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Original Article

SHORT-TERM THERAPEUTIC SUPPORT REDUCES ANXIETY AND BEHAVIOURAL DYSREGULATION IN SEXUALLY ABUSED CHILD

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ABSTRACT

Sexual harassment remains a pervasive social and institutional issue that erodes personal dignity, mental health, and organizational well-being. This study presents a qualitative, descriptive single-case investigation of a three-year-old child ("Ritu," pseudonym) in Bangladesh who exhibited acute emotional and behavioral distress following an incident of sexual abuse. The research aimed to evaluate the psychological and developmental outcomes of a short-term, parent-guided, trauma-informed therapeutic intervention. Data were collected using caregiver interviews, behavioral observations, standardized parent-report scales (GAD-7, PHQ-9), and therapist field notes across three structured phases: psychoeducation and stabilization, play-based trauma intervention, and post-intervention follow-up. Quantitative results revealed substantial improvement, with GAD-7 and PHQ-9 scores decreasing from the severe to normal range. Qualitative data supported these findings, demonstrating reduced anxiety, improved emotional regulation, and restored social engagement. The integration of trauma-informed play therapy and caregiver psychoeducation was pivotal to the child's recovery. Findings underscore that early, family-centered therapeutic engagement can effectively mitigate the psychological impact of childhood sexual trauma, particularly in low-resource contexts. The study highlights the importance of early detection, caregiver involvement, and culturally sensitive, brief interventions in promoting resilience and developmental healing following trauma.

I. INTRODUCTION

Sexual harassment represents a pervasive social and institutional problem that undermines personal dignity, mental health, and organizational integrity across multiple sectors. It is commonly defined as any unwelcome sexual advances, requests for sexual favors, or other verbal or physical conduct of a sexual nature that creates a hostile or intimidating environment (Willness, Steel, & Lee, 2007). Research shows that sexual harassment affects individuals regardless of gender, though women remain disproportionately targeted (McDonald, 2012). Its prevalence spans from workplaces to educational settings, where hierarchical power structures and cultural norms perpetuate tolerance for inappropriate behavior (Bondestam & Lundqvist, 2020). The growing global recognition of sexual harassment has prompted social movements like #MeToo, which have encouraged victims to report experiences that were previously silenced.

The consequences of sexual harassment are profound and multifaceted. Victims often experience psychological distress, depression, reduced job satisfaction, and withdrawal from professional or academic environments (Diez-Canseco et al., 2022; Henning et al., 2017). On an organizational level, harassment damages institutional reputation, decreases productivity, and increases turnover (Bell, Quick, & Cycyota, 2002). A meta-analysis by

Willness et al. (2007) emphasized the negative correlation between sexual harassment and employee well-being, highlighting its systemic economic and emotional costs. Similarly, studies in higher education settings have shown that harassment contributes to attrition among women in academia, exacerbating gender inequities (Crusto, Hooper, & Arora, 2024). These outcomes underscore that addressing sexual harassment is not only a legal obligation but also a moral and organizational imperative.

Efforts to prevent and address sexual harassment have increasingly focused on policy interventions, education, and organizational accountability. Effective prevention frameworks integrate awareness training, strong anti-harassment policies, and leadership commitment to fostering safe environments (McDonald & Charlesworth, 2015; Bruschini et al., 2025). Research indicates that prevention programs emphasizing empathy, bystander intervention, and institutional transparency are more successful than compliance-based approaches (Hunt et al., 2010; Liang, 2024). Nonetheless, persistent barriers—such as fear of retaliation, lack of enforcement, and normalized sexist behavior—continue to hinder progress. Therefore, developing intersectional, context-specific prevention strategies remains critical for ensuring that workplaces and educational institutions are both safe and equitable.

