over their emotions and furthermore act as co-therapists in the treatment module.

Lastly, preventive work in the above case was as integral as the cathartic work, stressing on the importance of handling caretaker's role, support, insight and encouraging skill training in them, to mindfully address and prevent relapse in future.

Key reflections of the therapists on management issues faced in above case:

One central issue faced was limitations in the young children's memories: Young children comprehend and remember fewer specific details and recall central rather than peripheral events when compared to older children, especially related to complex sequel of abuse. Hence forming a conclusion about 'what, when, how' of events of sexual abuse was unclear and unrevealed by the child, in this case.

Young children's suggestibility to leading / unclear questions is greater, while interviewing them. Hence, the second issue in this case was that direct interviews were not effective in addressing the thoughts, emotions, and the experiences of abuse. Therefore, abuse in the latter case report had to be substantiated from history provided by the caretakers and the offset of inappropriate sexual behaviors, as the child could not provide with descriptive accounts of abuse related events.

The other highlights of difficulties encountered during management of this client was, the conservative socio-cultural orientation of the caretakers and their hesitancy to discuss sexual issues, in sessions with the therapist and when communicating the same with the child. Lastly, another challenge to the therapist was the tender age and temperament of the victimized client, due to which the duration of the sessions had to be extended, pace of therapy had to be slowed down and an extra-effort of the therapist was required in order to attune oneself, to maintain the delicate balance between Silence, empathetic exploration (of past experience, emotions, body- image, intimacy), and expressive resolution, in directing psychotherapy sessions.

Limitations of the present case report: There were times when the therapists, stood at a standpoint in therapy from where we could not make further progress. These were related to 2 central issues.

Firstly, the parents of the child projected their beliefs supporting the culturally supported social stigma against sex abuse, female child. From that point onwards, promoting parents to take required medico-legal action, if need be in future, against child sex abuse, particularly for their girl child, was hard in therapy sessions. This was the reason, due to which, the parents reported that they would probably want keep the 'incident' in secrecy, concealed from the child and others, in future, even when the child grows up.

Secondly, the child's extent of sexual inclination, inquisitiveness, knowledge and keenness could only be disguised from social display and moulded in behavioral appropriate ways. Nevertheless, these interests arouse out of the abusive experiences, which the present therapy could not be completely erase from the child's naïve mind.

Implications for future: The case report presented above provided a brief overview and extent of usefulness of TF-CBT, for trained and licensed mental health clinicians working with child cases of abuse. Future works in the area of sexual behavior problems in abused children, can focus on devising specific tools/outcome measures, in Indian contexts to assess psychopathology in abused children. Also, researchers interested in working in this area, can devise better methodology and better designs to study the effectiveness of TF-CBT and other management strategies in such cases.

In conclusion, the success of any effective psychotherapy lies as always, in process goals attained by dyad of the trained clinician and the client, no matter what the diagnosis or complexity of the case may be. Research in Indian setups needs to lay its foundations in terms of acknowledging these essentials of psychotherapy.

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