

Article

Complex Clinical Profile in Adult Female Survivors of Childhood Sexual Abuse: Dissociation, Psychopathology, and Somatic Comorbidity

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Abstract

Background: Childhood sexual abuse (CSA) is associated with long-term psychological and somatic consequences in adulthood. However, detailed clinical characterisations of female survivors remain limited from a public health perspective. **Methods:** This exploratory cross-sectional study was conducted in Spain (March 2022–June 2023) with 31 adult women (18–58 years) with a history of CSA. Participants were recruited through non-probabilistic sampling from clinical services and a survivors' association. Sociodemographic and clinical variables were assessed using validated instruments, including the EGS-R, SCL-90-R, DERS, DES, RSE, and PID-5-BF, administered in structured online guided sessions. Descriptive statistics, Pearson correlations, and independent samples *t*-tests were performed. **Results:** The sample reported early-onset CSA (mean age = 7.17 years), predominantly intrafamilial, repeated, and prolonged, with high rates of revictimization and low disclosure. Participants reported clinically relevant levels of post-traumatic, psychological, and dissociative symptoms. The mean DES score was 11.89 (SD = 7.75). Women reporting a current somatic illness showed significantly higher levels of post-traumatic symptoms, general psychological distress, and dissociation, together with lower self-esteem. Earlier age of CSA onset and younger current age were associated with several indicators of greater symptom severity. **Conclusions:** In this exploratory clinical sample, adult female survivors of childhood sexual abuse reported substantial psychological distress, dissociative symptoms, and frequent somatic illness. The observed associations between trauma-related variables and clinical outcomes should be interpreted cautiously and require replication in larger and more diverse samples. Nevertheless, the findings support the potential relevance of trauma-informed and multidisciplinary approaches when working with clinically vulnerable survivors of childhood sexual abuse.



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1. Introduction

Childhood sexual abuse (CSA) is regarded as one of the most severe forms of maltreatment, with a propensity to engender persistent psychological, emotional, and relational consequences that persist throughout the lifespan of the victim. It is defined as the involvement of a minor in sexual activities that are not fully comprehensible to them, for which

they are not developmentally prepared, or which violate social or legal norms and occur within a context of power asymmetry [1]. From a public health perspective, CSA represents a significant global issue, with well-documented adverse effects in adulthood [1–3].

The scientific literature consistently indicates that CSA is associated with an increased risk of a wide range of psychopathological outcomes, including depression, anxiety, post-traumatic stress disorder (PTSD), and dissociative disorders, as well as impairments in self-esteem, emotional regulation, interpersonal relationships, and overall well-being [2–4]. Recent studies were consistent with the notion that these experiences are not only linked to psychopathology but also to higher rates of physical comorbidity, poorer quality of life, and significantly increased use of healthcare and social services [3–6].

In recent decades, the notion of complex trauma has witnessed a marked escalation in its relevance. Initially described as DESNOS (Disorders of Extreme Stress Not Otherwise Specified), it refers to emotional, cognitive, and relational disturbances resulting from early, repeated, or prolonged traumatic experiences, such as CSA [7,8]. This construct was subsequently incorporated by the World Health Organization into the International Classification of Diseases (ICD-11) as complex post-traumatic stress disorder (CPTSD), thereby strengthening its clinical and empirical validity [9,10]. In adult women with a history of CSA, clinical profiles consistent with CPTSD are frequently observed. These are characterised by persistent dissociation, feelings of guilt or shame, treatment-resistant depressive symptoms, and marked difficulties in establishing stable affective relationships [11,12].

The extant epidemiological evidence indicates that female CSA survivors are at increased risk of developing mental disorders across the lifespan. This elevated risk is particularly pronounced when the abuse begins at an early age, is prolonged, or involves attachment figures [13]. Recent meta-analyses further corroborate the robust correlation between CSA and the emergence of psychopathology across diverse developmental phases, thereby reinforcing its function as a transdiagnostic risk factor [14]. Furthermore, CSA has been associated with maladaptive personality traits, emotional dysregulation, and internalising symptomatology [15,16].

In this context, research has identified dissociation and emotional dysregulation as key mechanisms in the relationship between childhood trauma and adult clinical symptomatology [15,16]. Research has suggested that dissociation is not only a frequent consequence of CSA but also a mediating process that contributes to the persistence of psychological distress and the clinical complexity of these patients [16]. Moreover, the extant literature underscores the interaction between trauma, identity, and coping processes, accentuating the heterogeneity and clinical complexity of this population [6].