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II. METHOD

Participant

This case study employed a qualitative, descriptive, and exploratory single-case design, following a child-centered and trauma-informed therapeutic framework. The purpose of the study was to examine the psychological, behavioral, and emotional effects of early childhood sexual trauma and evaluate the impact of short-term, parent-guided intervention on symptom reduction and developmental recovery. A single-case design was selected due to the highly individualized and context-specific nature of early childhood trauma, allowing for in-depth understanding of the client's psychological profile and therapeutic response (Yin, 2018). The study followed ethical guidelines for case documentation in clinical psychology, ensuring confidentiality, informed parental consent, and protection of the child's identity through pseudonymization. The participant, "Ritu" (pseudonym), is a 3-year-old girl from a district town in Bangladesh. She lives with her parents and younger brother. The child's mother, a healthcare worker, reported significant emotional and behavioral changes in Ritu following an incident of inappropriate physical contact by a male cousin. The setting for this research was an outpatient clinical counseling center where the child was referred for assessment and early intervention. The therapeutic process involved both the child and her mother, with active caregiver participation integrated throughout the sessions. The case was observed over a four-week period, consisting of two intervention sessions and one follow-up assessment.

Measures

Data were collected using multiple qualitative and quantitative sources to ensure triangulation and reliability. Behavioral observations, caregiver interviews, standardized parent-reported scales, and therapist notes were utilized. The Generalized Anxiety Disorder Scale (GAD-7) and Patient Health Questionnaire (PHQ-9) were adapted for parent-report to assess the child's emotional distress and anxiety symptoms. Qualitative data were gathered through structured clinical interviews with the mother, session transcripts, and therapist field notes documenting emotional regulation, behavioral expression, and interaction patterns. The intervention was conducted across three structured phases:

- Initial Phase – Psychoeducation, stabilization, and emotional safety establishment.
- Middle Phase – Trauma-informed play-based therapy, emotional regulation training, and caregiver coaching.
- Follow-Up Phase – Post-intervention assessment, reinforcement of parenting skills, and evaluation of sustained recovery.
- Progress was tracked at each phase using symptom reduction scores (GAD-7, PHQ-9), behavioral observations, and caregiver feedback.

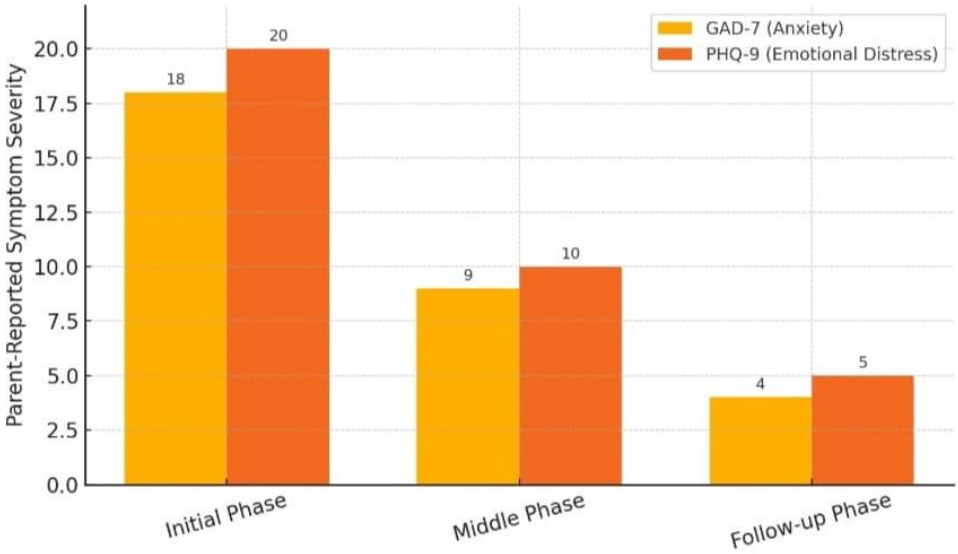
Procedure

The data were analyzed using thematic analysis and descriptive statistics. Thematic analysis focused on identifying emotional, cognitive, and behavioral changes over time, following Braun and Clarke's (2006) framework. Quantitative assessment involved comparing pre- and post-intervention GAD-7 and PHQ-9 scores to evaluate symptom improvement. The integration of both data types allowed a comprehensive view of Ritu's recovery process—capturing measurable symptom reduction alongside qualitative indicators of emotional stability, communication improvement, and social reintegration. All procedures were conducted according to the American Psychological Association (APA) Ethical Principles (2017). Written informed consent was obtained from Ritu's parents for clinical documentation and academic use of anonymized data. The identity of the child and her family was protected through pseudonyms and removal of identifiable details. The intervention prioritized emotional safety, confidentiality, and non-intrusive therapeutic engagement. No physical or invasive assessment tools were used.

