

"PSYCHOLOGICAL ASSESSMENT THROUGH VARIOUS TESTS: A CASE STUDY OF A 16-YEAR-OLD GIRL EXPERIENCING TRAUMA AND BEHAVIORAL CHANGES"

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ABSTRACT

This is a case of 16 years old girl suffering from PTSD. Her parents reported that she is avoiding her social circle, which she hardly did before. She report consistent nightmares and flashbacks as she has been crying constantly these days. She is also struggling with concentration during a conversation. She has been irritable these days followed by crying spells and anger outbursts. She has become socially withdrawn and lost interest in the activities she previously enjoyed. A structured interview along with psychological assessment was carried out. These included Revised Child Anxiety and Depression Scale (RCADS), Mini-Mental Status Examination, PTSD Checklist for DSM-V (PCL-5), and House Tree Person Test (HTP). The results highlighted significant psychological impact leading to a diagnosis of Post-Traumatic Stress Disorder. She has undergone sexual abuse in her school and later on started experiencing traumatic symptoms. In spite of these challenges, Cognitive Behavioral Therapy (CBT) and Eye Movement Desensitization and Reprocessing (EMDR) offer a structured procedure to help her manage her symptoms, and understand her trauma first.

Keywords: Post-traumatic Stress Disorder, flashbacks, intrusive thoughts & memories, sensory stimuli.

INTRODUCTION

One key aspect of PTSD is the difficulty in distinguishing between stimuli that are threatening and those that are not. This dysfunction is central to both the symptoms of PTSD and how we understand the mechanisms

behind it. Assessing trauma-related stimuli relies on the ability to detect and interpret sensory information, which involves balancing internally generated cues with external sensory input and how the individual perceives these inputs in

terms of threat (Brand, 2024). Recent research indicates that sensory processing plays a significant role in determining risk or resilience following trauma exposure (Roekner et al., 2021), and it may also help explain the different ways PTSD presents itself, such as the occurrence of intrusive symptoms like flashbacks (Bryant, 2019).

Intrusive symptoms and flashbacks are characterized by vivid sensory memories, where the individual feels as though the traumatic event is happening again. These experiences trigger strong physiological responses (Brand, 2024; Bryant, 2019). The intensity of these symptoms can increase when the trauma-related memory becomes overgeneralized to situations unrelated to the trauma. Therefore, understanding sensory processing in PTSD is vital for addressing the sensory disturbances that are common in this disorder. PTSD involves a complex interaction between sensory processing circuits and emotional responses to stimuli. While the role of threat-related circuitry is well understood, the integration of sensory processing into the neurobiological models of PTSD has not been given as much attention.

PTSD is widely recognized for its impact on processing the emotional aspects of sensory stimuli. Research has shown that individuals with PTSD experience changes in how they evaluate both pleasant and aversive emotional visual stimuli (Elman et al., 2018). Shalev and Avidan (2018) reported that PTSD impairs the ability to distinguish between neutral stimuli once those stimuli have been associated with aversive visual inputs. Beyond emotional processing, PTSD has also been linked to deficits in non-emotional visual functions. For instance, Marlatte et al. (2022) found that individuals with PTSD exhibit difficulties in imagining spatially coherent scenes and navigating complex environments.

Research highlighted that early exposure to trauma in an individual's life may result in difficulty processing sensations. Children who experience prolonged stressful experience, leading to inability to process emotional triggers (Clancy et al., 2020).

CASE STUDY

The client is a female aged 16-years. She was brought to BBH Hospital by her family due to significant psychological and behavioral

complaints. Her parents reported that she is avoiding her social circle, which she hardly did before. She reports consistent nightmares and flashbacks as she has been crying constantly these days. She is also struggling with concentration during a conversation. She has been irritable these days followed by crying spells and anger outbursts. She has become socially withdrawn and lost interest in the activities she previously enjoyed.

The clinical interview spanned for three sessions, during which noticeable changes in the client's behavior and expressions were observed. At first, she appeared reserved and somewhat guarded, limiting her ability to articulate her emotions fully. She slowly mentioned concerns about her classmates and cousins but refrained from delving into deeper emotional issues. During the third session, a significant breakthrough occurred. The client began to discuss her father, expressing feelings of inferiority and frustration stemming from his absence. She shared at length her sense of neglect and longing for her father's presence and support. She opened up about her anxiety regarding her social standing, revealing feelings of inferiority compared to her peers. This session marked a turning point as she disclosed her emotional struggles, feelings of isolation, and concerns about her physical and emotional exhaustion.

