CASE REPORT

Managing Abnormal Sexual Behaviours in an Adolescent Survivor of Chronic Childhood Abuse: A Multidisciplinary Approach

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ABSTRACT

Childhood sexual abuse (CSA) is a pervasive global issue with significant psychological, behavioural, and developmental consequences, particularly in vulnerable populations such as individuals with intellectual disabilities. This case report describes a girl in her middle adolescence who presented with abnormal sexual behaviours and a history of severe, prolonged CSA perpetrated by close family members. Her behaviours, including hypersexuality, aggression, and inappropriate interactions with animals, reflect the profound impact of trauma compounded by cognitive limitations. The patient was diagnosed with post-traumatic stress disorder (PTSD), intellectual disability, and sexual behaviour disorder. She was managed with a multidisciplinary approach, including pharmacotherapy (sertraline and risperidone), trauma-focused interventions, and safeguarding through social services. This case underscores the necessity of early detection, culturally sensitive and trauma-informed care, and tailored interventions for CSA survivors with intellectual disabilities. It highlights the complex interplay of trauma, cognition, and behaviour, emphasising the importance of a coordinated, ethical, and holistic approach to care.
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INTRODUCTION

Childhood sexual abuse (CSA) is alarmingly prevalent worldwide, with sustained abuse placing survivors at heightened risk for a variety of psychiatric and behavioural sequelae [1]. In CSA, particularly when perpetrated by family members, it often engenders profound trauma that can disrupt the normative development of self-regulation, interpersonal boundaries, and healthy attachment styles. Over time, survivors may reenact their traumas or develop maladaptive coping strategies [2].

Among adolescents, comorbid intellectual disability amplifies the complexities of treatment. Limited cognitive and adaptive functioning may impede their capacity to verbalise distress, understand social rules, and internalise therapeutic interventions [3]. Consequently, these adolescents can pose unique clinical and ethical challenges to mental health providers, social services, and caregivers. The case discussed here exemplifies the intersection of sexual trauma, cognitive vulnerability, and subsequent behavioural manifestations. This report highlights the need for holistic care approaches that integrate pharmacological support, psychosocial interventions, and robust safeguarding measures by highlighting clinical and psychosocial dimensions.

CASE REPORT

A girl in her mid-adolescence (referred to here as "the patient" to preserve anonymity) presented to a Child and Adolescent Mental Health Service (CAMHS) in mid-2023 due to persistent and escalating abnormal sexual behaviours. She had previously been exposed to frequent sexual assaults beginning around the age of five, perpetrated by immediate family members (including her father and stepbrothers) and their acquaintances. A summary of the patient's developmental and clinical

timeline is provided in Fig. 1 to facilitate understanding of the chronological progression of events.

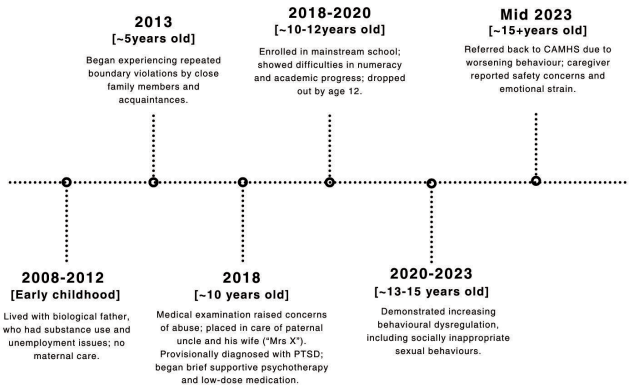

Fig 1: A summary of the patient's developmental and clinical timeline

Her early life was marked by significant familial disorganisation. Born out of wedlock, she was left in the care of her father, who struggled with drug dependence and unemployment. During childhood, she was sexually exploited at home, a situation that persisted for years before being uncovered. Following suspicions of rape discovered at a medical facility in 2018, she was temporarily placed in the care of her paternal uncle and his spouse (pseudonym: Mrs X). However, her uncle's job as a truck driver limited his availability, leaving most caregiving responsibilities to Mrs. X. In her early teens, she received a provisional diagnosis of post-traumatic stress disorder (PTSD) based on her history of repeated assaults and intrusive re-experiencing of events. There were also indications of below-average intellectual functioning, as although she was placed in a mainstream educational setting, she experienced notable difficulties in numeracy and no documentation of any academic achievement. In daily life, she was able to manage her personal hygiene, navigate digital platforms independently, and manage simple purchases, though her understanding of monetary transactions remained inconsistent. Despite initial treatment, including brief supportive psychotherapy and low-dose medication, she demonstrated an emerging pattern of socially inappropriate sexual behaviours, which intensified over time.

By the time she was re-evaluated after five years at CAMHS in 2023, her behaviours had become increasingly overt and distressing, as evidenced by her repeatedly touching male relatives' genitalia or male teachers at her school, peeping at male cousins when they were in towels, and occasionally attempt to appear nude or wear provocative attire around them. On one occasion, she was caught allowing a household cat to lick her genitals, suggesting a profound confusion about sexual boundaries. She also admitted attempting to poison her aunt, as she resented the aunt's measures to curtail her sexual urges. Socially, the adolescent had dropped out of formal education by age 12. Her aunt tried to accompany her constantly, including to local markets where the aunt sold food. However, tensions in the household escalated as the adolescent's actions caused significant distress to family members, prompting her aunt to seek help again.

