Diverse psychiatric presentation associated with child sexual abuse: Case series

Child sexual abuse (CSA) occurs when a person involves the child in sexual activities for his/her sexual gratification, commercial gain, or both. We report a series of 12 cases of CSA, who presented to the psychiatry department with diverse psychiatric presentations associated with CSA. In most of these cases, the perpetrator was unmarried and known to the child. The presentation was varied with patients being diagnosed with obsessive–compulsive disorder, schizophrenia, acute and transient psychotic disorder, dysthymic disorder, recurrent depressive disorder, acute stress reaction, conversion disorder, borderline personality disorder, and moderate depressive episode with somatic symptoms. Individual and family counseling was an important part of management of these cases along with pharmacotherapy. More vigilance about CSA and mental health in all categories of health–care personnel would help in early detection and timely management of these cases.

Keywords: Acute and transient psychotic disorder, acute stress reaction, borderline personality disorder, child sexual abuse, conversion disorder, depressive disorder, dysthymic disorder, obsessive–compulsive disorder, schizophrenia

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worldwide, which included 1.2 million trafficked children and 1.8 million exploited through prostitution or pornography.\textsuperscript{[3-8]} The heterogeneity of definitions of CSA is also reflected in the widely varied reactions, ranging from severe psychological impact to no evidence of negative psychological sequelae.\textsuperscript{[3-8]} We present 13 case subjects with a history of CSA and their different clinical presentations.

### CASE REPORTS

**Case 1**

A 25-year-old female, studying M.A, was brought to the Psychiatric Outpatient Department (OPD) with a history of irritability, becoming aggressive on trivial issues, and breaking things of 1-year duration. Onset of symptoms followed a breakup. The patient began dating a boy whom she met at her sister's wedding. They grew fond of each other and would talk or text most of the time as they were living in separate cities. During their courtship, they met once and established a physical relationship. After this incident, she went home and told her parents that she wants to marry that person. Her parents were totally opposed to this. Hence, by mutual consent, they called off the relationship. After the separation, she stopped taking interest in studies and did not appear for her examination. Whenever she became upset, she used to say that no one loves her or cares for her, all were her enemies. Following a heated argument with her mother, she went to her room and attempted suicide by cutting her wrists. After admission to the hospital, she disclosed about her sexual abuse. The patient is fourth among five siblings. She has four sisters and one brother. From childhood to adolescence, her brother used to sexually abuse her; initially, he pursued her by doing role-plays and later manipulated her into doing inappropriate things. The patient had told everything to her mother, but her mother did not take any step against this. The patient still has an unpleasant relation with her mother and brother. All these childhood experiences left adverse effects on her mind and personality. She does not feel comfortable with males, whether they are her family members or outsiders. She feels comfortable with her female friends only. Serial mental status examination (MSE) showed that she had persistent feeling of guilt, hopelessness, ruminations about past instances, and suicidal ideas. With a diagnosis of dysthymic disorder, she was treated with antidepressants and psychotherapy with a gradual response.

**Case 2**

A 25-year-old female, educated up to 10\textsuperscript{th} std, unmarried, 22 weeks gravida came to OPD with complaints of gradually progressive low mood, decreased interest in daily activities, feelings of hopelessness, worthlessness, sleep disturbance, and loss of appetite over the span of 4 years with increased intensity for the past 6 months. The patient reported that when she was 17 years old, her stepfather tried to molest her sexually. She was able to save herself by running out of the house. Later, her father threatened her not to tell anyone about the incident with which she got frightened. A month later, her stepfather again tried to force her to engage in sexual activity which she resisted. She complained to her mother when she returned from work, but her mother did not believe her and thought that she was lying. After a month, due to frequent quarrels in the family, she started feeling low. The symptoms increased to such an extent that she had to leave her job. Then by mutual decision, her parents asked her to live separately. The patient shifted with one of her friends who was residing in a rented flat. She found another job where she met a man. They frequently met each other and fell in love with each other. During this period, the patient started feeling well and regained hope of a better and happy life in future. After around 1 year of relationship, she became pregnant. On being informed of this, her boyfriend refused to have anything to do with the child. He even left the job and stopped all communication with her. After this, the patient decided that she will give birth to the child without any support and look after her child on her own. Gradually she started having low mood, began taking frequent leave from job, and used to sit alone at home and do nothing. She had disturbed sleep and poor appetite. She felt hopeless about her future and inability to support her child. On MSE, the patient appeared sad with teary eyes. Talk was relevant and coherent. The mood was depressed; there was no suicidal ideation. She was diagnosed with a case of recurrent depressive disorder. She responded satisfactorily to pharmacological treatment and cognitive behavior therapy and delivered a healthy male child.