In addition to the psychological consequences, CSA has been consistently associated with physical health impairments, including chronic pain, somatic disorders, and sexual health difficulties [4,5,17]. Recent studies have highlighted the mediating role of variables such as dissociation and alexithymia in the development of somatic symptoms among abuse survivors [18]. Furthermore, research has explored the relationship between trauma and sexuality in adulthood, revealing complex patterns characterised by the interaction of affect, guilt, and dissociation [19,20].

From a public health perspective, CSA represents a significant risk factor for both mental and physical illness, with substantial social and healthcare costs. Women with a history of CSA have been shown to have a higher prevalence of chronic disease, increased healthcare utilisation, and poorer quality of life [3,5]. In the Spanish context, extant studies corroborate the magnitude of this problem, whilst simultaneously emphasising its persistent invisibility and the barriers to detection and access to specialised care [21,22]. Consequently, a significant proportion of survivors do not receive adequate treatment, and existing services frequently fail to address the complexity of their clinical needs.

In this context, it is essential to provide a detailed characterisation of the clinical and psychosocial profile of adult women with a history of CSA in order to inform specific, integrated, and trauma-informed psychological interventions. The present study aims to characterise this clinical complexity and to identify associations between victimisation-related variables and symptom severity, contributing evidence relevant for clinical intervention planning and public health strategies.

The present exploratory study aimed to characterize psychological distress, dissociation, emotional regulation difficulties, personality traits, self-esteem, and somatic comorbidity in adult female survivors of childhood sexual abuse. A secondary objective was to explore potential associations between somatic illness, trauma-related variables, and psychological symptoms within this clinically vulnerable sample. Given the limited sample size, findings should be considered preliminary and hypothesis-generating rather than confirmatory.

2. Materials and Methods

A quantitative, descriptive, cross-sectional study was conducted with the objective of characterising the clinical and psychosocial profile of adult women with a history of childhood sexual abuse (CSA).

2.1. Participants, Recruitment Process and Procedure

The sample comprised 31 adult women (aged 18–58; $M = 39.42$; $SD = 10.23$) with a history of CSA, defined as non-consensual or inappropriate sexual contact with a minor by a person in a position of power or trust, occurring before the age of 16.

The inclusion criteria were as follows: the subject had to be female (in accordance with their self-declared gender identity), over the age of 18, and had to have experienced at least one instance of CSA before the age of 16.

Participants with severe neurocognitive impairment or difficulties in understanding the assessment tools were excluded from the study.

Non-probabilistic convenience sampling was employed due to the accessibility of a vulnerable clinical population. The recruitment process was conducted through specialist clinical services and in collaboration with the Association Against Child Sexual Abuse (ACASI). Participation was voluntary, and all participants provided written consent.

The data collection period spanned from March 2022 to June 2023. In the initial phase, participants were required to attend an information session via videoconference. During this session, the study was explained and informed consent was obtained.

Subsequently, the administration of the questionnaires occurred in synchronous group sessions via Zoom, with groups comprising six to eight participants. Each session was scheduled to last for approximately two hours, with a short break incorporated into the timetable.

Participants accessed the secure LimeSurvey platform individually, ensuring anonymity and confidentiality. The assessment was facilitated by means of an online survey tool from the University of Valencia. This facilitated the development of a remotely accessible questionnaire, which was capable of collecting data securely and anonymously whilst offering a high degree of flexibility to the participants. The synchronous online format was selected to facilitate participation from geographically dispersed participants while ensuring real-time professional support during completion of emotionally sensitive questionnaires. Participants completed questionnaires individually through a secure online platform and were instructed to connect from a private environment to maximize confidentiality and emotional safety.

The research team provided real-time instructions during the completion of the questionnaire. Each session was attended by two psychology professionals specialising in trauma and mental health assessment and intervention to ensure the provision of emotional support and psychological safety. Two trauma-informed psychologists remained available throughout each session to monitor emotional distress and provide immediate support if necessary. Participants could pause or discontinue participation at any time without justification and were offered referral guidance when clinically indicated.

No missing data were observed because all questionnaire items were configured as mandatory within the LimeSurvey platform before submission. Consequently, complete data were available for all analyses.

2.2. Measurements

The Rosenberg Self-Esteem Scale (RSE) [23,24]. It is a unidimensional 10-item scale that is utilised for the purpose of evaluating overall self-esteem. The scale demonstrates high internal consistency and adequate validity in a Spanish clinical population. Previous research reported excellent reliability (Cronbach's $\alpha = 0.92$).

