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# Unrecognized hospital trauma as a source of complex psychiatric symptoms: A systematic case study with implications for children's rights and evidence-based practice

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# Unrecognized hospital trauma as a source of complex psychiatric symptoms: A systematic case study with implications for children's rights and evidence-based practice

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## Abstract

This article describes the psychological assessment and treatment of Paul (12). For several years, he had received numerous diagnoses from a range of specialists and been unsuccessfully treated for epilepsy and obsessive-compulsive disorder. Treatment was based on a formulation-driven transdiagnostic approach. Soon it was clear that the correct diagnosis was posttraumatic stress disorder (PTSD) precipitated by an event in hospital when Paul was 6. Two sessions of Children's Accelerated Trauma Treatment (CATT) led to rapid resolution of the main symptoms and gains were consolidated and maintained in further treatment and follow-up sessions. The case material is used to examine why the correct case formulation had been missed, evidence for the efficacy of CATT, and implications for evidence-based practice and children's rights.

**Keywords:** trauma; cognitive behavior therapy; child psychotherapy; clinical case study; hospital

## The Case of Paul: Context and Method

This article describes the psychological assessment and treatment of Paul (12), who had been terrified of going to school for several months, appeared to be having psychotic episodes, and had made a number of dramatic suicidal gestures. For several years, Paul had received treatment intermittently for obsessive-compulsive disorder (OCD) without sustained improvement. Shortly after he started a new school, a severe exacerbation of symptoms led to his parents approaching the first author (CR).

Sandor Ferenczi (1930/1955) describes a terrifying attack of "nervous asthma" in a fellow medical student. "A rapidly sown and harvested crop of associations" showed that the panic was a reliving of a "trauma in his early childhood." When, in hospital for an operation, attendants had suddenly seized him and forced a chloroform mask over his face, he had "tried with all his might to escape from the anaesthetic." The panic attack was thus "affect without recollection" (Ehlers & Clark, 2000, p. 324) where re-experiencing occurs without episodic memory of the event itself. Similarly, Hackmann (2005) describes a case where an unrecognized trauma in hospital gave rise to disabling agoraphobia that lasted

20 years. Work on this traumatic memory cleared the way for her to overcome her previously refractory psychological problems.

Paul's symptoms were also precipitated by an earlier trauma in hospital. Once it was clear that this was the source of his symptoms, his condition could be understood parsimoniously as post-traumatic stress disorder (PTSD) and treated appropriately. However, there had been a long history of contact with a range of health professionals without the significance of the event being recognized. Although several diagnoses were given, these had not included PTSD. This case study provides a means of evaluating why the underlying problem was not identified sooner and of considering how such situations might be avoided in future. It also provides a basis for evaluating the Children's Accelerated Trauma Treatment (CATT), which was used to treat the PTSD, and for reflecting on the rights of children with mental health problems.

## Research Methodology

The everyday details of clinical experience elude the grasp of group comparison research. By highlighting some of the detailed processes of assessment,

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treatment and response to treatment, systematic case studies provide a basis for developing and refining the theory on which everyday practice draws (Barker, Pistrang & Elliot 2002; Dattilio, Edwards, & Fishman, 2010; Edwards, Dattilio & Bromley, 2004; Midgley, 2006). A narrative summary of Paul's history, and of the assessment and treatment process, was constructed from a range of data sources and structured in accordance of the recommendations of Fishman (2005) for the online journal *Pragmatic Case Studies in Psychotherapy*. These sources included:

1. Notes made by Paul's parents on consultations with health professionals in respect of Paul's problems, the earliest dating to when Paul was 3½.
2. Medical records: Reports and correspondence written by professionals whom Paul and his parents had consulted, the first of which was written when Paul was 6.
3. Records of assessment, treatment and follow-up sessions: Detailed process records were made of the 2 × 60 minute assessment sessions (referred to as A1 and A2), 16 × 60 minute treatment sessions (referred to as T1 to T16) and 3 month and 6 month follow-up interviews (FU1 and FU2).
4. Paul's productions within sessions include notes and drawings made in response to therapist interventions, and figures he created during the CATT intervention.
5. Photographs taken at the end of the treatment of Paul visiting places he would previously have avoided such as the school and hospital ward.
6. Children's Revised Impact of Event Scale (CRIES: Perrin, Meiser-Stedman & Smith, 2005) was administered twice (during T7 and FU1) with therapist assistance.
7. Anxiety self-ratings: Paul was trained to rate his anxiety on a 1–10 scale and record it on a chart within and between sessions.
8. Feedback from health professionals during and after treatment included a psychiatrist's assessment after A1, and a psychiatrist's and a pediatrician's assessment after T16, as well as notes on four multi-agency meetings and telephone conversations with the general practitioner (GP).
9. Emails from Paul and Paul's parents sent to the therapist between sessions approximately once a week, providing feedback on Paul's progress.
10. Records of academic and social behavior at school included end of term reports, results of

class tests, and minutes of monthly meetings at the school between Paul, his parents, Paul's Head of Year, the school health lead and the therapist which provided feedback on Paul's progress and a forum to discuss outstanding issues and support needed from the school.

11. Family counseling and feedback sessions: Records were kept of five 45 minute meetings with Paul's parents, covering behavior management and psycho-education (Paul attended some of the early ones) and of two informal meetings with Paul's grandparents, who provided feedback on their experience of him.

