

Hidden Trauma, Visible Symptoms: A Case Series of Adult Women Presenting With Psychiatric, Somatic, and Relational Sequelae of Childhood Sexual Abuse by Close Relatives



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Abstract

Background: Childhood sexual abuse by a trusted family member is a severe developmental trauma that may remain undisclosed for years and later manifest in adulthood through depression, post-traumatic symptoms, somatic complaints, sleep disturbance, suicidal behavior, emotional dysregulation, and impaired intimate relationships. Because many survivors present with nonspecific psychiatric or somatic symptoms, the underlying trauma may remain clinically unrecognized unless actively and sensitively explored.

Case Presentations: We describe three adult women from a North Indian clinical setting who presented with diverse psychiatric and somatic symptoms and were later found to have histories of childhood sexual abuse by close male relatives. The patients were in early adulthood to mid-adulthood. Two were married and one was unmarried. Perpetrators included a biological father, brother, grandfather, and cousin. Presenting symptoms included persistent headaches, insomnia, disturbing dreams, depressive mood, panic symptoms, intrusive thoughts, memory difficulties, emotional numbness, obsessive relationship insecurity, social withdrawal, medication non-adherence, aggression, recurrent suicidal ideation, and multiple suicide attempts. Clinical formulations included post-traumatic stress disorder, complex trauma phenotype, recurrent depressive disorder, somatoform symptoms, anxiety symptoms, and borderline personality traits.

Intervention: Management included psychiatric evaluation, pharmacotherapy where indicated, suicide-risk monitoring, psychoeducation, supportive counseling, grounding techniques, cognitive restructuring, behavioral activation, journaling, family or marital psychoeducation where appropriate, and phased trauma-focused psychotherapy after stabilization.

Conclusion: Adult women with histories of childhood intra-familial sexual abuse may present with heterogeneous and seemingly unrelated symptoms, including chronic headache, insomnia, depression, suicidality, relationship insecurity, panic, and functional impairment. Sensitive trauma-informed assessment is essential in adult female patients with recurrent depression, unexplained somatic symptoms, relational instability, or self-harm risk.

Keywords: childhood sexual abuse; complex trauma; PTSD; depression; somatic symptoms; suicidality; adult women; case series; trauma-informed care.

Introduction

Childhood sexual abuse is a major public health and mental health concern. The World Health Organization defines child maltreatment as abuse and neglect occurring in individuals younger than 18 years, including sexual abuse within relationships of responsibility, trust, or power.[1] Adverse childhood experiences, including sexual abuse, neglect, household dysfunction, and violence exposure, are associated with long-term psychological, behavioral, and physical health consequences.[2,3]

The adult psychiatric consequences of childhood sexual abuse are broad. Systematic reviews and meta-analyses have associated sexual abuse with increased lifetime risk of depression, anxiety

disorders, post-traumatic stress disorder, eating disorders, sleep disturbance, substance misuse, self-harm, and suicidal behavior.[4-6] The impact may be especially severe when the perpetrator is a trusted family member because the abuse is compounded by betrayal of attachment, secrecy, fear, dependency, and often family denial or suppression of disclosure. Clinically, survivors do not always present with explicit trauma complaints. Many present with persistent headache, insomnia, medically unexplained symptoms, depressive symptoms, panic, marital conflict, unstable attachment, emotional dysregulation, or recurrent suicidal thoughts. This indirect presentation creates a diagnostic blind spot. If clinicians treat only the

surface symptom—headache, insomnia, depression, or marital insecurity—the underlying trauma-based formulation may be missed.

This case series describes three adult women with histories of childhood sexual abuse by close relatives. The aim is to describe sociodemographic variables, abuse-related contexts, adult clinical presentations, risk patterns, and brief treatment approaches, with emphasis on trauma-informed recognition in routine psychiatric practice.

Methods

This retrospective descriptive case series was based on de-identified psychiatric and counseling records of three adult female patients who presented to a private mental health service in North India. The records included clinical history, psychiatric prescriptions, counseling assessment reports, symptom formulations, risk assessments, therapeutic interventions, and follow-up progress notes.

Cases were included if they met the following criteria: adult female patient; documented history of childhood sexual abuse; abuse perpetrated by a close relative or trusted family member; presentation with psychiatric, psychological, somatic, or relational symptoms in adulthood; and availability of sufficient clinical documentation to describe presentation and treatment course.

