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1 **TYPE OF ARTICLE:** Case Report

TITLE: Depression, personality disorder, substance use disorder and suicidal behavior in a young female with history of childhood sexual abuse: A case report

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Short Running Title: Young female with child sexual abuse history

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33 **ABSTRACT**

34

35 **Introduction**

36 Childhood sexual abuse is a major traumatic experience strongly linked with
37 depressive, personality, substance use disorders, and sometimes suicidal behavior
38 in later years. There is however dearth of scientific report on childhood sexual abuse
39 and suicidal behavior in Nigeria, and when reported, they are mainly findings from
40 surveys which usually lack in depth and quality of information, hence, this study.

41

42 **Case Report**

43 The present report is a case of a 19-year old female undergraduate student of a
44 Nigerian university referred for psychological assessment because of psychoactive
45 substance use and decline in academic performance. An in-depth interview was
46 conducted, while the Minnesota Multiphasic Personality Inventory – 2 Restructured
47 Form, Structured Clinical Interview for DSM IV-TR – II, adapted Alcohol and Drug
48 Involvement Scale, and DSM-5 Diagnostic Checklist for Substance Use Disorder
49 were administered for objective assessment. Our findings revealed serious
50 internalized, personality and substance use disorder relating with suicidal behavior in
51 the client. She revealed that she has been perpetually depressed and fearful since
52 her childhood and often have thoughts of dying. She explained her substance use
53 behavior as a way of escape.

54

55 **Conclusion**

56 This is a rare case of a young lady with history of repeated childhood sexual abuse
57 and now presenting with multiple psychopathologies with suicidal behavior. The case
58 illustrates the extent of psychological damage that could result from the trauma of
59 childhood sexual abuse.

60

61 **Keywords:** suicidal behavior, personality disorder, substance use disorder,
62 childhood sexual abuse.

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66 **INTRODUCTION**

67 Childhood sexual abuse (CSA) includes sexual contact that is accomplished by force
68 or threat of force, regardless of the age of the participants, and all sexual contact
69 between an adult and a child, regardless of whether there is deception or the child
70 understands the sexual nature of the activity. Audage [1], further asserted that any
71 sexual behavior involving two children whereby there is a significant difference in
72 their age, development, or size, and the younger child does not have capacity for
73 giving informed consent constitute child sexual abuse. Unfortunately, many cases of
74 child sexual abuse may remain undetected especially in situations where there is no
75 encouraging environment for the child to disclose the negative and traumatic event
76 [2].

77 Previous studies have shown that individuals with history of CSA exhibit a broad
78 range of psychological problems including suicidal behavior especially during
79 adolescence and young adulthood. Keyes, Eaton, Krueger et al [3] reported that
80 childhood sexual abuse increases the risk of mood disorders, anxiety disorders,
81 alcohol use disorders, drug use disorders, disruptive behavior disorders, antisocial
82 behavior, and psychosis. In a similar vein it has been shown that those who reported
83 childhood sexual abuse were more likely to be diagnosed with depression, conduct
84 and panic disorders or alcoholism, as well as being more likely to report suicidal
85 ideation and having a history of at least one suicide attempt [4], [5].

86 Apart from developing emotional problems, individuals with history of CSA have also
87 been found to exhibit difficulties in interpersonal relationship [6], [7]. Personality
88 disorder is another notable psychological problem that has been strongly associated
89 with history of childhood sexual abuse [8], [9]. Positive relationship has been
90 established between childhood sexual abuse and antisocial personality disorder [10],
91 and borderline personality disorder [11].

