Risky sexual behavior in a female patient with complex PTSD following childhood sexual abuse

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Abstract

Risky sexual behavior in women with a history of childhood sexual abuse is often associated with prior abuse and is frequently accompanied by complex post-traumatic stress disorder (CPTSD). Despite the clinical significance of this association, detailed reports of psychotherapy for such patients are scarce. This article presents the case of a 32-year-old woman with a history of childhood sexual abuse, symptoms meeting the ICD-11 diagnostic criteria for complex PTSD, and risky sexual behavior, who underwent psychotherapy. Therapy was conducted in stages using stabilization, trauma-focused, and body-oriented techniques over 96 sessions. Change was assessed using *the International Trauma Questionnaire* (ITQ) and self-report scales. The total ITQ score decreased by 42%, the severity of shame and self-blame decreased from 8–9 to 2–3 points, and the frequency of risky sexual encounters fell to zero; the outcome was maintained over a 6-month follow-up. The case suggests that, in the presence of dissociative symptoms, sustained improvement may be associated not only with processing traumatic experiences but also with the gradual development of self-regulation skills and the capacity to establish interpersonal boundaries.

Keywords: risky sexual behavior; childhood sexual abuse; complex post-traumatic stress disorder; trauma-focused psychotherapy; dissociation; clinical case.

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Introduction

Risky sexual behavior (RSB) in women with a history of childhood sexual abuse is considered one of the possible long-term consequences of psychological trauma.

Among women who experienced sexual abuse in childhood, the risk of developing RSB is 2–3 times higher than in the general population, while the severity and persistence of RSB patterns correlate with the severity and duration of the trauma as well as with a younger age at the onset of abuse [1, 2]. Current studies link risky sexual behavior to impairments in emotion regulation, self-blame, dissociation, disturbances in body perception and awareness of personal boundaries, and the use of sexual behavior as a means of coping with the consequences of psychological trauma [3]. At the same time, the literature continues to be dominated by epidemiological studies and research focused on individual mechanisms underlying RSB, whereas detailed descriptions of structured psychotherapeutic treatment, the sequence of therapeutic decisions, and factors associated with sustained change remain considerably less common.

Clinical guidelines provide detailed recommendations for the psychotherapeutic treatment of PTSD and CPTSD [4, 5]. By contrast, psychotherapeutic approaches targeting risky sexual behavior as a distinct treatment target are considerably less well developed: existing protocols do not always take into account the effects of psychological trauma on sexual functioning, particularly the mechanisms that maintain RSB and difficulties in forming intimate relationships. Few publications describe in detail the sequence of clinical decisions, criteria for transition between stages of therapy, and factors associated with sustained change.

The aim of this article is to describe the course of psychotherapy stage by stage using measurable outcome indicators for risky sexual behavior in complex PTSD following childhood sexual abuse; to identify therapeutic factors potentially associated with sustained symptom reduction; and to describe the key therapeutic targets and their sequence in similar cases.

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Clinical case

The data are presented with the patient's informed consent. All identifying information, including names and potentially identifying details, was altered or removed. An overview timeline of key events is presented in Table 1.

The patient was a 32-year-old woman who sought therapy because she wanted to establish stable intimate relationships. At presentation, she exhibited a pattern of numerous sexual encounters with partners she barely knew, accompanied by marked dissatisfaction and a subjective sense of loss of control over her behavior.

Patient history

She was the only child in the family and was raised by both parents. She spent summers in a village with her grandparents, where from the ages of seven to thirteen she was repeatedly subjected to sexual abuse by older adolescents, including non-penetrative genital contact and oral sexual contact. After the age of 13, trips to the village ceased; however, she continued to have sexual encounters with male and female friends in the city.

At the age of 18, the patient enrolled at university, after which her sexual behavior became riskier: the number of sexual partners increased markedly, and she began engaging in group sexual encounters, often while under the influence of alcohol or drugs. When describing her experience, the patient insisted that everything had occurred by 'mutual consent', referring to an internalized belief: 'I had been promiscuous since childhood.' After graduating from university, the patient began working in her field and reported career advancement and satisfaction with her professional development.

Conceptualization

The diagnostic assessment was conducted by the author of this publication and included a clinical interview structured according to the ICD-11 diagnostic criteria, as well as the ITQ for quantitative assessment of PTSD and complex PTSD symptoms.

Based on the ICD-11 criteria, the assessment yielded a clinical presentation consistent with complex post-traumatic stress disorder (6B41)[6], including a chronic sense of threat, marked difficulties in emotion regulation, negative self-concept ('I am to blame', 'I am unworthy'), disturbances in interpersonal relationships, avoidance of triggering topics, and dissociative phenomena (episodes of detachment during sexual encounters, a sense of 'watching from the outside', and fragmented memories of the traumatic period).