The Symptom Checklist-90-Revised (SCL-90-R) [25,26]. It is a 90-item questionnaire designed to assess general psychological distress across nine distinct symptom dimensions: somatisation, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation and psychoticism. The responses are collected using a Likert scale, ranging from 0 to 4, with 0 representing 'no distress' and 4 representing 'extreme distress'. In its Spanish adaptation, it demonstrates good internal consistency. Previous studies have reported excellent reliability (Cronbach's $\alpha = 0.98$).

The Post-Traumatic Stress Disorder Symptom Scale (EGS-R) [27]. It is a 21-item scale that is based on the DSM-5 criteria for the assessment of post-traumatic stress disorder (PTSD). The assessment utilised a multifaceted approach, encompassing four distinct symptom clusters: re-experiencing, avoidance, negative alterations in cognition and mood, and hyperarousal. In addition to the core dimensions of post-traumatic stress disorder according to DSM-5 criteria, the EGS-R includes a specific subscale for dissociative symptoms, which assesses phenomena such as depersonalisation, derealisation and detachment from the present experience. This dimension has been included in light of its clinical relevance in samples with a history of childhood sexual abuse, in which dissociation is a frequent response to trauma and an indicator of greater psychopathological severity and complexity of the post-traumatic condition. The scale has demonstrated adequate psychometric properties and high internal consistency in adult female survivors of childhood sexual abuse (Cronbach's $\alpha = 0.91$).

The Personality Inventory for DSM-5-Brief Form (PID-5-BF) [28,29]. It is a diagnostic instrument that evaluates the presence of maladaptive personality traits, as delineated by the dimensional model of the DSM-5. The scale consists of 25 items which are grouped into five domains: negative affect, detachment, antagonism, disinhibition and psychoticism. These traits enable the characterisation of persistent styles of emotional, interpersonal and behavioural functioning. The Spanish version demonstrates adequate psychometric properties and internal consistency across clinical and community samples.

The Difficulties in Emotion Regulation Scale (DERS) [30,31]. It is a scale designed to assess difficulties in emotional regulation. It does this by evaluating six distinct dimensions: non-acceptance of emotional responses, difficulties in impulse control, lack of emotional awareness, limited access to regulation strategies, lack of emotional clarity, interference with goals periods. The inventory comprises 28 individual items. The Spanish version demonstrates adequate internal consistency. Previous studies have reported high reliability for the total scale (Cronbach's $\alpha = 0.91$).

The Dissociative Experiences Scale (DES) [32]. It is a 28-item scale that measures dissociative experiences across three main domains: dissociative amnesia, depersonalisation/derealisation and absorption. The study assesses the frequency of these experiences. This approach is of particular relevance in populations with complex trauma histories. The Spanish adaptation has demonstrated adequate psychometric properties and reliability in Spanish samples.

Ad hoc sociodemographic and clinical record. The collection of data was achieved through the utilisation of a questionnaire, the purpose of which was to gather information pertaining to the subject's sociodemographic characteristics (e.g., age, gender, etc.), the nature of any abuse endured (e.g., age at which it occurred, relationship with the abuser, frequency and duration), the physical consequences thereof, and aspects relating to family and social support. Somatic illness was defined as the presence of a physician-diagnosed chronic physical health condition reported by the participant at the time of assessment. This variable was coded dichotomously (presence versus absence of somatic illness. Reported conditions included chronic pain syndromes, fibromyalgia-related symptoms, gastrointestinal disorders, autoimmune diseases, gynecological conditions, neurological disorders, and chronic fatigue-related symptoms).

Table 1 also includes reliability information for all assessment instruments used in the study. Specifically, Cronbach's alpha coefficients from the corresponding Spanish adaptations and from previous studies conducted with similar clinical populations were incorporated whenever available. This information is presented alongside the description of each measure to facilitate interpretation of the psychometric properties of the instruments employed.

Table 1. Summary of assessment instruments used in the study.

