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Intergenerational trauma and cultural idioms of distress: A case study of childhood sexual abuse and dissociative phenomena in socio-economic marginality

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Abstract
This study examines the case of a 23-year-old woman who survived Childhood Sexual Abuse (CSA) and presently exhibits dissociative identity disorder, locally attributed to spiritual possession during religious festivals. The case is established within a context of severe socio-economic deprivation, persistent family conflict, and unidentified mental illness in a primary caregiver. The survivor's father, diagnosed with chronic psychosis and displaying narcissistic traits, reported persistent delusional beliefs involving supernatural influence, a history of interpersonal violence, and an extramarital relationship framed as the result of magical coercion.
The paper endorse a qualitative, single-case study methodology, engulf in-depth clinical interviews, developmental history mapping, and genogram analysis. The discussion draws upon trauma theory, the model of structural dissociation, and the literature on intergenerational transmission of trauma to interpret the interaction between the father's psychopathology and the survivor's developmental trajectory. The phenomenon of dissociative possession is considered both as an idiom of distress within the cultural setting and as an expression of unresolved trauma and impaired emotional regulation.
The findings highlight the convergence of parental mental illness, early exposure to sexual boundary violations, emotional neglect, and cultural silence around abuse in shaping the survivor's vulnerability to dissociation and identity fragmentation. The study emphasises the importance of early intervention, integrated trauma-informed care, and culturally sensitive approaches to mental health and abuse prevention. This case offers insights into how unresolved trauma in one generation may perpetuate cycles of harm in the next.

Keywords: Childhood sexual abuse, dissociation, intergenerational trauma, cultural idioms of distress, trauma theory

1. Introduction

1.1 Contextualising the case: CSA, dissociation, and intergenerational trauma

Childhood Sexual Abuse (CSA) remains a critical public health concern due to its extensive and enduring psychological, physiological, and social reverberations (Maniglio, 2009) [26]. The developmental outcomes of CSA often last far beyond the immediate abuse, affecting cognitive, emotional, and relational functioning well into adulthood (Briere & Elliott, 1994). A particularly compounded manifestation of post-traumatic alteration is dissociation, which may appear in various forms including possession states. These possession-form presentations are not merely psychiatric phenomena but are embedded in cultural narratives and community interpretations, which can significantly shape both the course and recognition of the disorder (van Duijl *et al*., 2010) [27].
The current case study explores the effects of intergenerational transmission of trauma, 23 year old women who experienced CSA in early years of her life was observed to develop periodic episodes of dissociative personality. Her background trajectory includes of chronic exposure to father's unidentified mental illness along with unstable childhood due to economic deprivations and lack of consistent emotional support. This situates the unresolved psychological distress of one generation shapes the vulnerabilities and coping strategies of the next (Danieli, 1998; Kellermann, 2013) [8, 28].

1.1.2 The socio-economic dimensions of psychopathology

Course of psychiatric illness are profoundly influenced by poverty, marginalisation and overcrowding. The World Health Organization (2014) underscores that socio-economic

deprivation is a primary determinant of poor mental health outcomes. In extremely overcrowded settlements the scarcity of privacy involuntarily expose children to adult sexual activity which heightens psychological vulnerability. Due to limited excess to mental health support conditions such as untreated psychosis, maladaptive behaviours and harmful interpersonal relationship dynamics persist.

1.1.3 Psychosis, magical thinking, and sexual decision-making

Psychosis often involves distortions in perception and belief, such as hallucinations or delusions. In the Indian cultural context, psychotic symptoms may incorporate culturally specific themes such as *jaadu tona* (black magic) or spiritual warfare (Freeman *et al*., 2002). When such delusions intersect with impaired sexual boundaries, the result can be direct harm to dependents. This variability is likely evident in cases where an individual holds absolute authority within the household, limiting opportunities for others to intervene.