The assumption that dissociation played a significant role in maintaining risky sexual behavior in this case is consistent with findings from recent systematic reviews [7]. In these reviews, dissociation is considered one of the factors that lowers psychological barriers to impulsive and risky behavior and contributes to emotion dysregulation and disturbances in interpersonal boundaries.

In this patient, dissociative reactions manifested primarily as emotional detachment during sexual contact ('a feeling that this is not happening to me'), fragmented memories of the traumatic period, and episodic derealization in triggering situations. This pattern is consistent with findings on traumatic memory following sexual abuse: memories retain vivid sensory and emotional intensity, remain fragmented, and are difficult to verbalize, which impedes their processing and integration into autobiographical memory [8].

Time	Event
Ages 7–13	Sexual abuse by older adolescents
Age 18	Marked increase in sexual encounters; establishment of a persistent RSB pattern
Age 32	Initial presentation for psychotherapy
Session 3	Acute episode of shame after a spontaneous sexual encounter with a man she barely knew
Session 12	Completion of the safety and stabilization stage
Session 20	Key insight: recognition that the experience constituted abuse
Session 22	Dissociative episode while working with a traumatic memory
Session 45	First sustained refusal of a partner's advances
Session 96	Completion of therapy; frequency of RSB reduced to zero
+ 6 months	Follow-up: outcome maintained

Table 1. **Timeline of the clinical case**

An important factor contributing to the persistence of dissociative patterns was the social response to the trauma: the patient had no experience of safely disclosing the abuse and receiving a supportive response. Systematic reviews of the influence of the social environment on the course of PTSD indicate that such a lack of support increases the risk that dissociative symptoms will become chronic [9].

Thus, dissociation served a dual function in this patient: in the acute period it was adaptive (reducing intolerable affect), whereas subsequently it became maladaptive, maintaining risky sexual behavior as a coping strategy for managing internal tension and shame. This logic informed the choice of a staged therapeutic approach: stabilization and development of self-regulation skills were prioritized before work with traumatic memories began, and body-oriented techniques were integrated to restore connection with bodily experience and awareness of personal boundaries.

In the differential diagnosis, bipolar affective disorder and substance use disorders were excluded using the structured Mini International Neuropsychiatric Interview (MINI). Features of borderline personality disorder were assessed separately during the clinical interview on the basis of the ICD-11 criteria for personality functioning (see the section 'Personality Functioning') and did not reach the diagnostic threshold. Alcohol and cannabis use were episodic and did not meet criteria for dependence; impulsive sexual patterns were regarded as consequences of trauma rather than as an independent compulsive sexual behavior disorder.

Personality functioning

- *Emotion regulation:* avoidance of traumatic experiences and dissociative reactions predominated; high levels of shame and self-blame and a tendency toward self-punishment were present.
- *Interpersonal relationships:* alternation between seeking closeness and abrupt distancing; difficulties establishing and maintaining boundaries; a tendency to repeat traumatic relational patterns.
- *Professional life:* stable employment and high productivity as a means of compensating for internal instability.
- *Sexual functioning outside RSB:* inability to experience emotional intimacy; sex was experienced as a source of personal validation or as a means of relieving tension rather than as a source of pleasure or intimacy.

Mechanisms maintaining RSB

A set of interrelated mechanisms contributed to the maintenance of risky sexual behavior:

- Cognitive — internalized guilt and the belief 'I am to blame', which helped maintain the pattern of risky sexual encounters; persistent self-blame and shame following childhood sexual abuse have been described as key barriers to trauma processing [10].
- Affective — use of sex to regulate anxiety and shame.
- Behavioral — automatic responses to triggers, difficulty refusing unwanted sexual contact, and difficulty recognizing one's own desires.
- Dissociative — emotional detachment that reduced the subjective intensity of shame.

These mechanisms formed the basis for selecting therapeutic targets: ensuring safety and stabilization, processing traumatic experiences, reducing self-blame, developing skills for emotion regulation and setting personal boundaries, and developing safer patterns of intimate relationships.

Therapeutic process and dynamics of change

Psychotherapy was conducted over two years in weekly 50-minute sessions and was organized in stages according to changes in the patient's clinical condition. Treatment effectiveness was assessed using the ITQ and self-report scales measuring the frequency of risky sexual behavior, shame, and guilt. Assessments were conducted every eight weeks; follow-up assessment was performed six months after completion of therapy.