Instrument	Construct Assessed	Score Range	Interpretation	Reliability
EGS-R	Post-traumatic stress symptoms	0–63	Higher scores indicate greater symptom severity	Cronbach's $\alpha = 0.91$
SCL-90-R	General psychopathology	0–360	Higher scores indicate greater symptom severity	Cronbach's $\alpha = 0.98$
PID-5-BF	Personality dysfunction traits	0–75	Higher scores indicate greater dysfunction	Adequate reliability reported in Spanish samples
DERS	Emotion regulation difficulties	36–180	Higher scores indicate greater dysregulation	Cronbach's $\alpha = 0.91$
DES	Dissociative symptoms	0–100	Higher scores indicate greater dissociative symptomatology	Adequate reliability reported in Spanish samples
Rosenberg Self-Esteem Scale	Self-esteem	10–40	Higher scores indicate greater self-esteem	Cronbach's $\alpha = 0.92$

2.3. Statistical Analysis

The analysis was conducted utilising IBM SPSS Statistics v.28. The normality of the variables was assessed using the Shapiro–Wilk test, which permitted the implementation of parametric tests. Although normality was assessed using the Shapiro–Wilk test, the small sample size may limit the robustness of parametric assumptions. Therefore, findings should be interpreted as exploratory.

Descriptive analyses were performed (frequencies, percentages, means and standard deviations). Pearson's correlations were utilised to analyse the associations between variables, with effect sizes interpreted as small ($r = 0.10$), moderate ($r = 0.30$), or large ($r = 0.50$).

The statistical analysis comprised the execution of Student's *t*-tests for independent samples, with the calculation of Cohen's *d* (small = 0.20; moderate = 0.50; large = 0.80). The level of significance was set at $p < 0.05$.

Given the exploratory nature of the study and the relatively small sample size, the analyses were intended to identify potential associations and group differences rather than to establish causal relationships. Therefore, findings should be interpreted with caution and considered preliminary. No correction for multiple comparisons was applied because analyses were exploratory and hypothesis-generating. Therefore, inferential findings should be considered hypothesis-generating and interpreted with caution.

2.4. Ethics and Dissemination

The study was approved by the Human Research Ethics Committee of the International University of Valencia (Ref. CEID2021_07). All procedures were conducted in accordance with the Declaration of Helsinki (latest revision). The principles of informed consent, confidentiality, data protection and the well-being of participants were adhered to. Trial registration number: ClinicalTrials.gov Identifier NCT04813224 (Date of registration: 24 March 2021; The name of the registry: Intervention Through EMDR and CBT With Women Victim of Childhood Sexual Abuse. A Randomized Controlled Trial).

3. Results

3.1. Sociodemographic Characteristics

The sample comprised 31 adult women with a mean age of 39.42 years (standard deviation 10.23 years). The majority of the subjects were Spanish nationals (90.3%), had received a university education (61.3%), were employed (71.0%) and were in a stable relationship (54.8%). 64.5% of the subjects resided with their immediate family (see Table 2).

Table 2. Sociodemographic characteristics of the sample ($n = 31$).

Variable	Category	Mean	SD
Age (years)		39.42	10.23
		n	%
Nationality	Spanish	28	90.3
	Portuguese	2	6.5
	American	1	3.2
Sexual orientation	Heterosexual	21	67.7
	Homosexual	7	22.6
	Bisexual	3	9.7
Educational level	Primary	4	12.9
	Secondary	8	25.8
	University	19	61.3
Employment status	Employed	22	71.0
	Unemployed	9	29.0
Marital status	Married/partner	17	54.8
	Single	10	32.3
	Separated/divorced	4	12.9
Living situation	Family of origin	5	16.1
	Own family nucleus	20	64.5

Table 2. Cont.

Variable	Category	Mean	SD
Annual income (€)	Friends/acquaintances	4	12.9
	Alone/with child	2	6.5
	45,000–99,999	7	22.6
	25,500–44,999	7	22.6
	16,000–25,499	5	16.1
	10,000–15,999	3	9.7
	6500–9999	7	22.6
	<6499	2	6.5

SD: standard deviation.

3.2. Characteristics of the Abuse

The mean age at which child sexual abuse (CSA) began was 7.17 years (SD = 4.02). The majority of participants (93.5%) reported having suffered multiple episodes of abuse, with 80.6% of these episodes lasting for more than a year. In 77.4% of cases, the perpetrator was a family member, with the father being the most common perpetrator (25.8%). It is noteworthy that 64.5% of the women suffered subsequent revictimisation, and only 9.7% went on to report the abuse. With regard to the support received by participants, 22.6% reported receiving support from their family, while 45.2% reported receiving support from their social network (see Table 3).

Table 3. Characteristics of childhood sexual abuse (CSA).