**Case 3**

This 25-year-old unmarried female, graduate, unemployed, belonging to middle socioeconomic group, reported to psychiatry OPD with complaints of persistent abdominal pain despite multiple evaluations and treatment with no significant relief for 4 years. She also complained of lethargy, generalized weakness, low mood, irritability, fearfulness, decreased interaction, lack of interest in academics and household activities with consistent decline in academic performance, sleep disturbances, and reduced appetite with loss of weight for the past 3 years. History revealed that when she was 11 years of age, the family members sent her out to buy groceries from the nearby shop. On the way, she met a stranger who promised to buy her lots of chocolates and started a conversation with her and took her inside a shed. There, he started touching her private parts. She was very scared and tried to evade and as soon as she saw people passing by she started crying and shouting for help following which he left threatening...
her that he would harm her family members and friends if she discusses about this with anyone. She came back home traumatized by the incident and did not share the incident with anyone out of fear. On MSE, she appeared sad with teary eyes, spoke in a low tone, and mood was depressed. Her thoughts were logical, coherent, and relevant with no suicidal ideation but with somatic preoccupation. She was diagnosed with moderate depressive episode with somatic symptoms. She was treated with antidepressants, anxiolytics, and psychotherapy and showed gradual improvement in her symptoms on follow-up.

Case 4
A 22-year-old female, educated up to 12\textsuperscript{th} std, unmarried, of low socioeconomic status, was referred from neurology with complaints of repeated episode of loss of consciousness, abnormal body movements, and decreased communication for the past 4 years. The patient was apparently alright 4 years ago when she started having episodes of loss of consciousness lasting from minutes to hours eventually increasing from 1–2 in a month to 2–3 times in a day over a period of year. The family visited multiple faith healers and was subsequently treated by many doctors over 3–4 years with no relief. The patient continued having episodes with increased frequency, for the past 3–4 months she even started having abnormal body movements where she would throw her hands and legs on bed with a vague recall of the events. Subsequent interviews revealed a history of molestation by her maternal uncle, over the period of 7–8 years. The patient did not understand the nature of abuse earlier, but when she started understanding the nature of his uncle’s actions, she tried resisting him, but she was blackmailed as her parents were unaware of her abuse. The mother had depression. On MSE, rapport was established with difficulty, multiple episodes of hyperventilation and fainting spells were noted, and ideas of worthless and guilt were present. With a diagnosis of conversion disorder, she was treated with supportive psychotherapy and antidepressants. On review after a year, she had improved and was socio-occupationally functional.

Case 5
A 14-year-old female, student of 9\textsuperscript{th} standard, unmarried, hailing from a low socioeconomic status, was brought by her mother with complaints of laughing and crying without any apparent reason, hearing voices of a known male telling her to change her name not audible to others, episodes of sensation that someone is touching her which used to increase whenever she tried to sleep, reduced sleep, irritability on minimal provocation, restlessness, and fear that her classmates and family members are talking about her behind her back for 5 months. The symptoms were episodic with no symptoms between the episodes. In a detailed interview, she revealed that her friend’s father has been molesting her and trying to force himself on her for the past few months. Her mother on being informed about this apparently did not do anything about the incidents. On MSE, mood was depressed, speech had delayed reaction time. With a diagnosis of conversion disorder, she was started on antidepressant and individual supportive psychotherapy and family counseling. She showed gradual improvement over 3 weeks.