Stage 1. Safety and stabilization (sessions 1–12)

Main goals: stabilization, reduction of anxiety, and self-regulation training. ITQ scores decreased slowly; the most notable change was a reduction in the frequency of impulsive sexual encounters (from 3–4 times per month to 0–1) by Session 8. Shame remained high; however, the patient began to discuss more frequently in therapy the situations that preceded episodes of risky behavior.

Clinical illustration 1 (session 3). The patient came to the session in a state of acute shame after a spontaneous sexual encounter with a man she barely knew. The therapist used a stabilization strategy, normalizing her emotional responses and helping her identify the trigger (fatigue and alcohol use), pause before acting impulsively, and develop a plan for similar situations.

Stage 2. Trauma processing (sessions 13–30)

Work focused on modifying dysfunctional beliefs; as traumatic memories emerged, elements of EMDR were introduced. By Session 20, the patient stated

for the first time: 'What happened in the village was abuse, and it was not my fault.' This became a turning point in therapy: self-blame decreased, and her capacity to tolerate the memories increased.

Clinical illustration 2 (session 22). While attempting to process the memory of the first episode of abuse, the patient experienced intense dissociation. The therapist discontinued further exposure and returned to grounding in bodily sensations, resourcing techniques, and metaphor-based work. This helped avoid retraumatization and preserve the patient's engagement in psychotherapy.

Stage 3. Work with beliefs (sessions 31–50)

The focus was on modifying beliefs ('I am unworthy', 'my body is an instrument') using EMDR and cognitive behavioral techniques, both of which have demonstrated efficacy in treating the consequences of childhood sexual abuse [11], together with narrative methods. Self-esteem and the capacity for emotion regulation increased gradually; the patient began to recognize her own desires and say no when necessary.

Clinical illustration 3 (session 45). The patient described a situation in which she was able to say 'no' to an insistent partner. This was emotionally difficult for her, but she did not return to her habitual pattern.

Stage 4. Self-regulation of sexual behavior (sessions 51–96)

Training focused on recognizing impulses, communicating with partners, and developing a more positive relationship with her body. The frequency of RSB decreased to zero; the patient established a stable intimate relationship in which she was able to openly communicate personal boundaries and discuss her own needs.

By the end of therapy, the total ITQ score had decreased by 42%, the frequency of RSB episodes had fallen from 3–4 per month to zero, and the level of shame and guilt had decreased from 8–9 to 2–3 points on the self-report scale. At the 6-month follow-up, the patient maintained a stable relationship, continued to report no risky sexual behavior, and retained her self-regulation skills.

The choice of therapeutic interventions was determined by the patient's current condition, level of dissociation, and readiness to work with traumatic memories. During the stabilization stage, stabilizing and body-oriented techniques predominated; during trauma processing, EMDR and cognitive techniques for modifying beliefs were used; during the integration stage, interventions focused on developing skills for setting personal boundaries and building safe intimate relationships.

Discussion

The favorable outcome in this case was probably associated less with the sequential processing of traumatic experience than with the timely recognition of dissociation and the systematic development of behavioral self-regulation strategies (pausing before acting, saying no, and discussing difficult situations with the therapist), contrary to the expectation that sustained change would require, above all, integration of traumatic memories. This pattern is consistent with findings from systematic reviews identifying dissociation as a mediator between traumatic experience and maladaptive behavioral strategies [7] and suggests that, when dissociative symptoms are pronounced and premature exposure may increase the risk of retraumatization [12], behavioral stabilization may make a therapeutic contribution comparable to trauma processing rather than serving only as a preparatory stage for it.

Analysis of this case suggests that the risk of treatment failure might have increased if trauma processing had been pursued too rapidly without sufficient emotional stabilization, if dissociative reactions had been ignored, or if insufficient attention had been paid to developing skills for asserting personal boundaries.

The case suggests a sequence of key psychotherapeutic tasks. At the first stage, stabilization of the patient's condition was the priority. As emotional disorganization decreased, the work gradually shifted toward reducing self-blame, making sense of the traumatic experience, cautiously working with traumatic memories, developing the ability to establish personal boundaries, and building more stable and safe intimate relationships. This sequence appears to have helped avoid retraumatization and support the durability of treatment gains.

Conclusions and limitations

This case illustrates the potential of staged psychotherapy for risky sexual behavior in complex PTSD. Standardized assessment methods enabled clinical changes to be tracked over the course of therapy, while follow-up assessment allowed the durability of treatment gains to be evaluated.

Several limitations should be considered when interpreting these findings. A single case does not support generalizable conclusions. The absence of standardized assessment at each stage of therapy limits the detail with which clinical change can be characterized. Follow-up was limited to six months; therefore, the long-term durability

of treatment gains requires further study. The findings need to be confirmed in studies with larger samples.

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