During the behavioral observation and mental status examination (MSE), the client's appearance was noted as appropriate for her age, though she occasionally appeared disheveled or withdrawn. Her mood was observed as depressed, with an anxious affect, and she frequently became tearful. Her thought process remained organized, though she was often preoccupied with distressing memories. Cognitively, she demonstrated intact functioning but experienced difficulties with concentration and maintaining focus. Her insight and judgment were limited, with only partial awareness of her emotional struggles.

The family reported that she has been disturbed from the past month. She was normal previously, she was attending her school, tuition, engaged in her friends and social interactions and family time. Her mother observed a change in her daughter's behavior one day when she gets back to home from school, she was frightened and directly went into her room without talking to

her mother, which she has hardly done previously. When her mother asked about this she started crying and after almost an hour she revealed that she had been chased by a dog. She became quiet after this event and her performance started declining. She started doing odd things that her mother had hardly noticed before.

In the days that followed, the client began isolating herself, spending most of her time in her room and avoiding her cousins, with whom she had previously enjoyed spending time. When her cousins called her to visit, she would make excuses to avoid them. She was often observed lying in her room, staring at the ceiling, and refusing to explain her behavior when questioned by her mother. Her school attendance began to decline, and she skipped classes without providing any reasons. She initially continued attending tuition classes in the evening, her interest in studies waned. Her tuition teacher informed her mother that she appeared disengaged and quiet during lessons. She began skipping tuition classes as well, showing an overall lack of motivation.

The client's mother reported that during this time, her appetite and sleep significantly decreased, leading to noticeable weight loss. She ate only when forced by her family, including her extended relatives who lived nearby. Her family was concerned about her behavior, they started suspecting that something had happened to her at school, though initially, they also observe her changes to academic stress as she had recently entered the 9th grade. Previously, the client was a good student with a keen interest in studies and extracurricular activities. She was known for her neat appearance and was admired by both her immediate and extended family. Her condition worsened as she began experiencing frequent nightmares, leaving her scared and unable to sleep through the night. She reported having daytime nightmares as well, during which she would ask for forgiveness, even while awake.

The client was the fourth child in her family, born full-term via C-section delivery. Although she was an unplanned pregnancy, her arrival as a daughter was celebrated, as the family already had three sons. Her development progressed normally, with no delays in physical, cognitive, language, or psychosocial milestones. There was no prior history of psychological or medical

issues. Fifteen days after the onset of her psychological symptoms, the client attempted to harm herself by strangling her neck with her dupatta in the middle of the night. Her mother recounted that she woke up frightened, asking for forgiveness, and ran out of the room and the house. After being restrained by her family, she made further attempts to harm herself, prompting her family to bring her to Benazir Bhutto Hospital in Rawalpindi.

Socially, the client had been very active, enjoying time with her friends at school and her cousins at home. Over the past month, however, she has withdrawn from these interactions and shown no interest in reconnecting with them. Academically, she has consistently performed well and was previously enthusiastic about attending school, where she was well-liked by teachers and peers. Before the recent changes in her behavior, the client was described as extroverted, sociable, and well-adjusted, with no significant difficulties forming friendships. She was confident, friendly, and actively participated in school events. The onset of persistent psychological symptoms has led to noticeable changes in her behavior, social interactions, and overall emotional well-being.

Revised Child Anxiety and Depression Scale (RCADS)

Her scores on RCADS assessment highlighted that she suffers from both depression and anxiety. Her scores on depression are 75 that are above the cut-off scores of 70, whereas her anxiety scores are 60 falls within the range of (60 - 64) that shows her borderline range.

Mini-Mental Status Examination

Her scores on MMSE is 12, due to difficulty concentration, anxious and depressed condition. She was constantly crying and was having a guilt feeling. She was unable to focus and respond appropriately to asked questions.

PTSD Checklist for DSM-V (PCL-5)

Her scores on PTSD checklist are 71 indicating severe range of PTSD Symptoms. She reported that she has been going through distressing memories but was unable to open up at the very beginning.

House Tree Person Test (HTP)

Projective analysis revealed that she has feeling of worthlessness. She perceive her environment as stressful, and has an insecure feelings. Lack of control and feelings of powerlessness has been noted. Hyper vigilance, lack of emotional growth and hopelessness also come up as an important theme.

RESULTS

The scores on RCADS assessment highlighted the fact that she exhibits both depressed and anxious symptoms. Her scores on depression were 75 that is above the threshold of depressive symptoms scores, whereas her scores on anxiety scale is 60 which falls within the borderline range.