Paul and his parents signed consent for the publication of this article and have approved its content. Pseudonyms have been used and information omitted that might identify them.

### Paul's Medical History

Paul's history is summarized here to contextualize what follows, although not all the details emerged during the initial assessment. Paul (12) lived with his parents and brother, Joe (6). His parents were caring and interested in their sons' welfare and three grandparents were supportively involved in the family. Paul's mother worked part time after Paul's birth and stopped working when Paul was 6. Aged 3½, Paul was diagnosed with asthma and epilepsy and over the next 3 years underwent several medical tests and interventions. A year later, a diagnosis of nocturnal epilepsy was made. At 6½, Paul still had nocturnal epilepsy (or later "benign partial epilepsy") for which he was on medication, and was sent for a sleep EEG. It was here that the critical incident occurred (the details of which only emerged in T7). In the hospital, a nurse gave him yoghurt into which she had put melatonin to induce sleep. Paul saw her putting it in and asked about it. She smiled at his mother and denied putting anything in it. Since this was clearly untrue, Paul didn't trust her and refused to eat it. The nurse then told him that there was an easy or a hard way to continue and it would have to be the hard way. Three nurses forcibly held him while he was given an injection. Paul was terrified and screamed repeatedly. The nurses prevented his mother from intervening, and threatened to remove her if she didn't act constructively. Paul became drowsy, but was still distressed and did not fall asleep in time for the allocated EEG appointment. In the car park, as they left, Paul looked up at the sky and said "Well thanks for nothing, God. If you're real, why on earth did you let that happen to me?"

Shortly after this his parents recorded that Paul reported hearing screaming in his head, seeing distortions of the faces of people he interacted with, and behaving violently at home. When Paul was 7, a pediatrician also noted these symptoms, which, when he was 8½, were called “hallucinatory episodes” and, together with the behavioral disturbances, had become chronic. A clinical nurse specialist noted that Paul was a worrier, but when his mother mentioned the traumatic incident in hospital and her guilt about having not intervened, the significance was underplayed, and attention was directed towards her perceived over-protectiveness. When family therapy was offered to address this, she felt unjustly accused. Because of the risk of seizures, medical staff had recommended that someone familiar with his condition should always monitor Paul closely. This meant, for example, leaving the bathroom door open when he was in the bath, and checking on him while falling asleep, and while sleeping. As a result, his mother routinely fell asleep beside him and went to him whenever he awoke distressed. Later, when the frequency of seizures decreased, his parents encouraged him to fall asleep alone, but he would become fearful, and scream, sometimes until he vomited or induced an asthma attack. Paul’s mother felt confused as to how she could have avoided being protective of him in these circumstances and the family therapy was not pursued.

Aged 9, Paul was assessed over 3 days at the National Centre for Young People with Epilepsy (NCYPE), following a psychiatrist’s report of “hallucinatory episodes,” hearing people screaming in his head, and barricading himself in his room. Notes made at NCYPE described episodes lasting 5–10 minutes during which he would become fearful and aggressive, scream, and appear disorientated and unresponsive to instructions. It was thought these could be seizures, while a psychiatrist made a diagnosis of OCD and a note that there were some symptoms of Tourette’s disorder. Anticonvulsant medication was continued and cognitive behavior therapy (CBT) for OCD was recommended. Although one report indicated Paul was unable to engage with CBT because he needed a family member present, a later psychologist’s report indicated some benefit from CBT just before his tenth birthday. However, aged 10 and 11, there were regular reports of OCD, anxiety, dissociative experiences and the same disturbed behaviors. Clinicians were unclear whether he was having panic attacks or seizures or both. Soon after he turned 11, a neurologist concluded that the episodes were not epileptic and noted that although he was still having occasional “nocturnal seizures” he was doing well

academically. Nevertheless, anticonvulsant medication was continued.

Soon after Paul started secondary school, shortly before his twelfth birthday, a pediatrician noted additional disturbed behaviors. He had run away from home in his pajamas in the snow, hit himself, causing large bruises, bitten himself, kicked furniture, causing flesh wounds, and threatened to kill himself. A week later, the pediatrician noted that Paul was terrified to leave home to go to school and would freeze, leaving his parents to dress him. No one knew that behind this behavior was a belief that the teachers were killing children and disposing of their bodies—CR only identified this when she assessed him later. In addition, blood or needles caused agitation, and compulsions included straightening curtains and shutting cupboard doors.

The pediatrician questioned the diagnosis of epilepsy, made a diagnosis of severe OCD with panic attacks, recommended urgent treatment at a unit specializing in complex OCD and prescribed Risperidone, used in the treatment of adolescent schizophrenia and bipolar disorder. Funding for the specialist unit was not supported by health authorities, and Paul’s parents faced the prospect of hospitalizing him. Then, Paul grabbed a kitchen knife, pushed it against his stomach and warned anyone who made him go to school that he would “stick it in.” At this point, a friend of the family, whom CR had previously helped, recommended that they approach her.

