Research Paper: Sexual Mistreatment and Posttraumatic Stress Disorder

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A. Contemporary Epidemiological Information - For children under 6 years old the requirement for PTSD is different than the “typical” criteria. For this paper, I will be using the criteria used for children above the age of six because that will correlate with the research I have found. PTSD is classified as the series of symptoms that a person will experience after a traumatic experience. The exposure as to be actual or threatened death, serious injury or sexual violence. The person must have either: (1) directly experience the traumatic event, (2) witness it in person as it occurred to others, (3) learned that the traumatic event occurred to a close family member or friend, (4) experiencing peated or extremer expose to aversive details of traumatic events. For this particular diagnosis there is not a particular age of onset, because this trauma response an occur at any age from oldest to the youngest. It is found that around 10% of women will experience PTSD in their lifetime as opposed to the 4% of men. Something is also very interesting is that 1 in 4 girls and 1 in 10 boys experience sexual abuse by an adult or peer. Unfortunately, the reality of that number when it comes the case of boy, is that it should be lower. The unfortunate reality is that boy get sexually abused as well, but often times it gets brushed under the rug because he wouldn’t be a “man” if he turned down the sexual advance of someone else; despite it being unwanted. Boys are being raised in a society that tell him he need to take ever sexual experience as a win and not a threat, if it does get reported the boys/man’s sexuality can even be questioned. Thus, as a result, many sexual mistreatments go unreported within the male gender.

B. Contemporary understanding of etiology – The research I have chosen to use are all about children suffering from PTSD from the ages 6-15 (across the four different articles I referenced from). In this particular article “Sexually abused children and post-traumatic stress disorder” the case illustration was done on a 10-year-old girl who was sexually abused (breast fondling, vaginal penetration by various object) by her uncle. These events were taken place over the course of several occasions throughout the year. When it comes to the etiology and maintenance of PTSD in sexually abused children, unfortunately it is not fully understood although it is likely that many interactive factors are involved (King et al., 2000). What was mentioned is that often times when abuse occurs to a child by a member of the family, the child harbors guilt. They believe and feel as though it was their fault, and they are to be blamed. Something else that was mentioned which I thought was very important is that ironically it is the family structure that can help bring back that child. As the parents start to divide the more the child feels to be blamed. The article said it best when they said “Further, the family context has been shown to be a critical influence on post abuse adjustment researchers have found that parental emotional distress, lack of maternal support and maternal depression appear to exacerbate emotional and behavioral disturbances in sexually abused children” (King et al., 2000). I believe this to be true because after a traumatic shift in the child’s reality, the fundamental pillar in their life needs to remain to help guide them through what seems like an unmanageable tunnel.

C. Optimal assessment strategy – As a mental health counselor, the assessment tools/approach I would want to use is the PTSD Symptom scale interview (PSS-I and PSS-I-5) and/or CAPS-5. The PSS-I is a 17-item interview, and it is used for assessment and diagnosis. This checked to see the severity of the PTSD symptoms that the client has had in the past month. This assessment

also checks to see how much the symptoms have interfered in the client's day to day life. The last thing this assessment does is that it checks to see the onset of the symptoms as well as the possible durations. This assessment takes a proximately 20 minutes and it is great because it does have any probing or follow questions. I say that is great because once again when dealing with PTSD clients, especially children, we want to be very gentle and nurturing (at least the is the approach I would want to take with my client). The next assessment I would consider doing would be the CAPS-5 (Clinician-Administered PTSD scale for DSM-5). The CAPS-5 is a 30-item structured interview. This test was initially developed by the staff at the U.S. department of Veteran Affairs National Center for PTSD. With this interview, a clinician can make a diagnosis, determine lifetime diagnosis, or assess PTSD symptoms over the previous week. This interview typically takes 45-60 minutes. I really like this one because it is really in-dept, it allows you to see things that the other interview would only give you a peak at. With this interview it allows you to be able to pick the proper approach because of all the extra information you are receiving.

D. Optimal interventions/treatment approach – The treatment approach I would like to take is to use CBT. In the article mentioned earlier, as well as another article by Hébert, M., & Mélissande Amédée, L., the approach of CBT was used to reduce the symptoms of PTSD. The reason why is that CBT focuses on the relationship in the client's thoughts, feelings, and behaviors. Some of the types of CBT that may be effective is Cognitive Processing Therapy (CPT) and Prolonged Exposure (PE). With CPT the counselor and client work through what the client is thinking and telling him/herself but the trauma that they experienced. Together the counselor and the client examine those thought to see if it is true or not. PE works by exposing

the client to the repeat exposure of their thoughts, feelings, and situations that the clint has been avoiding. The goal here is the show the client that trauma does not and should not be avoided.

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