1.1.4 Intergenerational transmission of trauma: theoretical lens

Intergenerational trauma refers to the transmission of the effects of trauma from one generation to the next, both through psychological processes and biological mechanisms. Fraiberg *et al*. describe the "ghosts in the nursery" phenomenon, wherein unresolved parental trauma shapes the caregiving environment. Attachment theorists Main and Hesse (1990) highlight the role of disorganized attachment in perpetuating cycles of fear and neglect. More recent epigenetic research suggests that trauma-related stress responses can alter gene expression, creating heightened vulnerability in offspring even before birth.

1.2 Childhood sexual abuse and developmental disruption

CSA has been found to disrupt critical developmental tasks, including the formation of secure attachment, acquisition of self-regulation skills, and establishment of healthy interpersonal boundaries (Alexander, 1992). The betrayal and violation inherent in CSA often generate persistent patterns of hypervigilance, self-blame, and affective dysregulation (Briere & Elliott, 1994). From a neurobiological perspective, CSA can alter the functioning of the Hypothalamic Pituitary Adrenal (HPA) axis, leading to chronic dysregulation of stress response systems. These changes increase susceptibility to dissociation, depression, and anxiety. In the current case, the subject's early exposure to sexual violence occurred in a context devoid of protective interventions, compounding the effects of trauma by reinforcing a worldview characterised by danger, mistrust, and powerlessness.

1.2.1 Child sexual abuse and later dissociative phenomena

The relationship between Child Sexual Abuse (CSA) and dissociative disorders is well-established in psychiatric literature. Sar (2011) notes that possession states, particularly in non-Western societies, are frequently rooted in histories of CSA, with dissociation serving as a psychological escape from overwhelming experiences. Ross (1997) further elaborates that chronic dissociation can evolve into structured identity disruptions, manifesting in culturally recognizable idioms of distress.

1.3 Dissociative possession in cultural context

Possession-form dissociation is widely documented in South Asian cultures, where such experiences are often interpreted within religious or spiritual frameworks (Somasundaram, 1998). While these cultural idioms of distress may provide a socially sanctioned way to express psychological suffering, they can also delay recognition of underlying trauma and psychiatric conditions (Kirmayer & Young, 1998). In this case, the subject's episodes of altered consciousness during community religious events were initially perceived as signs of divine possession, leading to repeated engagement in ritual practices rather than clinical treatment.

1.3.1 Historical context of dissociative possession in South Asia

The phenomenon of dissociative possession has been documented across diverse cultures, but in South Asia, it holds a particularly entrenched place in both religious and folk narratives. Terms such as *mata aana* (the arrival of a goddess) or *bhoot-pret* (spirit possession) have historically served as frameworks to interpret unusual behavior, especially among women. In rural and semi-urban India, spirit possession is often perceived as a supernatural event rather than a psychiatric condition, leading to religious rituals as the primary intervention (Kakar, 1982; Mills, 2010) [17]. This cultural context not only shapes the manifestation of symptoms but also influences help-seeking behavior, delaying psychiatric diagnosis and treatment.

1.4 Intergenerational Transmission of Trauma

The intergenerational transmission of trauma describes the process through which unresolved trauma in parents influences the emotional and psychological well-being of their children, often via maladaptive parenting patterns, insecure attachment, and learned coping strategies (Yehuda *et al*., 2016). This process can be mediated by both psychosocial and biological mechanisms, including epigenetic modifications (Kellermann, 2013) [28]. In the present case, the father's untreated psychosis, coupled with narcissistic traits, resulted in inconsistent caregiving, emotional neglect, and a home environment dominated by instability and fear. These conditions not only hindered the subject's recovery from CSA but also perpetuated a familial pattern of unaddressed psychological distress.