92 Over the years however, the most devastating outcome of childhood sexual abuse
93 has been suicidal behavior in the later future. Suicidal behavior as a general
94 construct usually includes suicidal thoughts/ideations, threats of suicide, non-fatal
95 suicide attempts and completed suicide attempts. It is relatively clear that childhood
96 abuse increase the risk for death by suicide [12], [13], [14], [15]. Further, Joiner et
97 al., [16] suggests that CSA might be more related to suicide deaths than any other

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98 types of abuse because victims experience more physical pain with sexual abuse
99 than with other types of abuse, such as neglect.
100 According to the World Health organization [17] no fewer than a million people die
101 annually from suicide, which represents a global mortality rate of 16 people per
102 100,000 or one death every 40 seconds. The WHO's 2012 statistics also show that
103 in 65 of every 10,000 Nigerian commit suicide annually. A more recent data
104 presented in some of the national newspaper suggests an increase in the prevalence
105 of suicidal behavior in Nigeria. For instance, Saturday Telegraph investigations (24th
106 September, 2016) reported over 62 cases of suicides between April and September
107 2016 in seven out of the 36 states of the federation sampled.
108 Reports from previous studies further suggest that female gender, adolescents and
109 young adults are at greater risk of psychological problems that are associated with
110 history of childhood sexual abuse [18].
111 However, despite great risk and consequences individuals and society face as a
112 result of conditions and complications of childhood sexual abuse and its associated
113 psychological problems including suicidal behavior, there is little empirical report of
114 the problem in Nigeria. In addition, little that is know come from surveys which
115 eventually have detailed information especially about the severity of the problem
116 overshadowed as a result of survey method of data collection. Furthermore, to our
117 knowledge, presentation of a young individual with serious co-occurring
118 psychopathologies (depression, personality disorder, substance use disorder and
119 suicidal behavior) is barely reported in the literature. Hence, the present case report.
120

121 **CASE REPORT**

122 Miss A is a 19-year-old single, undergraduate female with no prior history of
123 psychiatric treatment presented for evaluation for substance use disorder. She was
124 referred by her school counseling unit upon suspicion that she might be involved in
125 the use of psychoactive substance(s). Her urine toxicology screen was positive for
126 cannabis, and opiates which called for further substance use disorder assessment
127 and admission for detoxification.
128 On the second week of miss A's admission she had her first assessment session
129 with the clinical psychologist. This session was basically on rapport building, brief

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130 history taking and administration of a brief paper and pencil test (The BFI). The
131 session was closed with a schedule for a full assessment session after she was
132 briefed of how long the session will take and what to expect.
133 Miss A presented alone for assessment as scheduled on the following day. She was
134 appropriately dressed. She was oriented to person, place, time, and situation. She
135 was well motivated in responding to test items. She was calm and cooperative during
136 assessment, maintained good eye contact, and speaks loud and clearly. Her
137 attention and concentration during assessment was also good. Patient did not exhibit
138 any notable difficulties with expressive or receptive language during the assessment.
139 She was interviewed and administered the following psychological tests:
140 Minnesota Multiphasic Personality Inventory – 2 Restructured Form (MMPI 2 RF)
141 Structured Clinical Interview for DSM IV-TR – II (SCID II)
142 Big Five Personality Inventory (BFI)
143 DSM-5 Diagnostic Checklist for Cannabis Use Disorder
144 Draw a Person Test (DAP)
145 Family history indicated that the patient was a first-born and only female child among
146 two siblings, the family of 5 live together in a 5bedroom apartment. The patient had
147 no adverse past medical history and had never been admitted in a hospital prior to
148 the present admission.
149 When she was confronted with the findings of the objective tests she responded to,
150 and after a good level of therapeutic trust has been built, she opened up on her
151 childhood adverse events – repeated sexual abuse she experienced while growing
152 up – and the fact that no one ever knew about it except one of her friends who had
153 similar experience, she referred to the friend as the only person who has ever shown
154 to care and understand her. According to Miss A, she had been repeatedly sexually
155 abused by her 20 years old cousin since when she was 8years old. She added that
156 "the most painful thing about sexual abuse is when it happens to you at a time you
157 did not even know what was happening and any implication of it". She further said
158 that she had also been repeatedly abused by one of their close family friends who
159 happened to be a friend with her cousin. According to Miss A, she has been living
160 with the negative experience all her life and kept it to herself because her parents
161 were never available when she needed them most. She added that they (her