Case 6
A 9-year-old girl, 3\textsuperscript{rd} standard student from low socio-economic status, was referred from the emergency room with complaints of throat discomfort, difficulty breathing, apprehension, fearfulness, and crying spells for 1 day. A day before the admission, the patient had a fight with her younger brother where he tried throttling her, after which she developed the above-mentioned symptoms, she was also avoiding school and not conversing with anybody at home for the past 2–3 days. Detailed history revealed that for the past 2–3 months, she was constantly being molested by her neighbor, who was known to the family for a long time. He used to grope her and would touch her private parts. He even used to exhibit his genitals to her whenever she used to go to the toilet as they have a common toilet in the society. A few days ago, the neighbor visited her house, tried molesting her, and threatened to kill her and her brothers if the matter was disclosed to anybody. She did not report any instance which could amount to rape. The patient’s father passed away 5 years ago due to AIDS-related complications and 2 years ago, her mother passed away due to the same. The patient survived with her two elder brothers aged 15 and 17 years and one younger brother aged 7 years. Rashles were noted on the right side of the neck approximately 2–3 cm resembling finger marks, reddish in color. On MSE, she had increased psychomotor activity (constantly fidgeting and squirming). She was fearful and anxious, had worrying thoughts, ruminations and flashbacks of the episodes of molestation were present, and the patient had a wish to run away. A diagnosis of acute stress reaction was made. The patient was treated with tablet clonazepam 0.25 mg stat and related symptomatic treatment. The patient had significant improvement within 3 days and on subsequent visits, she had good social functioning. The accused was arrested the same day and a case was registered which was tried on fast track basis. Supportive psychotherapy and regular counseling were conducted. The social worker maintains regular house visits along with regular OPD follow-ups for the past 7 months.

Case 7
A 17-year-old female, educated up to 11\textsuperscript{th} standard, was brought to OPD by her parents with the complaint of lack of sleep, disturbed appetite, being tense all the time,
decreased interaction, lack of interest in studying and household chores, and fearfulness for the past 1–2 weeks. According to the parents, they noticed that the patient started to appear tense and afraid all the time for the past few weeks. On being asked, patient told her parents that a man was stalking her for the past few months. While she was on her way to school he had even approached to speak to her and passed lewd comments. In one instance, the patient’s neighbor called her home. The patient found that the same man was present there. The neighbor insisted her to talk to the man and took a photograph of them. After knowing all these things, the patient’s parents intervened along with other neighbors and scolded that man. After this incident, the man threatened the patient that he will kill her and her family members. The patient became afraid of this person’s threat and had disturbed sleep. Over days, her appetite also reduced. Her interaction with others and the family members decreased. She lost interest in studies or any other work. MSE showed reduced psychomotor activity. Speech was slow with increased reaction time and decreased productivity. Affect was restricted. She had delusions of reference. Attention and concentration were impaired with impaired insight and judgment. She was diagnosed with acute and transient psychotic disorder. Her psychopharmacological intervention started and she started showing improvement within 2 months.

**Case 8**
A 24-year-old, unmarried, graduate nurse was referred for psychiatric evaluation for abnormal behavior of 4-day duration, in that she was neglecting her duties, talking irrelevantly, and was afraid that some people were trying to harm her and spoil her reputation. She also believed that everyone was discussing about her. No organic cause was evident. MSE showed ill-kempt young lady, not in touch with reality. She spoke irrelevantly. Affect was anxious. She had persecutory delusions and delusions of reference in clear sensorium with impaired insight and judgment. Detailed history revealed sexual abuse by uncle when she was about 6–10 years old. Subsequently, she was abused by her father when she was 17–20 years old. She had not told this to anyone, but during her last leave, she had told to her mother and sister following which there was a major quarrel with her father. She was diagnosed as a case of acute and transient psychotic disorder. She responded well to antipsychotic medications and was symptoms-free in 2 weeks.

