**Clinical Case Presentation: S**

*January 31, 2013*

**What is your clinical question or what feedback would you like from the group?**

1. When is an appropriate time to start the trauma narrative, given criminal and custody court hearings, and the possibility of placement change?
2. How might I address ongoing dynamics between the parents, as well as mother’s alleged substance use?
3. What other skills should I consider teaching prior to the start of the narrative?
4. Any helpful strategies with cognitive restructuring for younger children?

**Client profile:**

* *Demographics:* 7 year old biracial female (Caucasian and African American)
* *Living situation:* Currently living with her biological father. Biological mother is also in the home, but has been known to leave unexpectedly for days or weeks at a time without contact. History of domestic violence in the home. Verbal arguments between parents continue, reportedly no physical violence since 2008. In 2008, mother left unexpectedly with both children, was psychiatrically hospitalized out of state and S was in care of maternal grandparents for 8 months.
* *Additional considerations:* Custody dispute between father and maternal grandparents (out of state). Criminal court scheduled for same week as next custody hearing (03/13). S to testify. Mother acknowledges her own anxiety, depression, and abuse of prescription medications and is reportedly seeking services. She is court ordered not to transport children nor be alone with S’s younger sister. According to father, mother has broken this court order on two occasions and on one occasion had S transported to school by herself in a cab.

**Trauma history and reason for referral to agency:**

S was referred to CAP in 06/12 following disclosure of sexual abuse by a male teenager who occasionally babysat for S. S disclosed to a family friend. Symptoms included fear at bedtime, initial bedwetting, emotional and physiological reactivity when go by alleged abuser’s home, difficulty talking about the abuse, irritability, hypervigilance.

**Assessment results:**

• *Results of CPSS-IV (10/31 father; 11/7 child)*

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| --- | --- | --- | --- | --- | --- |
| Scale | Parent-Report Score(Father) | Child-Report Score | Clinical Significance Cut Off | Is Parent-Report Score Significant? | Is Child-Report Score Significant? |
| Re-experiencing | 4 | 8 | >4.6 | No | Yes |
| Avoidance | 4 | 10 | >6.1 | No | No |
| Arousal | 5 | 8 | >5.4 | No | Yes |
| Total Score | 13 | 26 | >15.7 | No | Yes |

**Parental/Caregiver involvement:**

* Mother was supposed to transport for first several appointments, three no shows. Father became primary contact and has consistently transported S to sessions. Father participates in collateral check-ins each session. Often presents as angry and defensive, though is tearful when he discusses his daughter’s abuse and relationship with S’s mother. Responsive to empathy. On one occasion, a staff member thought she smelled alcohol on father. Clinician addressed this with father, who denied substance use. Father engaged in S’s treatment, helps practice skills, asks questions about treatment. Therapist provided him with referral for individual tx. Father is seeking sole custody as a result of maternal grandparents seeking custody and 2008 incident. Is ambivalent about his relationship with S’s mother. Father reportedly assaulted alleged offender when saw him in neighborhood. Of note, GAL recently indicated that she may recommend a custody change due to concerns about father allowing inconsistent contact with mother.
* Mother acknowledges her own anxiety, depression, and abuse of prescription medications and is reportedly seeking services. When present, she is often tearful. She and S’s father verbally argue during collateral sessions, but not in front of child. Mother ambivalent about relationship with father but stated that she is back in the home “for good.” Mother supportive of S, warm in sessions, explains things in developmentally appropriate ways. S appears more comfortable physically with mother. Mother often appears to have altered mental status; eyes partially open, occasionally slurring words.

**Review of the PRACTICE components:**

\***P**sychoeducation: Played “What do you know?” Card game with S to review education on Child Sexual Abuse and Domestic Violence. Provided parents with psychoeducation on CSA and DV. Provided both parents with education on TF-CBT, including tripartite model and narrative process. S has been involved in helping teach these to her parents.

\***P**arenting Skills: Praised support of S, engaged in safety planning. Modeled positive reinforcement

**\*R**elaxation: S is very good with deep breathing, practices regularly and taught skill to her parents. She also enjoys child-version of PMR and created her own example (pretend a hippo is going to step on your belly, tightening muscles and relaxing them).

\***A**ffect Modulation: S regularly uses the SUDS scale to identify her feeling (Scared). Her parents have helped her track her SUDS for her homework assignments. Mother engaged well with this skill, helping make the scale developmentally appropriate and salient for S (“Tell me what a 4 means?”) Have helped parents model affect recognition. S very good at noticing physiological markers and labeling feelings.

\***C**ognitive Coping: Engaged in thought identification, and “detective” game (evidence for/evidence against), evaluating “Stinky Thinking.” Reviewed Stinky Thinking with parents, and most recently gave S an assignment to write about what Stinky Thinking is to ensure her understanding.

\***T**rauma Narrative: Not done yet. Needed pre-work with in-vivo desensitization (see below)

\***I**n Vivo Desensitization: Practice saying alleged offender’s name, talking about abuse in general. Gradual exposure that has increased S’s ability to talk (initially would become silent and ask to draw)

\***C**onjoint Session: Not there yet.

\***E**nhancing Future Safety: Early sessions focused on safety, particularly in home neighborhood where alleged offender lives. Have routinely assessed for presence of DV and created safety plan with S. Have addressed concerns re: possible DV and parental substance use with parents and GAL.

**What adaptations did you make to any of the components to fit the individual needs of the child/family:**

I initially incorporated the Coping in Court model, teaching deep breathing and self-statements to S and helping the family make practical plans for the days surrounding the planned court date (i.e. choosing what to wear, planning a reward regardless of outcome). Game-oriented instruction of cognitive coping (“detective” game that followed child’s lead when she talked about a fear of zombies).

**Repeat clinical question for group feedback:**