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Research Article

Psychological Assessment, Diagnosis And Psychotherapy Of A Sexually Abused Girl At Preschool Age, By Using Different Psychometric Tools And Therapeutic Techniques

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ABSTRACT

The current study looked at the hidden mental and behavioral problems of adolescent girls who had been sexually abused as a young child at preschool age. We used a clinical intake interview and thorough psychological testing, including the Beck Depression Inventory (BDI), Beck Anxiety Inventory (BAI), Standard Progressive Matrices (SPM), and Rorschach Ink Blots, to report the impact of sexual abuse (SA) on her personality and mental execution. These evaluations were helpful in determining a diagnosis as well as a treatment strategy. The girl had a significant depressive episode and borderline personality disorder (BPD), according to diagnostic criteria. In similar circumstances, this integration of test of psychological evaluation could be helpful in setting up an exact multiaxial analysis and comprehending the behavioral and psychological consequences of child sexual abuse (CSA). According to the findings, schema-focused therapy is a helpful remedial methodology for survivors of early CSA and have BPD.

KEYWORDS: child sexual abuse, borderline personality disorder, Rorschach Inkblot Test assessment, CBT, ABA

Introduction:

Child sexual abuse (CSA) is a general issue with grave deep-rooted results. According to World Health Organization (WHO) CSA is characterizes as “the involvement of a child in sexual activity that he or she does not fully comprehend and is unable to give informed consent to, or for which the child is not developmentally prepared, or else that violate the laws or social taboos of society.” This conduct between a child and a grown-up or one more kid who is seeing someone obligation, trust, or power, the lead being intended to satisfy or meet the other individual's needs, is proof of CSA (World Health Organization, 2021). According to Kempe (1978, p.105) CSA is characterized as "the engagement of reliant, mentally immature kids and teens in sexual behaviors that are beyond their range of knowledge but to which they aren't really qualified to give assent". Literature has defined CSA in a variety of ways; however, the term chosen for current case report centers on a kid that is immature, who lack the knowledge and meaning of sexual activity and is not mature enough to grant permission (Le Roux & Engelbrecht, 2000, p. 344). Additional varied CSA definition put a more prominent influence of the grown-ups' position and control over the kid (Diaz & Manigat, 1999).
The word CSA incorporates a variety of actions such as “intercourse, attempted intercourse, oral-genital contact, fondling of genitals directly or through clothing, exhibitionism or exposing children to adult sexual activity or pornography, and the use of the child for prostitution or pornography.” CSA damage is not temporary, but it has long-term negative psychological impacts on a survivor, especially if it is kept unsettled (King et al., 2000). CSA sufferers experience a variety of psychological issues that often do not emerge until maturity (Banyard et al., 2001). As a result, initial detection and study of such mental disorders could help to alleviate problems in juvenile or puberty while also slowing advancement of various mental and character problems throughout maturity.

In present case the hidden mental and conduct consequences of CSA in an 18-year-old woman (Ms. R.) who was molested at the age of 3-4years are describe. Further therapy approaches were also recommended to help her cope with her anxiety.

CASE STUDY

Ms. R. was an 18-year-old unmarried woman living with her mom and stepfather in her final year of secondary school. She is the youngest of four brethren, with two brothers and sisters. After one of her schoolteachers (along with the principal) told her mom of many challenges noted at school over the preceding six months, her treating advisor therapist alluded her for a full mental evaluation She became more socially reclusive, interacted less with other students and teachers, and had worsening exam outcomes because of these behaviors.

She also cut herself with a scalpel following a disagreement with her mother and stepfather (with no suicidal intent). One of her teachers noticed the cuts and reported it to the school's principal, who then informed her mother. Ms. R. stated that her irritability has increased in recent months, and that she has been tormented at school by numerous of her peers. She assumed that the main reason for the bullying was because her peers were aware of her love for animals. She added that she often found it difficult to respond to their negative comments, which intensified her anger even more.

In initial interview, Ms. R. was anxious and trembling during (especially during administration of psychometric assessment), and her eye-to-eye connection was restricted, with her frequently glancing out the workplace window.