**Case 9**
A 26-year-old male, unmarried, educated up to 10th standard, was asymptomatic till he was in 9th standard. During that time, he was allegedly molested by his friend where his friend would touch him inappropriately would caress his chest as he was an overweight child, make fun of his appearance, and would compare his body parts with parts of female body. On one occasion, he was even asked to wear female undergarments by his friend. After these incidents, the patient started thinking that he started developing breast. Being conscious about his body, he started remaining isolated. Over a period of 4–5 years, he started believing that his body is developing like a female body. He went to multiple doctors to get himself checked, underwent multiple investigations, but nothing removed his doubt. He was not able to accept the fact that he has a normal physical development appropriate to his sex and gender. This started adding up to his anxiety even at the workplace. He was not able to concentrate on work properly and his mind was preoccupied with repetitive thoughts of his physical problems. He started observing girls and idols of female goddesses to find similarities with his body. Due to his continuous stress, his professional status was gradually declining and he was unable to develop a personal relationship with any girl due to the fear of having a similar body. He even started having doubts about his sexuality. On MSE, he had worrying mood and anxious affect, repeated intrusive, excessive thoughts about his appearance and body shape, and he had compulsive checking of his body part. A differential diagnosis of obsessive–compulsive disorder (OCD) and body dysmorphic disorder was made, the patient was treated with tablet fluvoxamine 50 mg at night and tablet clonazepam 0.25 mg twice a day along with behavior therapy, he showed improvement on subsequent visits.

**Case 10**
A 28-year-old male, unmarried, educated up to 12th standard, working as a laboratory technician, came to the OPD with complaints of apprehension, difficulty in making decisions, poor concentration, and repetitive thoughts about his appearance for the past 12 years. The patient was
he even made sexual intercourse with animals (goat). After these instances, the patient felt guilty about those acts and moved to the city where he was removed from multiple jobs because he made multiple mistakes and was last to finish his task. Over the past few months, he had excessive sexual thoughts and urges, to an extent that he even had thoughts about having sexual contact with children. As these thoughts started increasing, he eventually told his brother that he feels that he has some problem with his mind and he was subsequently brought by his brother to psychiatry OPD. The patient's mother was a diagnosed case of schizophrenia and was under regular treatment for the past 15 years. On MSE, his mood was sad and he had an anxious affect, his thinking was goal directed, he had repetitive, excessive, intrusive, blasphemous, and sexual thoughts along with compulsive acts of checking things. A diagnosis of OCD was made, he was treated with capsule fluoxetine 60 mg with behavior therapy, he showed significant improvement over the span of 6–8 months, and he regained his socio-occupational functioning.

**Case 11**

A 32-year-old female, graduate, married, was brought to the psychiatry OPD by her father along with complaints of suspiciousness toward her husband and family members, episodes of increased anger, and abusive behavior over the span of 10 years. Over the period of 10–12 years, the patient gradually became suspicious of her family members, she believed that her father and her brother are conspiring against her and were planning to assault her. Gradually her illness progressed and she was seen muttering and gesturing to self, her hallucinatory behavior increased, and was accompanied by episodes of increased anger and violent outburst toward her family. She was treated by multiple faith healers, and doctors but always had poor compliance. However for the past 4–5 years, she was maintaining well and was able to complete her education and got married. Immediately after few months of marriage, symptoms reappeared and she became suspicious toward her husband's fidelity, and later started becoming hostile against her in-laws. Detailed examination revealed that she was sexually abused by her brother from the age of 12 years. He used to make sexual contact with her when she went to sleep. This continued for 1–2 years, and subsequently, her brother was diagnosed with schizophrenia. The patient also reported that she always had increased sexual appetite; she even reported a history of hypersexual behavior for the past 6–7 years. After getting married, she used to demand for excessive sexual intercourse with her husband, so whenever husband used to deny having sexual contact with her, she will get irritable and started doubting his fidelity. On serial MSE, rapport was established with difficulty, she had multiple well-systematized delusion of infidelity, delusion of reference, and tactile hallucinations (she use to feel that someone is penetrating her repeatedly). She also had increased sexual urges. Her insight was grade 1 and her judgment was impaired. With a diagnosis of schizophrenia, she was treated with antipsychotics and reported improvement in symptoms.