### Guiding Framework for Treatment Planning

Treatment drew on current evidence-based approaches to OCD, PTSD, and Separation Anxiety Disorder (SAD). For OCD, treatment guidelines were drawn from the National Institute for Clinical Excellence (2005) and Waite and Williams (2009). Several CBT treatments have been shown to be effective in treating PTSD in children (Entholt & Yule, 2006). Paul was treated with CATT, an integrative protocol that draws on current evidence-based approaches and contemporary theories (Brewin & Holmes, 2003; Ehlers & Clark, 2000). Developed over the last 10 years, in partnership with children and young people with PTSD (C. Raby, 2010, Raby, 2011; S. Raby, 2010), CATT is child-centered and has much in common with the pediatric version of the Ehlers and Clark treatment that has been shown to be efficacious (Smith et al., 2007). There are 12 stages in the CATT protocol (see Figure 1). In stage 8, the traumatic episode is retold, using characters created from craft materials. In stage 9, a new character is introduced as a basis for re-scripting dysfunctional appraisals embedded

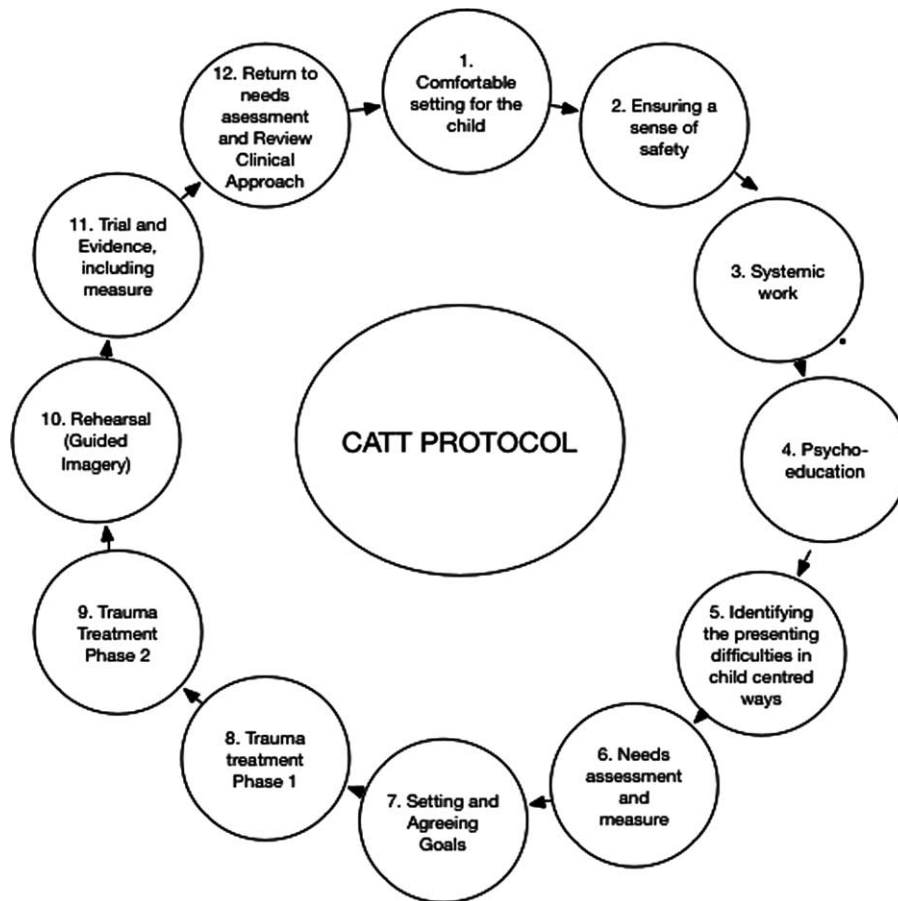


Figure 1. Summary of CATT protocol.

during the original trauma, or altering the emotional tone of the original story. This is similar to re-scripting methods used with adults with PTSD (Grey, Young, & Holmes 2002). Finally, effective treatment for SAD in children and adolescents, based on anxiety management and graded behavioral tasks, has been available for well over a decade (Kendall, Aschenbrand, & Hudson, 2003) and was used as the basis for Paul's treatment.

### Assessment, Formulation and Treatment Contract

Session A1 took place the following day at the family's home with both parents present as Paul felt unsafe leaving his mother's side. Paul was agitated, repeatedly tapping his feet, wringing his hands and picking his fingers, and was mistrustful because he felt that previous professionals had been unable to help him. Anticipating this, CR had taken care to present herself in a manner that would put him at ease. During the brief telephone conversation the previous evening, his mother had mentioned he had a new puppy. CR printed photos of her own dog to take with her, and dressed casually. When she

arrived, she sensed he felt physically threatened and made sure to keep to a distance he felt safe with, before striking up a conversation about puppies and dogs. Once he felt more at ease, Paul requested that CR sit next to him and his mother on the sofa, and CR ensured she directed all communication to Paul directly, rather than to his parents. Soon, Paul coherently communicated what he considered to be the problem. He was terrified of attending school, not because of the separation from his mother, but because he believed that the teachers were killing children and disposing of their bodies, a belief he rated at 100%. The associated anxiety disrupted his focus during class. He explained that, when a teacher asked a question, "the answers fly all around in my head and there's so much stuff spinning round I can't think of the answer." Fear of being reprimanded exacerbated his anxiety.