All names, addresses, unique patient identifiers, contact numbers, exact consultation dates, and other directly identifying details were removed. Ages are presented approximately where necessary to reduce identifiability. No photographic or personally identifying material is included.

Ethics and consent:

Written informed consent for publication of de-identified clinical information was obtained from all patients.

Case Presentations

Case 1

A woman in her early twenties, married and enrolled in a professional pharmacy course, presented with severe recurrent headaches, insomnia, disturbing dreams, crying spells, anxiety, and prominent insecurity regarding her marital relationship. She reported persistent fears that her husband might be unfaithful, leading to repeated reassurance-seeking, obsessive questioning, and distress after minor relational triggers.

Her developmental and family history revealed a chronically insecure home environment, paternal infidelity, family conflict, and exposure to controlling or aggressive interpersonal dynamics. She disclosed repeated childhood sexual exploitation by her brother beginning during school years. The

disclosure was reportedly not adequately acknowledged within the family, and she experienced denial, silencing, and lack of protective response. She later entered an arranged marriage partly as an attempt to escape the abusive home environment.

The adult clinical picture included depressive mood, intrusive fears of betrayal, marital insecurity, disturbing dreams, emotional dependence, compulsive monitoring of the spouse, and difficulty distinguishing past betrayal trauma from present relational reality. Her records documented multiple prior suicidal behaviors and impulsive self-harm-related acts. Depression severity was clinically significant, with one documented Hamilton Depression Rating Scale score in the very severe range. The working clinical formulation included post-traumatic stress disorder, major depressive disorder, generalized anxiety symptoms, and high suicide-risk history.

Management focused first on safety and stabilization. Interventions included psychiatric medication, suicide-risk monitoring, psychoeducation regarding trauma responses, supportive counseling, and cognitive restructuring. Therapy addressed the projection of earlier betrayal trauma onto the current marital relationship, reduction of reassurance-seeking, differentiation of past and present threat cues, and strengthening of academic and personal identity outside the trauma narrative. Marital psychoeducation was introduced after partial stabilization to improve communication and reduce conflict escalation.

Case 2

A woman in her mid-thirties, married and mother of two children, presented with persistent headache, insomnia, depressed mood, emotional numbness, hopelessness, social withdrawal, loss of motivation, and recurrent suicidal ideation. Her symptoms were initially somatic and depressive in appearance but were embedded in a long-standing developmental trauma history.

Her early childhood was marked by the death of her mother, paternal alcohol use, caregiving disruption, and transfer of responsibility to extended relatives. She reported sexual abuse by her grandfather in early childhood and later sexual exploitation by a cousin during adolescence. Disclosure was reportedly suppressed or invalidated within the family. During adolescence, emotional neglect, family conflict, and lack of protective support contributed to insecure attachment and emotional deprivation.

She was married in late adolescence to a significantly older man. The marriage was described as emotionally unsafe, with poor mutual respect and domestic conflict. Later life stressors included the death of a stepbrother who had served as a major

emotional support. She had a history of three suicide attempts, including one before marriage and two during married life.

Her clinical presentation was consistent with a complex trauma phenotype: chronic somatic distress, insomnia, depressive mood, recurrent suicidal ideation, emotional emptiness, helplessness, insecure attachment, relational dysfunction, and functional withdrawal. The provisional formulation included complex post-traumatic stress disorder features, recurrent depressive disorder of moderate to severe intensity, somatoform symptoms, and significant suicidal risk.

Treatment included psychoeducation about trauma responses, normalization of survival-based symptoms, supportive counseling, medication adherence reinforcement, emotional journaling, behavioral activation, and suicide-risk monitoring. Family psychoeducation was necessary because family discouragement of psychiatric medication and treatment non-adherence were identified as important clinical risk factors. The treatment plan emphasized continuity, structured routine, supportive relational environment, and prevention of relapse into suicidal crises.

Case 3

An unmarried woman in her early twenties presented with chronic headache, sleep disturbance, overthinking, memory difficulties, panic symptoms, low mood, intrusive thoughts, emotional instability, and academic impairment. Her symptoms had begun before completion of school and were associated with progressive functional decline.

Her developmental history revealed a dysfunctional family environment and repeated childhood sexual abuse by her biological father beginning in early childhood and continuing until around puberty. Disclosure remained delayed because of fear, shame, dependency, and family secrecy. Later partial disclosure occurred within the family, but open confrontation and protective resolution were limited. She also experienced significant bereavement after the death of an elder brother in a road accident. Following the bereavement, she developed emotionally dependent attachment to a male peer; the relationship later became manipulative and contributed to further emotional turmoil. She had attempted suicide twice.