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162 parents) have always had a wrong idea about her, that while she has been in pain
163 and depressed all her life, they thought otherwise, and she kept wondering if it was
164 too much for her to expect that her parent should care to just know some things
165 about her life.
166 When she was interviewed on symptoms of depression, we found that the patient is
167 deeply depressed with repeated suicidal ideations. She however said that she has
168 been long depressed that she has mastered how to fake happiness. She added that
169 she wakes up every morning feeling tired and bad with the burden that she will have
170 to go about with fake smiles, this she acknowledged as a major factor to her being
171 tired of living which fuelled her two suicide attempts (as at the time of this report,
172 detail of the attempts is not known).
173 When she was asked about how she has been coping with her problem, she
174 responded that first, she said she has been so used to negative emotions all her life
175 such that she has grown to accept it as what her life is all about and therefore cannot
176 even imagine how it would be to feel otherwise. She said by the time she knew the
177 terrible things that had happened to her, instead of her speaking up about it and
178 even confront the perpetrators, her grief and pains turned her to become timid and
179 permissive. She said she started running from these guys, ensuring that their paths
180 don't cross. She referred to herself as a 'runner' who would rather find way to avoid a
181 problem if she can rather than take her stand to confront the problem. She said she
182 does not know how to say 'NO' even if she wanted to in the face of abuse.
183 Miss A started using marijuana about 2 years ago because of her sad feeling and
184 'loneliness', and to her, the drug serves a purpose of making 'get away from her
185 problems' especially for the time she is on the drug, therefore it was convenient for
186 her to continue the use despite knowing that the use attracts consequences. She
187 added that her codeine use is basically to help her sleep because of her poor sleep
188 which she has been experiencing for a long time.
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194 **Test Results**

195

196 **MMPI 2- RF Synopsis**

197 Scores on the MMPI-2-RF validity scales provides valid and interpretable protocol.
198 The test taker was able to understand and respond relevantly to the test items.
199 Furthermore, there is no evidence of fixed, content-inconsistent responding. There
200 was however a possibility of over-reporting of psychological dysfunction despite
201 evidence for credible symptoms as a result of genuine psychological difficulties.
202 Interpretations of substantive (clinical) scales were therefore applied with caution.
203 With the caution noted, scores on the substantive scales indicate significant
204 emotional, thought, behavioral, and interpersonal dysfunction. Emotional-
205 internalizing findings relate to feeling of sadness and dissatisfaction with present life
206 circumstances, as well as suicidal ideation. Dysfunctional thinking includes
207 unrealistic thinking. Behavioral-externalizing problems include history of antisocial
208 behavior and substance abuse. Interpersonal difficulties relate to non-assertive
209 communication style.

210

211 **Emotional Dysfunction**

212 Miss A. reports feeling of sadness and dissatisfaction with her current life
213 circumstances. This suggests feeling of hopelessness and pessimism about the
214 future. Her responses also indicate that she does not cope well with stress, has low
215 esteem, ruminative and feels insecure. She is also likely to be self-critical and guilt-
216 prone.

217 She further reports a history of suicidal ideation and attempts. She is likely to be
218 preoccupied with suicide and death and to be at risk for current suicidal ideation and
219 attempts. This risk is exacerbated by substance abuse.

220

221 **Interpersonal Functioning**

222 She has negative feelings about and attitude towards her family members, and
223 sometimes blames them for her difficulties. She has cynical beliefs, distrustful of
224 others and is hostile and feels alienated from others, which put her at risk of having
225 negative interpersonal experience.

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226 **SCID – II**

227 Miss A's raw scores on the SCID-II show elevation on avoidant (7/7), schizoid (6/7),
228 and borderline (9/14) personality disorder classifications.

229 **BFI**

230 • **Neuroticism:** Miss A's responses indicate a very high tendency (92.5%) to
231 experience unpleasant emotions such as anxiety, anger, or depression.
232 • **Openness:** She has a high tendency (78%) to appreciate art, adventure and
233 unusual ideas; high imaginative and curious mind.
234 • **Extraversion:** Her score shows moderate tendency (50%) to seek
235 stimulation and company of others.
236 • **Agreeableness:** A high tendency (77.8%) to be compassionate and
237 cooperative.
238 • **Conscientiousness:** She however displayed a low tendency (31.1%) to
239 show self-discipline, act dutifully, and aim for achievement.
240

241 **DSM-5 Diagnostic Checklist for Cannabis Use Disorder**

242 Miss A responded positively to 9 out of the 11 items on the DMS-5 diagnostic
243 checklist for cannabis use disorder which met the classification for severe cannabis
244 use disorder.