Upon presentation, she appeared markedly underweight, with a body mass index (BMI) of 13.83 kg/m^2—below the third centile for her age. She displayed pronounced anxiety, often wringing her hands and avoiding eye contact. Although she wore long sleeves and a hijab (reflecting cultural expectations), her restless demeanour suggested an underlying hyperarousal or discomfort.

Given concerns about her cognitive status, a formal assessment using the Wechsler Intelligence Scale for Children-Fifth Edition (WISC-V) was conducted. Her performance revealed significant variability: i) Verbal Comprehension: extremely low (68), indicating significant challenges in language-based tasks; ii) Fluid Reasoning: low-average (82), hinting at reduced but workable abstract problem-solving skills; iii) Working Memory: within the average range (91), iv) Visual-Spatial Abilities: Within the average range (94) and v)Processing Speed: very low (77). These results underscored the uneven nature of her cognitive profile, rendering a single Full Scale IQ score less meaningful. Her poor verbal skills hindered her ability to express emotions and anxieties constructively.

During an interview, the patient demonstrated an intense preoccupation with sexual themes. When asked to complete a sentence about her father's interests, she repeatedly referenced sexual content. She acknowledged finding it challenging to inhibit impulses to touch male relatives, explaining that she often felt an overwhelming urge that she could not control.

Given her chronic trauma history, intellectual impairment, and ongoing high-risk sexual behaviours, the psychiatric team diagnosed her with (1) PTSD, (2) intellectual disability, and (3) abnormal sexual behaviours secondary to severe childhood abuse. The integrative treatment plan included sertraline 50 mg nightly for anxiety and mood regulation, and risperidone 1 mg nightly to manage impulsivity and hypersexuality. She was referred to specialised therapists experienced in child sexual abuse and intellectual disability, with an emphasis on adapting trauma-focused therapy to her cognitive abilities. Several behavioural and safety strategies were implemented both at home and through clinical follow-up to manage the patient's inappropriate sexual behaviours and reduce her vulnerability to exploitation. These included close caregiver supervision in public settings, safety measures at home to prevent elopement, and a referral for behavioural therapy with a clinical psychologist. Psychoeducation was also

provided to her caregiver, emphasising safeguarding strategies and promoting the patient's developing insight and impulse control, though contraception was not initiated at this stage. Social welfare services were informed of her situation's severity and discussed potential alternative living arrangements for closer supervision by trained professionals or foster caregivers.

DISCUSSION

Sexual behaviours in adolescents who have endured CSA often manifest as reenactments of the abuse or as an attempt to gain a sense of control [4]. In this patient's case, her early introduction and repeated exposures to sexual pleasures and acts, combined with repeated abuses by multiple perpetrators, normalised a distorted view of sexual boundaries. The resulting hypersexuality appears to be an entrenched coping mechanism, albeit a highly maladaptive one that places her and others at risk.

Her intellectual disability adds another layer of complexity. The low verbal comprehension and processing speed suggest that she struggles with higher-level reasoning, impulse control, and understanding consequences. Teicher and Samson (2016) note that neurodevelopment can be affected by chronic early trauma, potentially aggravating any pre-existing cognitive challenges [3]. Given these vulnerabilities, she requires an intensive, individualised approach to psychopharmacological and psychotherapeutic treatment. Pharmacological intervention included sertraline to address underlying anxiety and emotional instability, alongside risperidone for impulse control and sexually disinhibited behaviour—an evidence-based approach particularly relevant in trauma-exposed youth when behavioural strategies alone yield limited benefit [5]. Standard interventions for PTSD, such as trauma-focused cognitive behavioural therapy (TF-CBT), may need modifications to account for her reduced verbal skills and poor impulse modulation.

In certain cultural contexts, family members may underreport sexual abuse due to stigma or fear of social repercussions. This case underscores the difficulty faced by the aunt, who initially attempted to rationalise and manage the patient's behaviours on her own. Over time, the resulting strain led to delayed help-seeking, which may have escalated detrimental behaviours. Societal, cultural, and religious frameworks also influence how survivors of CSA are perceived and treated. Addressing the familial environment is thus essential: the patient's uncle and aunt must receive support and guidance on boundary-setting, consistent reinforcement of rules, and emotional containment.

The primary ethical concern is the patient's safety and well-being, along with the caregivers' right to protection from harm. Involving social services was essential for exploring out-of-home care and specialised residential placements to manage her behaviours better. Confidentiality must be maintained, with identifying details removed or altered in records and publications.

CONCLUSION

This case highlights the profound consequences of prolonged childhood sexual abuse on an adolescent with intellectual disability, manifesting as pervasive hypersexual and aggressive behaviours. It underscores the necessity of a trauma-informed, multidisciplinary treatment plan that includes vigilant safeguarding, pharmacological support for comorbid PTSD and severe behavioural dysregulation, and specialised psychosocial interventions. Early and proactive collaboration among mental health clinicians, social services, and supportive families is paramount to preventing further harm and guiding the patient toward a safer developmental trajectory.

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