Despite his fears, he had done well in primary school. He had been confident, socially outgoing. He was captain of the football team and was made head boy. He had not been anxious about moving to secondary school, but a series of difficult interactions with teachers had precipitated the intensification of symptoms. He became fearful of a female teacher

who criticized his homework. His parents reported Paul's vivid and terrifying experiences of hearing voices or seeing his teachers' faces changing. They told how anxiety attacks sometimes lasted all day and, on several occasions, his urge to escape from school had been so intense that he fled, even rugby tackling teachers to the ground when their faces appeared to transform. He had withdrawn from formerly enjoyed sporting and leisure activities, including golf, rugby, football, basketball and athletics, which were all school based. Almost daily he barricaded himself in his room, and, if made to go to school, threw himself at the door, banged his head, behaved aggressively and went into a frozen state requiring bathing and dressing by his parents and restraint to get him in to the car. His distress increased on the journey and school staff had to restrain him to get him into the building.

Pushing the kitchen knife against his stomach was an act of desperation, on being forced to go to school. It was not a hopeless action. Paul wanted to feel better. Although he was getting a great deal of attention and care from family members as a result of his behavior, Paul did not seem to relish this. He felt a lack of agency and control over anything, as everyone was looking after him. Asked what life would look like if therapy was successful, he said he would wake up, go downstairs, eat breakfast, go to school without feeling worried and come home, relaxed at the end of the day. But he doubted that this would be possible. CR focused on building trust, offering a collaborative relationship in which Paul's concerns and needs would be attended to. At the end, she invited him to express any further concerns or ask for clarification of anything he did not understand. Paul made a personal commitment to working with her on addressing his difficulties by signing a contract.

Session A2 was a behavioral assessment: CR observed Paul's behavior when preparing for school. Arriving at the house, she could hear Paul in distress upstairs, and his father trying to reassure him. It took both parents some time to get him downstairs. He was in a frozen state and his mother had to dress him. Both parents worked together in a practical way, focused on getting him to school. In the car, his mother used distraction techniques, but throughout the 20 minute journey both parents repeatedly tried to reassure him with respect to his many fears. On arrival, Paul was pale and fearful. Nevertheless, he went in and both parents left quickly and confidently. The therapist was impressed that Paul had tried so hard. His mother indicated that today had been easier. On many previous occasions it had taken considerable time to get him into the building, often with the help of male staff who physically restrained

him. Then he would be crying or screaming, something she found distressing and embarrassing both for herself but also for him.

### Diagnostic questions

By now, it was clear that epilepsy was not the main problem, a conclusion already reached by the pediatrician. SAD, for which he met criteria, was also not the primary problem as Paul's mother did not appear to be overprotective and invested in promoting dependency on her. She was concerned that Paul's problems were having a negative impact on her good relationship with her husband, as well as on Joe. She had many other interests that she was keen to rekindle and had previously worked for many years for the emergency services, a job she enjoyed due to her solid and calm responses to crisis situations. She came across as an empowering parent who liked to facilitate growth and independence in her children. She responded non-defensively to CR's suggestions for behavioral changes in her responses to Paul's distress, and when, in due course, this led to improved autonomy for Paul, this was celebrated by both parents.

Paul's main problem was a specific phobia of school (school refusal) as his symptoms seemed to be entirely related his belief that the teachers were killing children and might kill him. However, school refusal is typically associated with fears related to bullying, being punished or victimized by teachers or being humiliated by poor academic performance. Another specific phobia, of needles and injections, was also reported. The belief that teachers were killing children suggested a delusional or psychotic disorder, but there were no other symptoms of psychosis. A diagnosis of OCD could also be made, based on the intrusive thoughts and images together with several compulsions (covertly repeating answers three times before responding to a question, counting the colors in the room before talking, touching the floor with both hands several times an hour, needing the cupboard shut and the curtains straight and uniform before he could sleep). There was a family history of this as Paul's father and grandfather reported difficulties with anxiety and compulsions. On the other hand, Paul's thoughts and images were not typical of the intrusions (obsessions) found in OCD and there was an absence of the sense of personal responsibility usually associated with intrusions (Salkovskis, 1985): he was afraid of being killed himself not of being responsible for killing others.

The visual and auditory images and the belief that teachers were killing children might also have been traumatic flashbacks and therefore evidence of

PTSD. There was evident hyper-arousal and avoidance, and nightmares in the past, but at this stage the therapist could find no obvious trauma and Paul could not recall any recent nightmares. There was no record of Paul having been assaulted or nearly killed or of having been exposed to such a situation vicariously and there was, as yet, limited information about the hospital trauma at age 6½. Whatever the diagnosis, Paul's anxiety episodes met criteria for panic attacks.

### **A Problem-Oriented Transdiagnostic Formulation**

A cognitive-behavioural case formulation focused on the specific problematic emotions, cognitions and behaviours described by Paul and his parents (Sim, Gwee, & Bateman, 2005; Westbrook, Kennerley, & Kirk, 2007) so that, in effect, a transdiagnostic approach (Fairburn, Cooper, & Shafran, 2003) was followed. Initially it was agreed that Paul's OCD symptoms would be targeted, and the focus was on Paul's belief that teachers were killing children. When, after a few sessions, it became evident that the main problem was PTSD related to the trauma in hospital, treatment focused on processing and integrating the trauma memory. After that the SAD was addressed.