Variable	Category	Mean	SD
Age of onset (years)		7.17	4.02
		n	%
Abuse frequency	Single episode	2	6.5
	Several isolated episodes	4	12.9
	Repeated episodes (1–5 years)	12	38.7
	Repeated episodes (5–10 years)	5	16.1
	Repeated episodes (>10 years)	8	25.8
Relationship with perpetrator	Father	8	25.8
	Mother	2	6.5
	Sibling	5	16.1
	Uncle	3	9.7
	Cousin	3	9.7
	Other relative	2	6.5
	Known person (friend/neighbor)	7	22.6
	Stepfather	1	3.2
Reported abuse	Yes	3	9.7
Family support	Yes	7	22.6
Social support	Yes	14	45.2
Revictimization	Yes	20	64.5

Note: SD: standard deviation; CSA: childhood sexual abuse.

3.3. General Clinical Comorbidity

In terms of health history, 58.1% (n = 18) of the sample reported the presence of a current somatic illness, and 64.5% (n = 20) reported a history of psychiatric conditions.

As indicated by the data, anxiety (74.2%), depression (54.8%), post-traumatic stress symptoms (54.8%) and eating disorders (25.8%) were among the specific self-reported clinical conditions that were particularly prevalent. Furthermore, 25.8% of the subjects reported the occurrence of physical sequelae resulting from the abuse, and 74.2% of the total sample indicated that they had previously received psychological or psychiatric treatment (see Table 4).

Table 4. General clinical characteristics (n = 31).

Variable	n	%
Current somatic illness	18	58.1
Psychiatric history	20	64.5
Anxiety	23	74.2
Depression	17	54.8
Post-traumatic stress disorder (PTSD)	17	54.8
Addictive behaviors	7	22.6
Eating disorders	8	25.8
Personality disorders	6	19.4
Anxiety disorder	5	16.1
Manic episodes	2	6.5
Physical sequelae	8	25.8
Previous psychological/psychiatric treatment	23	74.2

3.4. Post-Traumatic and Psychopathological Profile

Post-traumatic stress symptoms were assessed using the EGS-R, whereas general psychopathological symptoms were evaluated using the SCL-90-R. The mean EGS-R score was 30.93 (SD = 15.53), exceeding the cut-off score of 20 proposed for identifying probable PTSD cases. However, mean group scores should not be interpreted as diagnostic prevalence estimates. The Global Severity Index on the SCL-90-R scale was found to be 147.86 (SD = 65.38), with depression (M = 26.68; SD = 10.87) and somatisation (M = 20.11; SD = 12.22) being the most prominent dimensions. Women with somatic illness also reported significantly greater symptom intensity, as reflected by higher Positive Symptom Distress Index scores ($t = 7.52$, $p < 0.001$, $d = 3.68$).

The presence of somatic illness in women with medical conditions was found to be significantly associated with elevated scores on various post-traumatic symptomatology scales, including total post-traumatic symptoms ($t = 2.91$; $p < 0.01$; $d = 1.11$), somatisation ($t = 3.92$; $p < 0.001$; $d = 1.61$), and global clinical severity ($t = 2.49$; $p < 0.05$; $d = 0.95$). These findings are presented in Table 5, which also compares the study groups. The effect sizes were substantial, though it is imperative to exercise caution when interpreting these findings, given the modest sample size. (see Table 5).

Table 5. PTSD symptoms (EGS-R) and psychopathological symptoms (SCL-90-R) according to somatic illness status.

Variable	Total Sample M (SD)	Somatic Illness YES (n = 18) M (SD)	Somatic Illness NO (n = 13) M (SD)	t	d
EGS-R (PTSD symptoms)					
Total PTSD score	30.93 (15.53)	37.31 (11.93)	21.83 (16.29)	2.91 **	1.11
Re-experiencing	6.62 (4.39)	7.69 (3.98)	4.92 (4.66)	1.69	0.78
Avoidance	4.41 (2.85)	5.37 (2.58)	3.00 (2.79)	2.32 *	0.91
Negative cognitions	10.76 (5.67)	13.12 (4.63)	7.25 (5.43)	3.09 ***	1.17

Table 5. Cont.