Her voice had a typical loudness and tone, yet it was frequently monosyllabic. At some time, she appeared aloof and showed a limited variety of emotional responsiveness. She reported her mood as "low", yet objectively she seemed normothymic and nervous. She also expressed feeling of insecurity and low confidence. She also stated that she "doesn't care what other people think" and that she "hates people with kids." She remarked that spending time with animals, particularly horses, made her feel better. She said to have distracted effectively when understanding books or sitting in front of the TV, and that her memory had worsened as a result. She was mindful regarding her weight, identifying herself as overweight despite the fact that she was not clinically obese (BMI of 22kg/m2). She showed her preferences to be thinner and was picky about what she eats. However, no indication, of a serious concern of overweight, major distorted body image, self-purging, substances abuse or purposeful excessive weight loss was seen. she reported that her weight concerns started about the age of 14 years. She did mention that she disliked her nose shape, considering it to be "too flat," however her opinion wasn't at a paranoid point, and no similar complaints about additional body parts. No obvious signs of mental illness, such as hallucinations or perceptual anomalies like hearing things. At the age of 11 she her IQ was evaluated using Wechsler Intelligence Scale for Children (Wechsler, 1991). Which showed that she had average verbal IQ and below average non-verbal IQ.

A single episode of deliberate self-harm (DSH) was reported by her 6 months ago. It was attempted after a she had a disagreement with her mother and stepfather, however she had with no suicidal intent. She said that she was furious at that time and wanted to "get release," so she superficially cut her arm with a blade but not a deep cut as she had no intention of suicide. This was the only episode she reported of DSH during her teenage years.

Furthermore, she reported infrequent use of alcohol however, she does not admit alcohol abuse or using any-other illegal psychotropic materials. There was no forensic account reported. She refutes having any past connections of sexual nature, portraying just one brief nonsexual relationship with a boy quite a while ago.

She reported that her birth of Ms. R was normal, and her developmental milestones were achieved on time. It was also reported that her mother stayed in prison for the possession of drug, at the time when Ms. R was around the age of 3. Her 4 older siblings stayed at alternative foster care, however.

This was the time when she was sexually abused. During this placement, a 14-year-old boy allegedly sexually assaulted Ms. R. when she was three and a half years old when she was playing in her backyard. She did not report the attack to the authorities, and thus was not counseled properly.

When her mother returned from prison, she observed that Ms. R. Interaction was reduced with herself and others. Her mother claimed she had been socially isolated for the previous five years. She grew up with alone with no friendships and in school she was bullied because of being fat. According to her mom, Ms. R. father passed away when she was around the age of three years, because of physical complications induced by alcoholism. Because her parents split before he died, Ms. R. said she had no knowledge of her father. Her father had a long criminal record and was accused of misusing numerous psychotropic drugs in their home.

Her mother is currently receiving unemployment benefits, and her father is working at a low-wage job. Over the course of five hour-long sessions, a variety of psychological tests were administered to evaluate her IQ (SPM), degree of nervousness (BAI), sadness (BDI), and persona (Personality and Rorschach Inkblot Inventory). Ms. R. did not illustrate specific indications of post-traumatic stress disorder (PTSD) like persistent and/or unpleasant disturbing emotions or memories of circumstances following the sexual assault she underwent, thus the tools used in current analysis were chosen centered on her preliminary evaluation. However, in her initial presentation, she mentioned despair, anxiety, and self-destructive behavior, all of which are documented as CSA side effects and are linked with BPD symptoms (Kendall-Tackett, et al., 2001).

AESSESSMENT MEASURES AND RESULTS

At the time of her initial appointment, Ms. R's BAI and BDI scores placed her in the mild to severe levels of anxiety and depression, respectively. She scored between the tenth and twenty-fifth percentile rank on the SPM, putting her with in grade IV area (below average non-verbal IQ). She was identified with having severe MDD episode after her mental evaluation (with comorbid anxiety symptoms). The Rorschach Inkblot Tests' descriptive findings are offered the format of ration and percentages. She responded to ten Rorschach cards with a total of 24 replies, demonstrating acceptable overall efficiency (Ogdon, 1973), with normal famous reactions (P = 50%) reflecting ordinary view of the world (Cox & Sarason, 1954) and sufficient reality ties (Schafer, 1954). Physical appearance of her was excellent. Her accomplishment level was below average (F+ = 16.66 %) depicting considerable mental dysfunction (Vinson, 1960) and personality depletion (Singer, 1960). She gave poor total answers (W = 8.49 percent) and high unfinished answers (W = 29.33 percent) in the Location category, indicating a disorganized and imperfectly organized perceptual domain (Blum et al., 1975). Her high-ranking confabulatory replies (DW = 31.39 percent) reflect oversimplification, a proclivity for jumping to erroneous conclusions, a lack of reasoning ability, and a refusal to confront difficulties (Piotrowski, 1957). She had sufficient form answers (F = 50%) in the Determinant category, that are average motor answers (Ogdon, 1973). Though, her increased number of animal movement responses (FM: M = 3:2) indicates excessive restraint, a drive for fast fulfilment driven by pleasure principles (Klopfer & Davidson, 1962), and significant nervousness (Levitt & Grosz, 1960). Also, her result had a greater percentage of Pure Color reactions (C = 25%), suggesting that she was unable to manage her emotion (Rappaport et al., 1968), which is readily overpowered by affective states, that was indicated from her Landscape responses (Phillips & Smith, 1953). Her Rorschach protocol's lack of achromatic responses indicates rigidity and a higher suicidal thoughts (Weiner, 1956). She gave more Animal (A = 33.33 percent) than Human (H = 16.66 percent) responses in the Content category, indicating a desire to ignore socialization (Phillips & Smith, 1953), an absence of enthusiasm in everyday routines (Sarason, 1954), and extreme utilization of repression defense mechanism (Sarason, 1954). The presence of Object (clothes) and Plant (tree and leaf) reactions is associated with narcissism (Schafer, 1954), reliance, and trouble with relationship with opposite sex (Phillips & Smith, 1953; Piotrowski, 1957).