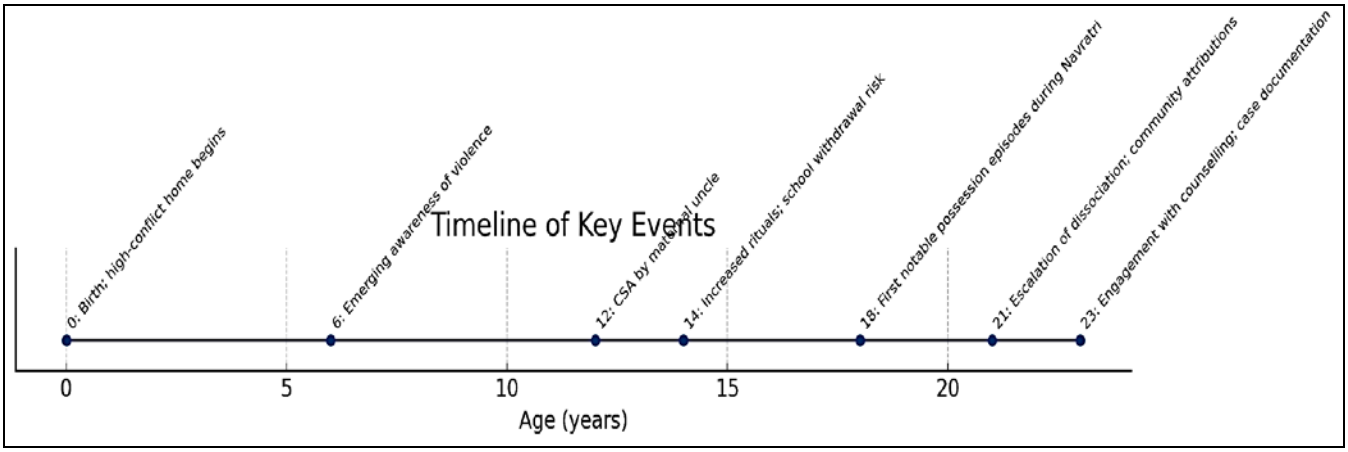

Fig 1: Timeline of key events

1.5 Narcissistic traits and interpersonal violence in low-resource settings

Narcissistic traits characterized by a pervasive need for admiration, lack of empathy, and exploitation of others may be amplified in contexts where patriarchal norms reinforce male authority (Twenge & Campbell, 2009). In low-resource settings, such traits can manifest in coercive control over family members, emotional neglect, and the perpetuation of psychological harm. When paired with psychiatric symptoms, narcissistic patterns can create highly toxic family systems that contribute to intergenerational cycles of trauma.

1.5.1 Narcissistic parental traits and attachment disruption

Parental narcissism is marked by an inability to empathise, a tendency toward emotional invalidation, and prioritisation of the parent's own needs over the child's welfare (Miller *et al*., 2010). These traits disrupt the formation of secure attachment bonds, leaving children vulnerable to low self-worth, chronic shame, and impaired emotional regulation. In this case, the father's self-preoccupation and dismissive responses to his daughter's distress reinforced her sense of invisibility and abandonment, deepening the long-term psychological impact of her CSA.

1.7 Gendered cultural scripts of trauma expression

In patriarchal societies, women lack socially acceptable avenues to lucid distress. Spirit possession, particularly by female deities, can paradoxically grant them temporary authority and attention in otherwise oppressive contexts (Halliburton, 2005). This framework may explain why women, more than men, are diagnosed with dissociative possession in certain regions symptoms are mediated not only by individual psychopathology but also by gendered cultural scripts.

1.6 Rationale

This case represents a convergence of three significant domains: the enduring impact of CSA, the expression of trauma through culturally embedded dissociative possession, and the amplification of vulnerability through intergenerational trauma. Studying such cases is critical for developing culturally sensitive diagnostic and therapeutic approaches that address both the psychological and socio-cultural dimensions of trauma. By integrating trauma theory, the structural dissociation model, and cultural psychiatry, this study contributes to a more nuanced understanding of trauma expression and transmission within specific cultural contexts.

Literature Review

1. Dissociative possession as a cultural idiom of distress

1.1 Cultural and historical context

Spirit possession beliefs have deep roots in South Asian folklore and religious traditions, often linked to moral codes, gender norms, and social control (Kakar, 1982) [17]. In many rural and urban-poor communities, altered states of consciousness are framed not as psychiatric illness but as manifestations of divine contact, ancestral spirits, or malevolent forces (Mills, 2010). Such interpretations can delay or obstruct clinical intervention.