Research also support the use of RCADS with children, as Chorpita et al., (2000), highlighted this tool’s validity. Various other researchers also use this scale to track clinical change of severity of symptoms (Weems et al., 2005; Ross et al., 2002). Her scores on MMSE falls within the range of 12. This cognitive decline is noted due to her constant crying behavior and guilty feelings. This moderate to severe scores on MMSE depicted difficulty with language, problem solving and memory. The scores on PTSD checklist falls within the range of 71 that depicted severe disturbances, associated with abuse during her schooling. HTP revealed fear of disapproval, feeling of helplessness and guilt. She faced difficulty in coping with situations.

Test	Raw Scores	Range
RCADS	D = 75 A = 60	Severe Borderline
MMSE	21	Moderate to Severe
PCL-5	71	Severe Disturbance
HTP	Themes: Helplessness Fear of disapproval	Associated with: Guilty Feelings Crying Behavior

DISCUSSION

The client’s susceptibility to develop PTSD appears minimal in regard of genetic predisposition, as no family history for any mental health condition is reported. Certain personality traits could be a reason for her PTSD that consisted of dependency, and overly pampered behavior towards her. Her parents reported that they suspected an abuse in her school, but they don’t want to report it as she is engaged and it might impact her life. It was not easy for them to open up, but they need help for her daughter. She has undergone only three sessions that is why the assessment could not be conducted further. Her condition during the first session was much compromised she was not in the state to be taken any information. Her parents revealed during that session that they took her out from her school.

During second session, MMSE and PTSD has been done. The third session was based on HTP. The psychologist wanted to continue with further evaluation and probing of her abuse and get into the client’s world but due to the unavailability of the patient in the hospital anymore, the sessions could not be taken further. The traumatic event

that triggered her symptoms was the sexual abuse experience she had that disrupted her emotional well-being and sense of security. She was not able to explain her condition to her parents but they saw change in her and gets an idea about it. She struggles to manage herself independently.

Some other factors that has perpetuated her symptoms were lack of emotional and social support, either from her parents and peers. She was unable to process her trauma effectively due to lack of support. Her maladaptive coping mechanism, including her self-harm and avoidance behavior further exacerbate her symptoms. She was reluctant to engage with psychologist at first for she has the unprocessed trauma and there is a cycle of distress. In spite of these challenges, Cognitive Behavioral Therapy (CBT) (González-Prendes & Resko, 2012) and Eye Movement Desensitization and Reprocessing (EMDR) (Davidson & Parker, 2001), offer a structured procedure to help her manage her symptoms, and understand her trauma first.

She exhibits variety of emotions besides PTSD that reflects her profound trauma, she struggled with anxiety and depression, with crying spells, guilty feelings and helplessness. She has been

undergoing sleep difficulties, repeated dreams, she started avoiding situations that reminded of her traumatic event. She reported constant headaches and somatic complaints.

PTSD could also arise from the Disregulation or disruption in various brain functions, particularly in brain areas that regulate stress and memory. The amygdala is responsible for emotional regulation, it usually become hyper activated which increase the sensory threshold (Ressler et al., 2022). Whereas the activity of prefrontal cortex is reduced that impairs the ability of emotional regulation thus leading to a state of confusion between past experiences that are negative and the present experiences. Dysregulation of the hypothalamic-pituitary-adrenal (HPA) axis further increases these issues by impacting the body's ability to effectively manage stress, resulting in prolonged physiological arousal and emotional disturbances (Tsigos & Chrousos, 2002).

Cognitive-behavioral theories (González-Prendes & Resko, 2012) further give explanation of how Post Traumatic Stress disorder symptoms could arise from maladaptive coping mechanisms. The phenomenon of classical conditioning highlights that neutral stimulus along with traumatic event make the stimulus fear provoking and the response is to perceive it as a threat. Negative beliefs about oneself and the world, such as feeling powerless or viewing the world as inherently unsafe, perpetuate hypervigilance and intrusive memories, creating a cycle of emotional and behavioral dysregulation.

CONCLUSION

Social and cultural factors (Schubert, 2028) play a critical role in shaping PTSD outcomes. A lack of social support intensifies feelings of isolation and hopelessness, hindering recovery. Conversely, positive social connections and a supportive environment can buffer the effects of trauma and promote healing. Cultural attitudes toward mental health and coping also influence how individuals process trauma and seek help, significantly shaping their recovery trajectory (Schubert, 2018). By addressing these interconnected factors, comprehensive treatment plans can help the client achieve emotional stability and resilience.

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