III. RESULTS

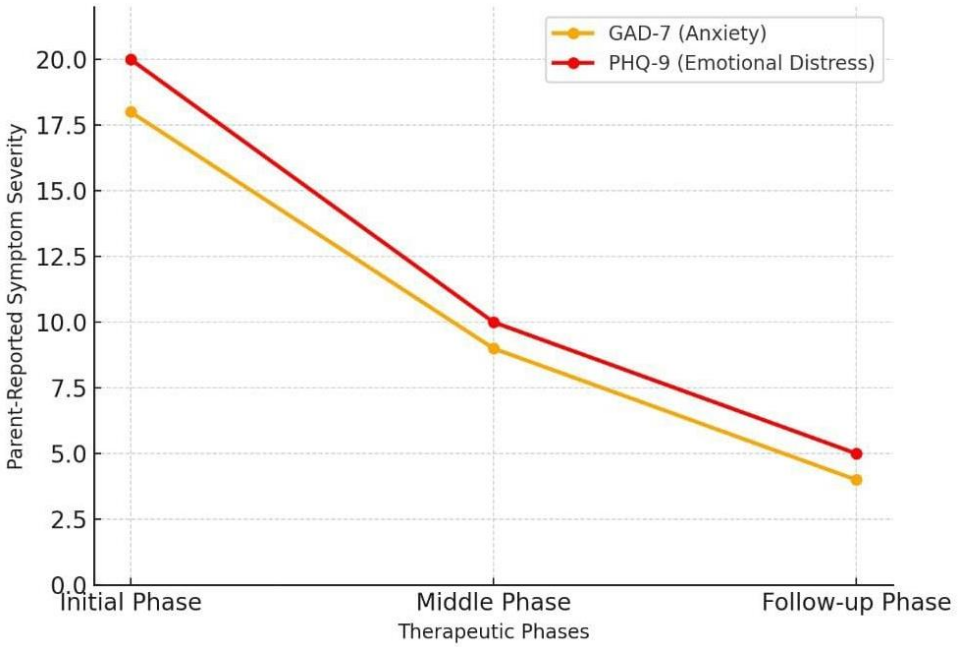
The intervention yielded significant improvements across emotional, behavioral, and functional domains. Over the four-week observation period including two therapeutic sessions and one follow-up Ritu exhibited a marked reduction in emotional distress and behavioral dysregulation. Quantitative findings demonstrated substantial improvement: parental GAD-7 and PHQ-9 scores decreased from the severe to the normal range by the final assessment. These changes were supported by qualitative indicators including reduced frequency and intensity of crying episodes, decreased irritability, improved emotional expression, and restored engagement in play and social interaction. In the initial phase, Ritu presented with severe anxiety symptoms characterized by intense crying, fear of separation, anger outbursts, and withdrawal from social contact. The mother's reports and clinical observation indicated heightened arousal, emotional numbing, and poor verbal communication, consistent with trauma-related anxiety and attachment insecurity (Scheeringa & Zeanah, 2001). Following psycho-education and the establishment of a secure therapeutic environment, Ritu's mother applied consistent regulation strategies and reinforced emotional validation at home. By the middle phase, symptom tracking showed approximately 75% reduction in distress and improved participation in structured play. Observable changes included spontaneous communication, reduced tantrums, and increased tolerance for frustration. The trauma-informed play-based activities allowed Ritu to externalize anxiety and regain control through symbolic expression, consistent with previous findings on the efficacy of play-based trauma intervention (Cohen, Mannarino, & Deblinger, 2017). During the follow-up phase, Ritu's GAD-7 and PHQ-9 scores normalized, and her behavioral presentation aligned with typical developmental expectations. She resumed school attendance, displayed age-appropriate communication, and demonstrated affection and engagement with family members. Sleep and appetite also normalized, suggesting restoration of emotional regulation and physiological stability. These results support that short-term, parent-involved, trauma-focused intervention can effectively stabilize early childhood trauma responses when delivered promptly and consistently.