### **Children's Rights and the Treatment Contract**

Establishing a working alliance with the child is a standard aspect of CBT (Stallard, 2005). It is strongly emphasized in the CATT protocol, which has a children's rights focus, and pays particular attention to Articles 12 and 13 of the United Nations Convention on the Rights of the Child (Hodgkin & Newell, 2008), to which the UK is a signatory. These emphasize placing children at the center of their care and involving them in decision making. Paul and his parents were given information on child protection and safeguarding written in child-friendly language, and signed a contract. It was agreed that Paul would be seen weekly for 1 hour and his parents for 45 minutes. As Paul did not want to separate from his mother, his sessions included 15 minutes during which he could send the therapist a confidential email to communicate anything he had not felt able to say with his mother present. Paul and his parents identified short, medium and long term goals, a series of graded steps towards Paul spending more time at school, more time in class and experiencing less anxiety. If at any point Paul was not progressing, or appeared to need specialist help or in-patient treatment, it was agreed that the therapist would discuss this with Paul and his parents.

## **The Course of Therapy**

### **Sessions 1–6: A Behavioral Experiment and Focus on OCD**

The central problem, Paul's belief that teachers were killing children and disposing of their bodies, was challenged through a behavioral experiment. The therapist and Paul drew up a table of what evidence they would expect to find on searching the school, if this were true. Paul agreed that this would include: at least 10 missing children over the last year, decomposing bodies of murdered children (which Paul believed might be in such places as the ceiling, behind the draft excluder), and hidden weapons used by teachers to murder children. With the school's permission, Paul agreed to conduct the search, assisted by family members, and report back at the next session. The therapist explained that, although she believed it unlikely he would find anything sinister, she would keep an open mind, and if any evidence were found, would immediately withdraw him from school and contact other authorities (such as the police). Paul seemed reassured by this and was pleased to take on this investigative role.

In T2, Paul reported that there was no evidence that teachers were killing children. However, this increased his anxiety, because he couldn't comprehend how there could be no evidence when he still felt it to be true. Reframing the fear as based on imagination rather than reality, the therapist provided psycho-education about OCD, including illustrations of how seeking reassurance can perpetuate anxiety (Waite, Gallop, & Atkinson, 2009). This motivated Paul to address the anxiety and associated compulsions using standard CBT procedures. With the help of anxiety management techniques, he agreed to remain at school each day until lunch time, in the learning support unit. He was even keen to speak to some teachers although he was still too fearful to attend classes. During T3–T6, in response to these interventions, Paul spent more time in school and his self-report measures showed that his anxiety was reducing. By T6, he was spending full days at school, and regularly speaking to most teachers. However, lessons themselves (and particular teachers) still induced high levels of fear.

### **Sessions 7–8: PTSD and CATT**

Paul's medication had been reduced and in T7 he reported repetitive nightmares. At first he refused to report the content, suggested the therapist talk to his mother, and tried to leave the room. CR encouraged him to stay and to tell her as much as possible. As he told her it was to do with needles and his time in hospital as a child, his heart rate increased significantly

and he began to sweat, appearing to be at the edge of his window of tolerance (Ogdon, Minton, & Pain, 2006). The therapist remembered the reports of needle phobia and his mother mentioned the severe distress evoked by the incident in the hospital. Along with the clear avoidance demonstrated, here was evidence that the primary diagnosis was PTSD precipitated by this episode in hospital when he was 6½. When the CRIES-8 was administered, Paul's score of 38 (Intrusions = 18; Avoidance = 20) was well above the clinical cut-off of 17 which indicates a likelihood of PTSD. The therapist discussed the implications of this with Paul, and his mother, and it was agreed that she would treat the PTSD with the CATT protocol in the following session.

In T8, Paul dramatized the events in the hospital with figures made of craft materials (see Figure 2). Using the title, 'The Injection of Death,' Paul told the story of needing an injection in hospital related to his epilepsy when he was 6. He started with a safe place, with his mother in the car on the way there. In hospital, his mother was with him, but when he wanted to ask questions about why he needed the injection and what they wanted to do, no one would explain anything to him, and he began to feel very anxious and out of control. When his mother tried to stop them holding him down, she was told to leave if she wouldn't co-operate. Staff then restrained him, and told him that if he did not do what they wanted they would kill him. The story progressed to his leaving the hospital, complaining to God in the car park, then continuing to his safe place, in the car with his mother when he knew he had survived. Hotspots identified during the initial telling of the story were: being lied to that there was nothing in his yoghurt, being held down and forcibly injected, his mother being prevented from protecting him, and

talking to God in the car park. It was clear that the hospital incident had been the source of several damaging cognitions: "If you don't do what adults in positions of authority want you to, they will try to kill you... Adults in authority cannot be trusted... Adults will try to trick you... My mother cannot protect me, so I need to look after myself." During the second retelling, only two of the hotspots were evident (his mother being told to sit down and the actual injections), and there were none during the third and fourth.