In conclusion, Ms. R.'s finding of Rorschach Inkblot Test results indicate issues of her character and personality in the form of low self-esteem, carelessness, poor housing, difficulty to deal with actual concerns, a desire of instant fulfilment of motivations deprived of fear of repercussion, and withdrawal from society.

THERAPEUTIC INTERVENTIONS AND SESSION PLAN

Sessions 1–5: Evaluation and Establishing Connections

First session: Goals for treatment, rapport-building, intake evaluation.

Sessions 2–5: Thorough evaluation of past trauma, present symptoms, coping strategies, assets, and strengths. Start establishing trust and a therapeutic connection.

Psychoeducation and Skill Development, Sessions 6–10

Psychoeducation regarding the effects of trauma on the body and brain, in sessions six and eight. instructed in relaxing techniques and grounding methods.
In sessions nine and ten, coping mechanisms such as progressive muscle relaxation, deep breathing, and mindfulness were introduced as a means of handling upsetting emotions.

Sessions 11–20: Dealing with Trauma

Sessions 11–13: Started using trauma-focused cognitive behavioral therapy (TF-CBT) or narrative therapy to process the trauma.

Sessions 14–17: Used strategies including cognitive restructuring to address trauma-related negative beliefs and schemas.

Sessions 18–20: Discussed self-blame, shame, and guilt. Encourage self-compassion and challenge self-critical thoughts.

Session 21-30: Building Resilience

The goal of sessions 21–23 was to reestablish a sense of security and empowerment. developed ability to set boundaries and be aggressive.

Sessions 24–27: Focus on strengthening wholesome connections and social support systems.

Sessions 28–30: Examine your values, objectives, and future aspirations. Encourage a meaning and purpose that goes beyond the tragedy.

Session 31–40: Relapse Prevention and Integration

Sessions 31–33: Combine the processing of trauma with more extensive life experiences. Take care of any outstanding problems or persistent symptoms.

Practice relapse prevention techniques and create a crisis plan during sessions 34–37. Talk about identifying and managing triggers.

Sessions 38–40: Discuss long-term objectives and create plans for continuing improvement outside of treatment.

Session 41–45: Discontinuation and Aftercare

Review progress, recognize accomplishments, and get ready to terminate in sessions 41–43.

Sessions 44–45: Talking about techniques for gradually ending therapy.

DISCUSSION

We examine, in current study underlying behavioral and mental repercussions of CSA in a preschool teenage girl (3 years of age). To investigate the mental and physiological consequences of CSA, we utilized a range of self-report and performance-based approaches. Ms. R. exhibited despair and anxiety symptoms in equal measure. In comparison to the general population, she used more of many negative schema patterns (such as defenseless person, impetuous kid, irresponsible child, passive surrender, distant guardian, self-aggrandizer, bully and attack) and used less of "happy child" and "healthy adult" schema patterns. Her frequent use of these problematic child behaviors implies that she is experiencing tremendous emotional anguish and fear of abandonment, that strongly suggests a link to the CSA she experienced. It was revealed that she employed dysfunctional schema pattern of coping like she remained emotionally distant, lacks empathy, engages in submissive self-deprecating behavior in the event of disputes or humiliation, and permits herself to be abused from people. Her scores of SMI clearly show that she has BPD.

There are a variety of investigative procedures able to detect numerous behavioral and emotional side effects of CSA. However, we suppose that the integration of self-report inventories and performance-based tools included in current report is complete and highly relevant for preschool survival of CSA, enabling the practitioner to comprehend a person's emotional trauma, determine the correct multiaxial diagnosis, and devise an effective therapeutic proposal. The two forms of psychometric evaluations utilized and treatment of patients who have experienced CSA are self-report and projective measures.