Variable	Total Sample M (SD)	Somatic Illness YES (n = 18) M (SD)	Somatic Illness NO (n = 13) M (SD)	t	d
Hyperarousal	9.14 (5.03)	11.12 (4.27)	6.67 (5.17)	2.49 *	0.89
Dissociative symptoms	4.33 (4.15)	6.50 (3.27)	0.00 (0.00)	2.87 **	1.10
SCL-90-R (Psychopathology)					
Global Severity Index	147.86 (65.38)	172.25 (49.22)	115.33 (71.90)	2.49 *	0.95
Somatization	20.11 (12.22)	26.44 (9.35)	11.67 (10.54)	3.92 ***	1.61
Depression	26.68 (10.87)	29.50 (9.29)	22.92 (12.04)	1.63	0.61
Anxiety	17.21 (9.20)	20.62 (7.56)	12.67 (9.51)	2.47 *	0.92
Positive symptom distress Index	1.93 (0.61)	2.29 (0.35)	1.21 (0.04)	7.52 ***	3.68

Note: M = mean; SD = standard deviation; d = Cohen's d. * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

3.5. Dissociation and Emotional Regulation

The mean dissociation score on the Dissociative Experiences Scale (DES) was 11.89 (SD = 7.75), calculated according to the standard scoring procedure (average score ranging from 0 to 100). Participants with a current somatic illness reported significantly higher dissociative symptoms than those without somatic illness (M = 16.12, SD = 6.68 versus M = 5.75, SD = 4.39; $t = 4.86$, $p < 0.001$, $d = 1.85$) (see Table 6).

Table 6. Emotion regulation (DERS) and dissociation (DES) according to somatic illness status.

Variable	Total Sample M (SD)	Somatic Illness YES (n = 18) M (SD)	Somatic Illness NO (n = 13) M (SD)	t	d
DERS (Emotion regulation difficulties)					
Total score	105.21 (29.55)	106.87 (28.21)	103.00 (32.38)	0.34	0.13
Lack of emotional awareness	17.04 (5.39)	18.37 (5.41)	15.25 (5.03)	1.56	0.61
Limited access to regulation strategies	21.14 (8.51)	22.12 (8.22)	19.83 (9.06)	0.69	0.31
DES (Dissociation)					
Total dissociation score	11.89 (7.75)	16.12 (6.68)	5.75 (4.39)	4.86 ***	1.85

Note: M = mean; SD = standard deviation; d = Cohen's d. *** $p < 0.001$.

3.6. Self-Esteem and Personality Traits

The PID-5-BF showed elevated scores for negative affect (M = 7.32; SD = 3.30) and psychoticism (M = 4.57; SD = 3.65). The mean score for self-esteem (RSE) was 24.89 (SD = 7.46).

The findings of the present study suggested that women afflicted with somatic illnesses exhibited diminished self-esteem ($t = 2.14$; $p < 0.05$; $d = 0.87$) and augmented levels of detachment ($t = 3.02$; $p < 0.01$; $d = 1.21$) and psychoticism ($t = 2.36$; $p < 0.05$; $d = 0.92$) (see Table 7).

3.7. Clinical Correlations with Age

The present age suggested a significant association with a number of clinical variables. A negative correlation was observed with depression ($r = -0.53$; $p < 0.01$) and negative affect ($r = -0.56$; $p < 0.01$), indicating greater symptom severity in younger participants. Conversely, a positive correlation was observed between age and self-esteem ($r = 0.52$; $p < 0.01$), suggesting a link between a younger age and reduced levels of self-esteem.

Concurrently, a younger age at the onset of CSA was associated with greater clinical severity, including phobic anxiety ($r = -0.62$; $p < 0.01$), global severity ($r = -0.50$; $p < 0.01$), and psychoticism ($r = 0.52$; $p < 0.01$).

0.01), post-traumatic symptoms ($r = -0.41$; $p < 0.05$) and dissociation ($r = -0.41$; $p < 0.05$) (see Table 8).

Table 7. Personality traits (PID-5-BF) and self-esteem (RSE) according to somatic illness status.

Variable	Total Sample M (SD)	Somatic Illness YES (n = 18) M (SD)	Somatic Illness NO (n = 13) M (SD)	t	d
PID-5-BF (Personality traits)					
Negative affect	7.32 (3.30)	7.81 (2.71)	6.67 (3.98)	0.91	0.31
Detachment	4.11 (3.65)	5.69 (3.52)	2.00 (2.69)	3.02 **	1.21
Psychoticism	4.57 (3.65)	5.88 (3.57)	2.83 (3.07)	2.36 *	0.92
RSE (Self-esteem)					
Total self-esteem score	24.89 (7.46)	22.44 (6.70)	28.17 (7.39)	2.14 *	0.87

Note: M = mean; SD = standard deviation; d = Cohen's d. * $p < 0.05$; ** $p < 0.01$.