For the imagery re-processing, Paul was encouraged to write a new story introducing an imaginary character to assist him during the most difficult moments. He chose the title "Death of the Nurses." He was helped by Harry Potter, who, before the injection, asked if he had any questions, listened to his concerns and responded helpfully. Paul was then comfortable to allow Harry Potter to give him the injection because he understood why he needed it. Harry Potter blasted the nurses with his spells for not listening, for being so mean, and for hurting Paul. Then Paul progressed to his safe place with his mother. At the end, he asked if he could destroy the nurses. With the therapist's permission, he ripped them to shreds and stuffed them forcefully into a bin. Then he laughed and said that felt a lot better!

Following this, Paul and his mother confirmed that his experiences of hearing screaming had been triggered by seeing hospital equipment such as a needle trolley and a bed pan, or by pain (shutting his finger in a cupboard). Furthermore, Paul's bedroom was the same color (yellow) as the hospital room. Most probably, these had all triggered flashbacks to the original incident. He had been told, "If you don't let us inject you, we will hold you down and do it anyway," but at the time he had believed they had



Figure 2. The craft figures made by Paul: Harry Potter, Paul's mother and Paul.



said they would kill him. He could see now that no one was currently attempting to kill him, and that he had been fearful of the new teachers in case they behaved like the nurses. He recognized that it was female teachers whose faces became distorted so that they looked like those female nurses of long ago. The fact that Paul could now speak about the incident objectively and reflect on it without emotional arousal provided evidence that the memories had been effectively processed. The therapist concluded the session with further imagery in which Paul was guided to imagine himself attending school without anxiety, a process which he enjoyed.

### **Sessions T9–T16: Consolidation**

There were seven more sessions in which standard CBT methods were used to support Paul in restoring previous activities and regaining his independence. During this time his medication was rapidly reduced so that his anxiety was at times unpredictable. Therefore, it was important to sustain his anxiety monitoring and management. Initially, the therapist attended lessons with him and helped him rate his anxiety before each lesson, after 5 minutes and at the end. By the time he had attended all classes for 2 weeks, something he previously believed would be impossible, his anxiety ratings were consistently 0 or very close. Soon he was also spontaneously attending social and activity clubs. Paul had no intrusive thoughts, except when there was a big change in the routine of the day, and in such situations he could effectively employ anxiety-reducing strategies. During T15, the therapist and Paul visited the hospital ward where the trauma had occurred, and a photo was taken of him sitting next to a trolley full of needles with a nurse present. He showed no anxiety, and the therapist felt confident in phasing out her support.

### **Follow-Up and Evaluation of Treatment Outcome**

During T16 Paul reported that he was feeling “great,” sleeping well, could go to bed alone, and that the family’s stress level had reduced significantly. He had reintegrated at school with his peer group, had lots of friends, had been seeing a girlfriend for 2 months, was captain of the cricket team, and had just helped his football team win a county cup. With CR, he reviewed photographs taken during the past few weeks of himself coping well in several contexts, including the hospital photo from T15. She emphasized how these provided evidence that he could now cope in situations he would previously have found impossible. Soon after,

CR assisted Paul’s parents in organizing a party to thank Paul’s peers and extended family members for their support, and to celebrate his success. Paul enjoyed the party and several people mentioned that they could see how Paul had progressed and was now quite a different child. His father said he felt he had his “child back again,” and his mother observed, with evident gratification, that he was now an ordinary teenager.

Paul’s psychiatrist assessed him independently, and recorded that Paul no longer met criteria for PTSD, SAD or OCD. This accorded with Paul’s score of 5 on the CRIES-8. There had been no further evidence of seizures, despite significant reduction of his anticonvulsant medication.

CR wrote a letter of complaint to the local health authorities pointing out that NICE guidelines for the treatment of OCD (their primary diagnosis) had not been followed, that attempts to work in partnership had failed, and that a positive outcome had been achieved based on a revised diagnosis of PTSD. After conducting an investigation, the authorities refunded the family for the cost of the treatment with CR. They expressed delight with Paul’s progress and offered not only an apology, and a review of his medication by a newly appointed psychiatrist, but also therapeutic support for the rest of the family, if this was needed in the future.

At FU1, a meeting with Paul and his parents 3 months later, Paul’s gains had been maintained despite transition to a new academic year group. He was now off all medication, and remained free of symptoms of seizures, anxiety, OCD and PTSD. His GP and psychiatrist judged that he required no further treatment. FU2 was an informal interview after a further 3 months that confirmed that gains has been maintained.

## **Discussion and Conclusions**

### **Why was the Correct Case Formulation Missed Before?**

Since Paul had been seen by several health professionals from different disciplines over a period of 7 years, the failure to identify the PTSD cannot be attributed to lack of services or negligence since there were so many independent assessments, including several specialist ones. A range of factors seem to have confused the clinical picture. First, professionals may fail to look for traumatic events in young people’s history because only recently has it been recognized that PTSD affects a significant number of children (Pynoos et al., 2009). Previously, it had been argued that “children were largely resilient to the psychological effect of exposure to

trauma” (Smith, Perrin, Yule, & Clark, 2010, p. 8). As few as 0.4% of children aged 11–15 were diagnosed with PTSD, and hardly any below the age of 10 (Cohen & Scheeringa, 2009; Meltzer, Gatward, & Goodman, 2000). A report of a prevalence approaching 1% among children and adolescents by the National Institute of Clinical Excellence (2005) suggests there has been marked under-diagnosis in routine practice.