Her clinical presentation included post-traumatic symptoms, persistent depressive features, panic episodes, dissociation-like memory complaints, emotional numbing, fear of abandonment, unstable attachment, and low self-worth. The clinical formulation included chronic post-traumatic stress disorder, persistent depressive disorder, and borderline personality traits.

Treatment began with crisis management, assessment of suicidal intent, stabilization, and psychoeducation. Grounding exercises, including sensory-based techniques, were introduced for panic and intrusive distress. Supportive counseling, cognitive reframing, therapeutic writing, symbolic release exercises, mindfulness, and trauma-focused cognitive behavioral therapy were introduced gradually after stabilization. Follow-up documented improvement in emotional regulation, concentration, daily functioning, journaling, and future orientation.

Table 1. Sociodemographic and Abuse-Related Variables

Variable	Case 1	Case 2	Case 3
Approximate age	Early twenties	Mid-thirties	Early twenties
Sex	Female	Female	Female
Marital status	Married	Married	Unmarried
Children	None documented	Two children	None
Education/role	Professional student	Household/caregiving prominent	Student/young adult
Setting	Semi-urban North Indian background	Semi-urban North Indian background	Semi-urban North Indian background
Perpetrator relationship	Brother	Grandfather and cousin	Biological father
Developmental timing	Childhood/school years	Early childhood and adolescence	Early childhood to around puberty
Disclosure pattern	Denial/silencing reported	Suppression/invalidation reported	Delayed disclosure and secrecy
Major family adversity	Paternal infidelity, coercive family dynamics	Maternal death, paternal alcohol use, emotional neglect, forced marriage	Dysfunctional family environment, brother's death

Variable	Case 1	Case 2	Case 3
Adult relational issue	Marital insecurity, fear of infidelity, reassurance-seeking	Emotionally unsafe marriage, domestic conflict	Emotionally dependent and manipulative romantic relationship
Suicidality	Multiple attempts/self-harm behaviors	prior Three suicide attempts, recurrent ideation	Two suicide attempts

Table 2. Adult Clinical Presentations Across Cases
Manifestations observed

Clinical domain	Manifestations observed
Somatic symptoms	Persistent headache, migraine-like complaints, fatigue
Sleep symptoms	Insomnia, disturbing dreams, poor sleep continuity
Mood symptoms	Depression, crying spells, hopelessness, emotional numbness
Anxiety symptoms	Hypervigilance, panic, overthinking, fear-based interpretation of relationships
Trauma-related symptoms	Intrusive memories, disturbing dreams, shame, betrayal-related distress
Cognitive/dissociative symptoms	Memory complaints, emotional detachment, difficulty integrating traumatic memories
Relational symptoms	Fear of abandonment, fear of betrayal, marital insecurity, reassurance-seeking, emotional dependency
Behavioral symptoms	Social withdrawal, medication non-adherence, impulsive self-harm, aggression
Suicide risk	Recurrent suicidal ideation and multiple suicide attempts
Functional impairment	Academic impairment, reduced daily functioning, reduced motivation, impaired household or interpersonal roles

Discussion

This case series illustrates the heterogeneous adult presentations of childhood sexual abuse by close relatives. The most important clinical finding is that none of the patients presented solely with a straightforward trauma complaint. Instead, trauma was expressed through a mixture of somatic, affective, cognitive, interpersonal, and behavioral symptoms.

All three patients reported persistent headache. This is clinically significant because somatic symptoms may become the presenting doorway to psychiatric care. The association between childhood trauma and adult somatic symptoms has been described in prior literature, although symptom patterns vary and mechanisms may include chronic hyperarousal, affect dysregulation, altered stress physiology, pain sensitization, and maladaptive coping.[7,8] In resource-limited or stigma-sensitive settings, somatic symptoms may be more acceptable to report than sexual trauma, depression, or suicidal ideation. Depression and suicidality were central across all cases. Each patient had suicidal ideation or prior suicide attempts. This pattern is consistent with literature linking childhood maltreatment and sexual abuse with increased suicidal behavior.[5,6] In clinical practice, this means that suicide-risk assessment in trauma survivors must go beyond current intent. It should include prior attempts, impulsivity, access to means, family invalidation,

treatment non-adherence, relational triggers, and the patient’s capacity to seek help during emotional flooding.