Table 8. Pearson correlations (r) between age variables and clinical measures.

Scale/Dimension	Age of Participant (r)	Age of Onset of CSA (r)
EGS-R (PTSD symptoms)		
Total PTSD score	−0.47 *	−0.41 *
Re-experiencing	−0.40 *	−0.35
Avoidance	−0.31	−0.26
Negative cognitions	−0.39 *	−0.41 *
Hyperarousal	−0.45 *	−0.33
Dissociative symptoms	−0.22	−0.28
SCL-90-R (Psychopathology)		
Global Severity Index	−0.49 **	−0.50 **
Somatization	−0.09	−0.41 *
Depression	−0.53 **	−0.49 **
Anxiety	−0.47 *	−0.49 **
Phobic anxiety	−0.46 *	−0.62 **
Obsessive-compulsive	−0.47 *	−0.36
Interpersonal sensitivity	−0.34	−0.42 *
Hostility	−0.44 *	−0.14
Paranoid ideation	−0.38	−0.16
Psychoticism	−0.46 *	−0.30
DERS (Emotion regulation)		
Total difficulties	−0.49 **	−0.31
Limited access to strategies	−0.51 **	−0.42 *
Lack of emotional awareness	−0.48 *	−0.27
Lack of emotional clarity	−0.49 *	−0.29
Impulse control difficulties	−0.37	−0.06
Non-acceptance of emotions	−0.15	−0.18
Difficulty persisting in goals	−0.25	−0.12
DES (Dissociation)		
Total dissociation	−0.37	−0.41 *
Absorption	−0.26	−0.21
Depersonalization/derealization	−0.35	−0.35
PID-5-BF (Personality traits)		
Negative affect	−0.56 **	−0.27
Psychoticism	−0.49 **	−0.14
Detachment	−0.35	−0.24
Antagonism	−0.36	−0.04
Disinhibition	−0.12	−0.21
Global personality symptoms	−0.51 **	−0.25
RSE (Self-esteem)		
Total self-esteem	0.52 **	0.38

Note: CSA = childhood sexual abuse. * $p < 0.05$; ** $p < 0.01$.

Furthermore, a significant correlation was identified between dissociation and difficulties in emotional regulation ($r = 0.47$; $p < 0.01$), as well as between self-esteem and depressive symptoms ($r = -0.52$; $p < 0.01$).

4. Discussion

The present study describes a broad range of psychological, post-traumatic, dissociative, and emotional regulation difficulties in a clinical sample of adult women with a history of childhood sexual abuse. These results are consistent with previous literature describing CSA as a risk factor for the development of complex trauma and persistent psychopathology in adulthood [2–5,14].

In accordance with the extant literature, the findings support the hypothesis that CSA is associated with a high burden of internalising symptoms, including depression, anxiety and post-traumatic stress [4,14,17]. In the present study, elevated scores on the EGS-R and SCL-90-R are indicative of a pattern of global clinical impairment, consistent with the extant literature which emphasises the transition from early trauma to complex psychopathological conditions in adulthood [5,9].

A salient finding of the study is the high prevalence of somatic illness (58.1%) and its correlation with heightened clinical severity, particularly with regard to somatisation, dissociation and post-traumatic severity. These results are consistent with the extant literature, which highlights a link between early trauma and somatic manifestations in adulthood [5,18]. From a clinical perspective, this lends further support to the notion that an integrated approach to mental and physical health is imperative. These findings are consistent with previous studies reporting associations between childhood trauma, somatic illness, and psychological distress in adulthood. However, the present cross-sectional design does not allow conclusions regarding the mechanisms underlying these associations.

Women reporting somatic illness showed higher levels of dissociative symptomatology across both trauma-related dissociative symptoms assessed with the EGS-R and broader dissociative experiences measured by the DES. This convergence across instruments suggests that dissociation may represent an important clinical correlate of somatic illness in this sample. This finding is consistent with the scientific literature, which identifies dissociation as a coping mechanism in response to early and repeated traumatic experiences [11,12]. In this regard, research has underscored the correlation between dissociation, interpersonal trauma, and elevated clinical complexity in cases of post-traumatic stress [13,15]. In addition, women with somatic illness reported substantially higher Positive Symptom Distress Index scores, suggesting not only a greater burden of symptoms but also higher subjective distress associated with those symptoms. Although these findings require replication, they are consistent with previous research linking childhood trauma to elevated psychological suffering and healthcare utilization.