Though some self-report procedures have been shown to be beneficial in assessing CSA, their usage alone has been linked to recollections of major events and has been prone to deception and change (Ceci et al., 1994). Projective methods, assess qualities of a person's character that they are reluctant or otherwise incapable to disclose (Cohen & Swerdlik, 2005). They also offer information about nonlinguistic forms of cognitive activities (Billingsley, 1995) especially in case of CSA. These reactions can then be tentatively connected to everyday life situations (Weiner, 1998). Despite these benefits, Rorschach Inkblot Test projective measures by itself does not provide enough info for diagnosis and should only be used as a supplement to more (subjective or objective) organized or less organized psychometric inventories (Billingsley, 1995; Ceci et al., 1994).

As a result, a meticulously selected mixture of self-report and performance-based procedures could properly evaluate the behavioral and mental expressions of preschool-aged CSA sufferer children (Lusk & Waterman, 1993). The link between preschool CSA and later dysfunctional buildup of personality (such as problems forming and sustaining relationships and develop an individual identity) is widely known (Cichetti & Toth, 1995). Furthermore, preschoolers who have experienced CSA have much greater rates of BPD than those who have not (Battle et al., 2004; Figueroa et al., 1997; Lobbestael et al., 2005). Because of its long-term nature, chronic condition (Alexander, 2006), and poor therapeutic response.

Many clinicians face difficulty in treating BPD because of its long course, poor outcomes (Alexander, 2006) and ineffective responsiveness to therapy to psychiatric drugs and most forms of cognitive therapy (Farrell et al., 2009). As we focus on Ms. R's problems and how they correlate to her CSA at preschool, other life stresses like her social anxieties of her father and his demise (even though she did not remember him), also the detention of her mother's and later her adaptiveness to neighbor, may have played a role. Additionally, recent difficulties such as being bullied at school and problematic ties with her parents may have influenced some elements of her clinical manifestations.

CONCLUSION

Current study illustrates how a thorough evaluation utilizing both self-report measures and performance-based tools for early age survivors of CSA can feature complex mental and behavioral problems, create a precise diagnosis, and offer a more possible treatment plan for CSA survivors. We believe that similar cases of preschool CSA could benefit from a mixture of self-report and performance-based approaches, along with complete clinical and collateral history, as used in present case.

However, as we have only given one case report, so our findings might not generalize on all survival of CSA. Therapeutic treatments for rehabilitating SA children that have been scientifically examined originate from a

variety of psychological models. The treatments based on the model of CBT, particularly trauma-focused CBT proposed and validated by Berliner and Saunders (1996), Cohen and Mannarino (1996), and Deblinger et al., (1996), have received the most investigations. Saunders et al., (2004) found that the CBT model is the only evidence-based therapy for the effects of SA in children in their study. The four trauma genic fields are catered in current treatment protocol such as traumatic sexualization, stigmatization, lack of power, and disloyalty (Cohen & Mannarino, 1997).

Coping skills training, gradual experience of fear, reprocessing unpleasant recollections and flashbacks, and learning about CSA, appropriate relationships, and training about private body protection skills are among the approaches used in the child's intervention. Others, such as CBT approaches, have been employed in conjunction with this therapy program. Thus, Jaber Ghaderi et al. (2004) used the Eye Movement Desensitization Reprocessing (EMDR) programmed on a treatment group, whereas other researchers combine various CBT techniques (King et al., 2000).

Programs based on psychodrama (MacKay et al., 1987) and play therapy (Scott et al., 2003) have been employed as part of the psychodynamic approach. The most employed therapies from the humanistic model were those based on CCT, whose major goal is to strengthen the individual's self of the child and self-reliance (Bagley & LaChance, 2000). Child and Family Protective Services (Child and Family Protective Services) offers support services to children and their families on a regular basis (McGain & McKinzey, 1995). Holistic approaches have also been adopted, with techniques for treating child and adolescent sexual abuse derived from a variety of theoretical perspectives (Kruzeck & Vitanza, 1999; Lanktree & Briere, 1995).

There are currently several empirical research evaluating the efficacy of various mental health therapies for CSA, with mixed results. Some empirical reviews conducted in this context suggest that non-behavioral techniques (psychodynamic, supportive, and humanistic therapy, and so on) have not been properly tested, because active principles are difficult to manualize and standardize (Saywitz et al., 2000).

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