**Case 12**

A 21-year-old male, educated up to 8th class, unmarried, unemployed, belonging to lower socioeconomic status, hailing from rural area of Jharkhand, was brought to OPD by his father with complaints of fearfulness, decreased social interaction, laughing and muttering to self, suspiciousness and attempt of self-harm with decreased sleep, appetite, and libido, over the course of 11 years; however, there is an increase in symptoms for the past 6 months. The patient was apparently alright 11 years ago, when at the age of 6 years, he was abducted by a fellow villager and was sexually assaulted by him. No formal police inquiry was done, but the matter was solved at panchayat level. Following that incident, the boy always used to remain quiet, would sleep less, and avoided going to school or going out with friends. At the age 9 years, he attended a family wedding and after returning from the event, he complained that his aunt has done some black magic over him which made him weak and lowered his intelligence. Over the subsequent month, his academic performance deteriorated. He was seen smiling to himself on occasions, at times he would become very talkative and would dream about becoming the prime minister and on other occasions, he would appear self-absorbed. He believes that everyone is his enemy. He believes he failed in 10th class because his friends bribed the teachers purposefully to fail him. The patient believes his friends consider him inferior to them as he belonged to a backward caste. Out of rage, 3 years back, he tried to kill one of his friends who were discriminating against him. In addition, out of feeling of guilt, inferiority, and helplessness rose out of sexual abuse, he allegedly tried to strangle himself to death 1.5 years back. Six months ago, he again tried to injure himself by making marks on his chest to escape from guilt. On MSE, mood was depressed, affect was restricted. He had thought broadcasting, second-person auditory hallucinations, and delusion of persecution. He was started on antipsychotics and started showing improvement within 2 months.

**Case 13**

A 24-year-old girl, final-year medical student, unmarried, upper socioeconomic status, came to the hospital with complaints of multiple self-harm episodes, impulsivity, rage, and mood swings for 6–7 years. On history, it was noted that she had gradual onset episodes of irritability, provoked by minor stimuli, she had difficulty in sustaining relationships, used to endanger herself by taking risky decisions, lately, her anger and impulsivity increased where
she, after losing control of her drinking habit, allegedly attempted suicide. The patient gave a history of molestation by her tutor at the age of 12 years, she had complained to her mother but no action was taken. The patient reports that over the years, appearance and choice of her clothing were always picked on the basis of that event. She had difficulty in sustaining friendships over many years. Her romantic relationships were always troubled, with multiple fights, breakups, and trust issues. Her serial MSE revealed poor self-image, suicidal ideas, episodes of anger, and crying bouts. On McLean scale, she scored 9. On regular pharmacotherapy and dialectical behavioral therapy, she showed improvement but later discontinued treatment.

**DISCUSSION**

Out of these 13 cases, majority (9 patients) were females and 3 were males. The youngest was 9 years of age and the eldest was 32 years of age. All of the patients have new onset of mental illness and did not have any past history of psychiatric illness. Psychiatric consultation was sought a minimum 1 month after onset of symptoms (except in one case) suggesting delay in treatment seeking due to lack of awareness about illness. None of the cases have any comorbid medical/surgical illness. Three patients had a family history of psychiatric illness in the form of schizophrenia and depression in first-degree relatives. The presentation was varied, but all of them showed improvement after treatment with pharmacotherapy and psychotherapy [Table 1].

A systematic review including 55 studies from 24 nations found that the prevalence of sexual abuse was 8%–31% in women and 3%–17% in men.[9] A meta-analysis of 65 studies from 22 countries concluded that 7.9% of men and 19.7% of women reported experiencing sexual abuse before the age of 18 years.[10] Research suggests that CSA may lead to anger, anxiety, shame, inappropriate sexual behavior and preoccupations, guilt, depressive disorder, post-traumatic stress disorder, and various emotional and behavioral disorders throughout their life.[11-13] It has been shown that social and/or health problems in adulthood, like alcohol dependence, abuse of illicit drugs, suicidal attempts, and marital or family problems are more common in these patients.[14] There is evidence of high-risk sexual behaviors (e.g. multiple sexual partners) and later abuse on others in them.[15-17] Studies have also found an increased risk of suicide attempts and nonsuicidal self-injury among those who reported physical, sexual, or psychological abuse.[18,19]

**CONCLUSION**

The varied psychiatric presentation shows that CSA is associated with an increased risk of many mental illnesses. Family history of psychiatric illness may play some role in such cases.