Participants presented elevated levels of emotion regulation difficulties overall. However, no statistically significant differences were observed between women with and without somatic illness. Therefore, although emotional dysregulation is frequently described as a core feature of complex trauma, the present findings do not suggest a specific association with somatic illness in this sample. Literature identifying emotional dysregulation as a central feature of complex trauma [12,30,31]. While not all dimensions of the DERS suggested statistical significance in the between-group comparisons within the present study.

With regard to personality, the results of the PID-5-BF show higher levels of negative affect, detachment and psychoticism, particularly in women with somatic illness. These findings are consistent with studies suggesting that maladaptive personality traits may act as mediators between early trauma and internalising symptoms in adulthood [16,29].

With regard to self-esteem, the results indicate moderately low levels in the overall sample, with significantly lower scores among women with a somatic illness. This finding is consistent with the extant literature, which describes impaired self-concept as a common consequence of CSA [23,24], and suggests that self-esteem may be a relevant indicator of psychological adjustment in this population.

A particularly salient finding is the correlation between age and clinical symptoms.

Younger current age and earlier age of CSA onset were associated with several symptom dimensions. Given the cross-sectional nature of the study, these associations may reflect multiple factors, including cohort effects, treatment-seeking patterns, adaptation processes, or differences in time elapsed since the abuse, and therefore should not be interpreted as evidence of developmental trajectories. These results are consistent with previous evidence indicating that early exposure to trauma increases the risk of severe psychopathology in adulthood [2,3,26].

Although the study does not permit population-level conclusions, the findings may have preliminary clinical implications for the assessment and treatment of women with histories of childhood sexual abuse, particularly those presenting concurrent somatic illness. The low rate of reporting that was observed, in conjunction with the high proportion of women with a history of previous psychological treatment, suggests that, although there is contact with the healthcare system, it may not be adequately addressing the underlying traumatic dimension. This pattern is consistent with the literature highlighting the under-detection of CSA and difficulties in mental healthcare [1,21,22].

The findings of this study support the need for integrated, trauma-focused therapeutic approaches that include not only the treatment of PTSD, but also emotional regulation, dissociation, somatisation and associated personality traits [7,8,10]. Furthermore, they emphasise the significance of early detection and interdisciplinary intervention in order to minimise the long-term impact of childhood trauma.

Earlier age of CSA onset was associated with greater symptom severity across several clinical domains. Although causal inferences cannot be drawn, this finding is consistent with previous studies suggesting that earlier trauma exposure may be linked to poorer psychological outcomes [1,2].

Several limitations should be acknowledged. First, the study included a small clinically selected sample recruited through convenience sampling, which limits statistical power, precision of estimates, and generalizability.

Second, the absence of a control group prevents determining whether the observed symptom levels are specific to survivors of childhood sexual abuse or reflect broader patterns observed in other clinical populations.

Third, the cross-sectional design precludes causal or developmental interpretations regarding the relationships between trauma exposure, dissociation, emotional regulation, somatic illness, and psychopathology.

Fourth, all measures were based on self-report and may therefore be influenced by recall bias or social desirability effects.

Furthermore, the exclusive inclusion of women limits generalizability to male and gender-diverse survivors, although this focus was considered clinically relevant given evidence suggesting increased vulnerability among women with histories of childhood adversity to trauma-related somatic conditions.

In addition, multiple statistical comparisons were conducted without formal multiplicity adjustment. Consequently, some statistically significant findings may represent false-positive results and require replication in larger samples.

Moreover, confidence intervals were not calculated for effect size estimates, and therefore the precision of the reported effects should be interpreted cautiously.

Finally, given the exploratory nature of the study and the number of statistical comparisons performed, findings should be interpreted cautiously and require replication in larger and more diverse samples.

5. Conclusions

In this exploratory clinical sample, women with a history of childhood sexual abuse reported substantial psychological distress, post-traumatic symptoms, dissociative symptoms, and frequent somatic illness. The observed associations between trauma-related variables and clinical outcomes should be interpreted cautiously due to the small sample size, non-probabilistic recruitment, and cross-sectional design. Further studies with larger and more diverse samples are required to confirm these findings. Nevertheless, the results support the potential relevance of trauma-informed and multidisciplinary approaches when working with clinically vulnerable survivors of childhood sexual abuse.

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