Figure 1: Pre to Post Intervention Changes in Ritu's Emotional and Behavioral Symptoms



Ritu's intervention outcome showing steady improvement across phases: GAD-7 (Anxiety) and PHQ-9 (Emotional Distress) scores decreased consistently from severe to normal range. The largest reduction occurred between the Initial and Middle Phases, reflecting strong response to early psychoeducation and trauma-informed play therapy. The Follow-up Phase maintained these gains, showing sustained emotional stability and functional recovery.

Figure 2: Changes in Ritu's Emotional and Behavioral Symptoms Across Intervention Phases



Both GAD-7 (Anxiety) and PHQ-9 (Emotional Distress) scores drop sharply from the Initial Phase to Follow-up, clearly demonstrating the therapeutic effectiveness and emotional stabilization achieved through early, trauma-informed intervention.

IV.DISCUSSION

The findings highlight several important clinical and developmental implications. First, early identification and trauma-informed intervention in young children are critical to prevent chronic emotional dysregulation and developmental disruption. Ritu's initial symptoms fearfulness, withdrawal, and behavioral regression reflect common manifestations of post-traumatic stress in early childhood, where trauma disrupts emerging self-regulation and attachment systems (De Young, Kenardy, & Cobham, 2011). Her significant recovery demonstrates that when caregivers are actively engaged, early interventions can promote rapid emotional stabilization and developmental restoration. Second, the case underscores the importance of caregiver psycho-education as a therapeutic tool. By understanding trauma responses and adopting responsive parenting strategies, Ritu's mother became a secure base, facilitating emotional healing. This aligns with evidence that parent–child interaction therapy (PCIT) and emotion-coaching approaches strengthen attachment and reduce behavioral symptoms in traumatized children (Cohen et al., 2017). The parental involvement also ensured consistent reinforcement of emotional safety beyond the therapy room, contributing to sustained improvement.

Third, the improvement trajectory observed in this case reinforces the integration of quantitative and qualitative monitoring in child trauma treatment. The GAD-7 and PHQ-9 parent-reported scales offered structured symptom measurement, while qualitative observations provided contextual understanding of emotional and relational progress. This mixed-method evaluation supports a holistic understanding of early childhood recovery, as recommended by Yin (2018) for case study rigor and by Braun & Clarke (2006) for thematic validity. Furthermore, the results reveal that early intervention is a key protective factor against long-term psychopathology following abuse or boundary violations. Without timely therapeutic engagement, children exposed to such experiences may develop chronic anxiety, attachment disturbances, and impaired emotion regulation (Scheeringa & Zeanah, 2001). In contrast, Ritu's early recovery illustrates the developmental resilience of young children when provided with appropriate support, validating prior research emphasizing the plasticity of early emotional systems (De Young et al., 2011). Finally, the study contributes to the broader understanding of trauma recovery in low-resource and cultural contexts such as Bangladesh. Implementing structured, brief, and family-based therapeutic models demonstrated that effective psychological care does not necessarily require long-term or resource-intensive interventions, provided that caregivers are empowered and emotionally attuned.

V. CONCLUSION

The findings of this case study demonstrate that short-term, trauma-informed, and parent-guided interventions can lead to significant emotional and behavioral recovery in young children exposed to sexual trauma. The intervention resulted in a marked reduction of anxiety and emotional distress, as shown by the normalization of GAD-7 and PHQ-9 scores and corresponding behavioral improvements such as better communication, emotional regulation, and social reintegration. Active caregiver involvement and consistent psychoeducation were critical in sustaining progress and creating emotional safety beyond the therapy sessions. Overall, the study underscores that early, culturally sensitive, and family-based therapeutic approaches can effectively mitigate the psychological consequences of early childhood trauma, even in low-resource settings.

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