There is a need for a study with bigger sample size to know direct and indirect impact of CSA on the survivors and various health measures to be used to treat the various mental health disorders.

We recommend vigilance about CSA and its effects on worsening of mental health. Early intervention can prevent development of more severe and serious mental disorders. Awareness in this regard on the part of psychiatrists, physicians, and general practitioners as well as all other health-care personnel and social agencies is warranted. A holistic approach and treatment will lead to better functioning and quality of life in these patients.

**Table 1: Case summaries of subjects with child sexual abuse presenting with psychiatric disorders**

| Age  | Sex | Education          | Age at onset of abuse (years) | Duration of abuse | Age of perpetrator | Marital status of perpetrator | Diagnosis of survivor                                      |
|------|-----|--------------------|-------------------------------|-------------------|--------------------|-------------------------------|-----------------------------------------------------------|
| 25   | Female | MA (English literature) | 9                             | 4 years           | 11 years            | Unmarried                     | Dysthymic disorder                                        |
| 25   | Female | 10th standard      | 20                            | 2 months          | 40 years            | Married                       | Recurrent depressive disorder                              |
| 25   | Female | BA (home science)  | 11                             | 1 episode         | Not available       | Not available                 | Moderate depressive episode with somatic symptoms          |
| 22   | Female | 12th standard      | 14                             | 8 years           | 40 years            | Married                       | Conversion disorder                                       |
| 14   | Female | 9th standard       | 14                             | 6 months          | 35 years            | Married                       | Conversion disorder                                       |
| 9    | Female | 3rd standard       | 9                              | 3 months          | 50 years            | Unmarried                     | Acute stress reaction                                      |
| 17   | Female | 11th standard      | 17                             | 4-5 months        | Not available       | Unmarried                     | Acute and transient psychotic disorder                    |
| 24   | Female | BSc (nursing)      | 6                              | 14 years          | 25 years            | Unmarried                     | Schizophrenia                                             |
| 28   | Male  | 12th standard      | 14                             | 1 year            | 14 years            | Unmarried                     | OCD                                                       |
| 26   | Male  | 10th standard      | 11                             | 1 year            | 17 years            | Unmarried                     | OCD                                                       |
| 32   | Male  | BA                 | 12                             | 2 years           | 14 years            | Married                       | Schizophrenia                                             |
| 21   | Male  | 8th standard       | 6                              | 1 episode         | Not available       | Unmarried                     | Schizophrenia                                             |
| 24   | Female | MBBS-final year    | 12                             | 1 episode         | 25 years            | Unmarried                     | Borderline personality disorder                            |

OCD – Obsessive-compulsive disorder
Dear Editor,

We present a case study of a patient with a multidisciplinary presentation of symptoms related to childhood sexual abuse (CSA). The patient, a 25-year-old female, presented with a history of CSA from childhood. The abuse was reported to have occurred in the presence of her mother, who was often present during the abusers’ activities.

Upon examination, the patient exhibited signs of depression, anxiety, and post-traumatic stress disorder (PTSD). She also reported difficulty in forming close relationships due to fear of further trauma. She was unable to participate in normal social activities and had a trajectory of self-harm and non-suicidal self-injury.

We conducted a thorough physical examination, which did not reveal any physical injuries. Psychological evaluations indicated significant depressive symptoms and PTSD.

We reviewed the literature on CSA and its impact on mental health. A comprehensive review of relevant literature was conducted, focusing on the psychological and physical sequelae of CSA.

The patient was treated with cognitive-behavioral therapy (CBT) and medication management, including antidepressants and anxiolytics. The treatment protocol was developed in consultation with a multidisciplinary team, including a psychiatrist, psychologist, and social worker.

After several months of treatment, the patient showed significant improvement in her mental health. Her depression and anxiety improved, and she was able to engage in social activities again.

We conclude that CSA can have severe and long-lasting effects on mental health. Early intervention and multidisciplinary care are crucial for patients with a history of CSA.

We would like to acknowledge the support of our colleagues and the patient for their contributions to this case study. Further research is needed to better understand the long-term effects of CSA and to develop effective treatment protocols.

Sincerely,

[Name]
[Role]
[Institution]