Second, traumatic experiences in medical settings have only recently been brought to attention as precipitants of PTSD (Colville, 2008; Colville, Kerry, & Pierce, 2008; de Jongh et al., 2008; Tedstone & Tarrier, 2003), although phobias initiated by blood/injections have long been recognized. Receiving an injection is not objectively life-threatening, so the critical incident in Paul’s case might be seen as excluding a diagnosis of PTSD. However, it was Paul’s belief that he was going to be killed that set in motion the same psychological processes as would have followed from an actual threat to life, just as, in the case described by Hackmann (2005), it was a 4-year-old girl’s belief that she had been left in hospital to die, abandoned by her family, that was the source of her subsequent panic attacks. Given the power of such appraisals, it is not surprising that “subclinical PTSD symptoms in children are commonly precipitated by a variety of low-magnitude stressors” (Copeland, Keeler, Angold & Costello, 2010). For Paul, and Hackmann’s patient, the PTSD was not subclinical.

Third, in the context of children’s medical problems, parents often become overprotective, and this can result in “problematic family functioning” (Colville, 2008, p. 613). Furthermore, children’s experience that their parents were unable to protect them, especially if accompanied by visible distress on the part of a parent such as “hearing cries of parental distress, experiencing a parent’s inability to protect, or being physically trapped” (Pynoos et al., 2009, p. 393), increases vulnerability to PTSD (see also Colville, 2008), resulting in high co-morbidity (63%) between PTSD and SAD. Cohen and Scheeringa (2009), p. 96) pertinently observe that because PTSD may be overshadowed by the more behaviorally observable comorbid symptoms of ODD (oppositional-defiant disorder) and SAD, professionals must be on alert when children present with sudden onset of new symptoms to evaluate for past traumatic events and do a thorough PTSD assessment.

Finally, in retrospect, it is probable that, although as a young child Paul had experienced epileptic seizures, he had outgrown these, and they had been replaced by psychogenic non-epileptic seizures (PNES). These are commonly precipitated

by traumatic events and patients with PNES frequently also have PTSD (Fizman, Vieira, A., Gomes Nunes, D’Andrea, & Figueira, 2004; Reuber, Howlett, & Kemp, 2005). CBT for PTSD can lead to a 50% reduction in frequency of seizures in PNES sufferers (Goldstein, Deale, Mitchell-O’Malley, Toone, & Mellers, 2004). PNES is also found in 20% of children who develop PTSD as a result of being in ICU. Hospital experiences that increase risk for this include “the sense that someone was trying to harm the patient” (Colville, 2008, p. 612). This association does not appear to be widely known: a neurologist had noted that Paul’s seizures were not epileptic, but the possibility that they were trauma-related was not raised. In addition, the epilepsy in early childhood meant that the later seizures were not initially recognized as PNES and the compulsions, separation anxiety and what appeared to be hallucinations also resulted in wrong diagnoses being regarded as primary. There was also the suppression by medication of symptoms that might have led to identifying the PTSD.

### Evidence for the Efficacy of CATT

The information summarized here provides evidence that, although Paul might have had epilepsy as a small child, the later seizures were psychogenic and caused by the trauma in hospital. His disabling symptoms were features either of PTSD and associated PNES or of complications that followed from these, and the symptoms largely resolved as a result of two sessions of trauma-focused assessment and treatment. It turned out that Paul’s distorted visual perceptions recognition involved his seeing teachers’ faces turn into the faces of the nurses from the hospital. This kind of distortion of faces in PTSD was also reported in a South African adolescent who had been raped and who saw her teacher’s face change into that of the rapist (Payne & Edwards, 2009). This suggested an explanation of why there had been an exacerbation of symptoms in his new school: at primary school he knew all the teachers well, but in secondary school, where he was the youngest child, he felt vulnerable and less in control. This lowered the threshold for triggering of trauma-related flashbacks, especially when encountering new female teachers.

The rapid remission of triggering and overgeneralized fear-laden appraisals, so characteristic of an unprocessed trauma memory, that followed the CATT intervention not only provides evidence for this formulation, but also attests to how rapidly trauma memories can be treated. As discussed above, CATT has many similarities to a cognitive therapy model for child PTSD which has been

shown to be efficacious (Smith et al., 2007). Although it is often argued that single cases cannot provide evidence for efficaciousness, this is misleading. In scientific enquiry the task is to seek an explanation for what is observed and to rule out competing explanations (Elliott, 2002). Given the detail of the narrative reconstruction of the case presented here, the variety of sources on which it is based, and the coherence of this explanation in relation to the history of Paul's symptoms and the process of treatment, the most probable explanation is that the most important contribution to change was made by the identification of the hospital trauma, the recognition that Paul had PTSD and its treatment using the CATT protocol.

This explanation is supported by the kinds of direct evidence that cases can provide, as summarized by Elliott (2002, pp. 6–7). These include “retrospective attribution” on the part of the client (Paul and his parents were quite clear that this was the critical process that brought about change), “process-outcome mapping”/“event-shift sequences” (specific events in the therapy are related to outcome both chronologically and in terms of theoretical coherence), and “early change in a stable problems” or a “slam-bang effect” (Kazdin, 1981, p. 185) In light of this evidence, other explanations, for example, in terms of spontaneous recovery, or a non-specific effect of the therapy relationship, or an extra-therapy event, are highly improbable. This does not mean that the relationship with the therapist did not play an important role. As discussed above, considerable attention was given to building a working alliance. It seems likely that this aspect, as well as other interventions employed, furnished necessary background conditions for change but it is unlikely that by themselves they would have led to resolution had not the dissociated memory of the hospital trauma been identified and addressed.