The intra-familial nature of the abuse was another defining feature. Abuse by a father, brother, grandfather, or cousin violates not only bodily autonomy but also the child’s basic attachment system. When disclosure is denied, minimized, or suppressed, the patient may internalize shame and helplessness. This can later emerge as mistrust, compulsive reassurance-seeking, fear of abandonment, emotional dependence, and difficulty distinguishing present relational threat from past betrayal.

The cases also highlight the clinical relevance of complex trauma. Although post-traumatic stress disorder captures intrusion, avoidance, negative cognition, and arousal symptoms, many survivors of repeated childhood interpersonal trauma show broader disturbances in affect regulation, self-concept, and relationships. These features were evident in all three cases, particularly in the form of emotional dysregulation, shame, chronic interpersonal insecurity, dissociation-like symptoms, and unstable relational patterns.[9,10]

A key error in managing such patients would be to treat only the surface presentation. Treating headache without asking about trauma, treating insomnia without exploring hypervigilance, treating marital insecurity without understanding betrayal

trauma, or treating suicidal behavior without addressing developmental shame will produce partial and unstable improvement. The correct approach is phased and trauma-informed.

First, immediate safety must be established. This includes suicide-risk assessment, removal or supervision of means where appropriate, crisis planning, and involvement of safe support persons. Second, stabilization should focus on sleep, medication adherence, emotional containment, grounding, routine, and psychoeducation. Third, trauma processing should be introduced gradually only when the patient has sufficient emotional regulation and therapeutic alliance. Evidence-based approaches for trauma-related disorders include trauma-focused cognitive behavioral therapy, cognitive processing therapy, EMDR, and phase-based interventions that include affect regulation and interpersonal skills before trauma processing.[11-14]

Family or marital involvement must be selective. In these cases, spouse or family psychoeducation was potentially useful when the involved person could become a stabilizing support. However, involving family members without careful assessment can be harmful if they are invalidating, coercive, abusive, or connected to the perpetrator system. The clinician must avoid the naive assumption that "family involvement" is always therapeutic.

This series has direct relevance for psychiatric practice in culturally conservative settings. Sexual trauma may remain hidden because of shame, fear of family dishonor, dependency, lack of protection, and stigma. Therefore, clinicians should screen gently but directly when adult women present with recurrent depression, unexplained somatic complaints, insomnia, panic, repeated self-harm, unstable relationships, or severe marital insecurity.

Clinical Implications

Adult women with childhood intra-familial sexual abuse may present with indirect symptoms rather than explicit trauma disclosure. Persistent headache, insomnia, depression, panic, suicidality, marital insecurity, and emotional dysregulation should prompt sensitive trauma-informed assessment.

Disclosure response matters. Denial, silencing, and family invalidation may worsen shame, helplessness, and chronic psychopathology.

Treatment should be phased. Safety and stabilization should precede trauma processing.

Medication alone is insufficient. Pharmacotherapy may reduce depression, anxiety, sleep disturbance, and impulsivity, but trauma-informed psychotherapy and relational rehabilitation are central.

Family involvement must be cautious. Supportive family or spouse participation may help, but coercive or invalidating family systems can worsen risk.

Limitations

This case series has several limitations. The sample size is small, and the findings cannot be generalized statistically. The data were obtained retrospectively from clinical and counseling records rather than standardized research interviews. Trauma scales, structured diagnostic interviews, and longitudinal outcome measures were not uniformly available. Some sociodemographic variables, including socioeconomic status, occupational details, and detailed educational history, were incompletely documented. Because all cases were from a single clinical setting, referral and documentation bias are likely.

Despite these limitations, the series provides clinically rich evidence of a repeated pattern: childhood sexual abuse by close relatives, delayed or suppressed disclosure, somatic presentation, depression, relational disturbance, and high suicide-risk burden.

Conclusion

Childhood sexual abuse by close relatives may present in adult women through diverse and overlapping symptoms, including persistent headache, insomnia, depression, panic, intrusive thoughts, emotional numbness, relationship insecurity, dissociation-like complaints, medication non-adherence, aggression, and suicidality. The trauma may be hidden behind somatic complaints or marital distress, making routine trauma-informed assessment essential.

These cases emphasize that adult psychiatric care must look beyond the immediate symptom. In survivors of intra-familial childhood sexual abuse, treatment should combine safety planning, pharmacotherapy where indicated, psychoeducation, supportive counseling, grounding, cognitive restructuring, family or marital psychoeducation when safe, and phased trauma-focused psychotherapy.

Conflicts of Interest

The authors declare no conflicts of interest.

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