245 **DAP Test**

246 Analysis of the patient's drawings indicates the following: passive, non-assertive
247 orientation, low self-esteem, indicative of an insecure, withdrawn, fearful and socially
248 isolated individual.
249

250 **DIAGNOSTIC CONSIDERATIONS**

251

252 **Emotional-Internalizing Disorders**

253 Major depressive disorder
254

255 **Behavioral-Externalizing Disorders**

256 Cannabis use disorder
257

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258 **Personality Disorders**
259 Avoidant personality disorder
260
261 **TREATMENT CONSIDERATIONS**
262 Areas for Further Evaluation
263 - **Risk for suicide**
264 - May require intensive treatment for substance use disorder
265
266 **Possible Targets for Psychological Treatment**
267 - Suicide prevention
268 - Negative and unpleasant emotions
269 - Poor self-concept and non-assertive communication
270 - Poor interpersonal relationship skills
271
272 **DISCUSSION**
273 We presented the case of 19year old female with history of child sexual abuse who
274 now presents with major mood disorder, personality disorder and substance use
275 disorder. Despite experiencing agonizing repeated sexual abuse, Miss A. Has kept
276 the problem to herself for a very long time, and the problem has been undetected
277 even by significant people in her life. This is in congruent with the assertion of the
278 Victoria [2] that it is usually difficult to detect child abuse, unless an atmosphere that
279 would encourage disclosure by the victim of abuse is created.
280 The case presented is a typical case of an individual with history of repeated CSA
281 resulting in serious psychological problems including suicidal behavior in later years.
282 According to our assessment, Miss A exhibits symptoms sufficient for diagnosis of
283 major depressive disorder, avoidant personality disorder and substance (cannabis)
284 use disorder. The patient also exhibit significant difficulties in interpersonal and
285 communication skills. This case affirmed several reports that all forms of child abuse
286 leaves the affected child with long-lasting emotional scars and serious psychological
287 problems [3] which could damage the child's sense of self, the ability to build healthy
288 relationships and function at home, work or school [6]. Furthermore, Putnam [5]
289 opined that CSA often results in the child turning to alcohol or drugs to suppress the

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290 painful feelings as well as developing emotional problems like anxiety and
291 depression. Joiner et al., [16] had also earlier identified a close relationship between
292 child sexual abuse and suicidal behavior. He suggested that childhood sexual abuse
293 might be more related to suicide deaths than any other types of abuse because
294 victims experience more physical pain with sexual abuse than with other types of
295 abuse, such as neglect.
296 The present case further showed sense and feeling of helplessness and passivity
297 developed by Miss A as a result of her history of abuse. This finding was supported
298 by Howes and Espinosa [6] and Kemoli and Mavindu,[7] who also presented a case
299 of a neglected and abused child who become helpless, passive, and displayed less
300 affect to things.
301

302 **CONCLUSION**

303 Childhood sexual abuse is a major traumatic life event which leaves a grave
304 negative impact more importantly psychological (both internalizing and externalizing)
305 problems on the life of the affected individual. Notable among such psychological
306 problems are mood disorders, substance use disorders and personality disorders
307 which are identified in the case presented.
308

309 **CONFLICT OF INTEREST**

310 Authors declare no conflict of interest
311

312 **AUTHOR'S CONTRIBUTIONS**

313 Samson Femi Agberotimi
314 Group1 - Conception and design, Acquisition of data, Analysis and interpretation of
315 data
316 Group 2 - Drafting the article, Critical revision of the article
317 Group 3 - Final approval of the version to be published
318

319 Helen O. Osinowo
320 Group1 - Conception and design
321 Group 2 - Critical revision of the article

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322 Group 3 - Final approval of the version to be published
323
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