### **Implications for Evidence-Based Practice**

The evident gap between the technical literature and the working knowledge of practitioners has implications for evidence-based practice (EBP). Even though Paul's mother had a vivid memory of the hospital trauma as a very distressing incident, professionals repeatedly failed to recognize its significance. Someone familiar with the literature pointing to traumatic experiences in medical settings acting as precipitants of PTSD, and the association of PNES with trauma and PTSD, would have been likely to ask the questions which could have led to the correct clinical hypothesis in Paul's case. However, despite observing Paul's attacks of intense fear

at NCYPE, those treating him at the time failed to make these links.

The use of diagnosis as a basis for recommending treatments shown to be empirically supported by randomized controlled trials results in many problems that have been widely discussed (Dattilio et al., 2010; Wampold, Imel, & Miller, 2009; Westen, Novotny, & Thompson-Brenner, 2004). By contrast, EBP promotes an idiographic approach in which clinicians tailor treatment to individual cases, drawing on the research literature, their clinical experience and local knowledge (Midgely, 2009; Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996; Sim et al., 2005). The transdiagnostic, case formulation approach employed in the present study is consistent with this. However, even with this framework, problems of implementation on the ground are increasingly recognized (Shafran et al., 2009).

EBP is an ideal in which practitioners synthesize the latest knowledge from the research literature with their clinical experience and knowledge of contextual factors, but there are obstacles to realizing this in practice (Goodheart, 2006), as shown in this case study. With the wisdom of hindsight, it is easy to ask whether any of the professionals who assessed Paul took a thorough history. Although history taking is frequently emphasized as central to psychiatric and psychological assessment (Eells, 2007), it is time-consuming especially in complex cases, and practitioners rarely have the time to do this thoroughly. Another problem is the sheer amount of research information out there. Neither CR, when she treated the case, nor DE when he embarked on providing the methodological support for writing it up, was familiar with all the literature reviewed here. As they sourced further information and engaged with the history and case material in detail, they could develop an increasingly coherent framework for understanding what had happened to Paul.

A related problem is that practitioners' may be exposed to a limited variety of research dependent on their professional role. In the present case, however, a range of professionals, including psychologists and psychiatrists, all failed to identify the significance of the hospital trauma. Continuing professional development programs are intended to ensure that practitioners remain up to date, but the case of Paul provides evidence of the practical obstacles to achieving this; obstacles likely to be exacerbated by current economic constraints as staff in the National Health Service in the UK experience increased workload, reduced time to devote to each case, and the looming threat of job cuts. Nevertheless, developing and passing on procedural knowledge derived

from work with difficult cases is probably best done by workshop training and supervised practice.

### Children's Rights in Health Care

The focus of EBP on evidence for the effectiveness of treatments easily leads to neglect of "listening to patients and their concerns, and legitimizing their questions" (Upshur, 2005, p. 480). However, as evidence accrues that greater appreciation of and responsiveness to patient's personal needs can improve the quality of their relationships with professionals, reduce anxiety and improve health outcomes (Street & Herts, 2005), evidence-based approaches to treatment planning must include this as a factor. For children, there has been significant policy development in Britain with respect to the obligations of the United Nations Convention on the Rights of the Child (1989), but much remains to be done to implement these principles at the front line.

Paul's comfort with the intervention attests to its child-friendly nature, a feature that contrasts with what appear to have been several previous failures to pay adequate attention to the voice of the child and family. This was particularly deleterious when Paul went for the sleep EEG and led to an initial waste of resources (as the sleep EEG could not be taken), and to further expenditure because of the intense symptoms precipitated by this trauma. During the CATT treatment, it became clear that Paul's terror was based on the belief that the nurses would kill him and that his protectors (mother/ God) were unable to save him. Had the procedures been discussed with him appropriately, it seems probable that he would have accepted the injection, just as in the re-scripting he was willing to accept it from Harry Potter, once he understood why he needed it. After the nurses had forcibly seized him, the terror and loss of control generalized in a global way to future triggering situations, a central cognitive feature of PTSD (Ehlers & Clark, 2000). Later, the child and family were again ignored when they volunteered information about the hospital trauma. The result was a misdiagnosis of psychosis, and unnecessary medications being administered over a 6 year period. Attention to Paul's voice and that of the family could well have led to his getting appropriate treatment sooner.

This study supports Rushforth's (1999) view that, in addition to specialist expertise, practitioners working with children need an understanding of child development and the skills needed to work collaboratively with children of all ages. Guidelines for assessing children's competency to participate in decisions related to their care pathway are available

(NSPCC Safeguarding Information Service, 2009) that enable clinicians to allow children and their families to have their say about their experiences, their symptoms, and their ideas about recovery. Unless children and young people are deemed to be unable to be involved in decision making, attending to their voices is likely to help them receive effective treatment sooner.

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