1.2 Clinical classification

The DSM-5-TR (American Psychiatric Association, 2022) categorizes dissociative possession under Other Specified Dissociative Disorders, highlighting identity alteration and trance states. The ICD-11 further refines this as a disorder characterized by replacement of a person's usual identity with an external entity, often following severe trauma (World Health Organization, 2019).

1.3 Possession in trauma contexts

Sar *et al*. (2010) demonstrated that possession-form dissociation is significantly associated with histories of chronic interpersonal trauma, particularly CSA. Such episodes may intensify during culturally significant rituals, providing a socially sanctioned outlet for expressing psychological distress.

Dissociative possession in South Asian contexts must be examined through a dual lens: as a legitimate cultural idiom and as a trauma-linked clinical presentation. This is essential for understanding the survivor's Navratri-linked episodes in the present case.

2. Intergenerational transmission of trauma

2.1 Psychodynamic perspectives

Fraiberg, Adelson, and Shapiro's (1975) "ghosts in the nursery" metaphor describes how unresolved parental trauma unconsciously shapes caregiving practices, often through projection and repetition of past harm. In psychodynamic terms, the parent's unintegrated affect is transmitted to the child via relational patterns.

2.2 Attachment disruption and developmental risk
Main and Hesse (1990) documented that unresolved trauma in parents leads to disorganized attachment in children, characterized by contradictory behaviors, hypervigilance, and poor affect regulation features commonly seen in survivors of CSA who later develop dissociative symptoms.

2.3 Biological transmission pathways
Provided evidence that parental trauma can induce epigenetic modifications, including altered methylation of the NR3C1 gene, affecting hypothalamic-pituitary-adrenal (HPA) axis functioning in offspring. This can lead to heightened vulnerability to stress-related disorders.
In this case, the father's untreated psychosis, delusional beliefs, and narcissistic traits, combined with socio-economic deprivation, created a high-risk developmental environment, making intergenerational trauma transmission highly probable.

3. Psychosis, magical thinking, and sexual boundary violations
3.1 Psychosis and cultural delusion formation
Psychosis often incorporates culturally familiar symbols and explanatory models into delusional frameworks. In South Asia, "jaadu tona" narratives can be integrated into psychotic reasoning to explain interpersonal and sexual relationships.

3.2 Narcissism and aggressive control
Narcissistic traits entitlement, lack of empathy, and exploitative tendencies amplify interpersonal harm, especially in combination with psychosis (Twenge & Campbell, 2009). In such contexts, violence becomes a means of reasserting control when perceived self-image is threatened.

3.3 Psychopathology and boundary violations
Research indicates that individuals with severe mental illness who also have antisocial or narcissistic features are more likely to commit sexual boundary violations, often rationalized through delusional belief systems (Schug *et al*., 2011).
The father's magical coercion delusion ("Jaadu Tona") functioned as both a personal rationalization and a culturally resonant framework, facilitating the normalization of his abusive behavior in his own mind.

4. Child sexual abuse and dissociative outcomes
4.1 CSA as a predictor of dissociation
Putnam (1997) and Ross (1997) established CSA as a primary risk factor for chronic dissociation. Dissociation enables psychological survival in the face of overwhelming trauma by partitioning awareness, memory, and identity.

4.2 Possession-form dissociation in CSA survivors
Sar (2011) identified that survivors in possession-belief cultures often develop possession-form dissociation, especially when trauma disclosure is obstructed by family or community silence.

4.3 Cultural silence and social barriers
Kumar (2016) found that in India, CSA often remains unreported due to stigma, fear of family dishonor, and lack of trust in legal mechanisms. Survivors in such environments are more likely to internalize distress, manifesting in somatic or culturally acceptable idioms like spirit possession.
The subject's Navratri-linked possession episodes reflect the intersection of CSA trauma, culturally normative idioms of distress, and a silenced disclosure pathway amplified by an unstable, trauma-saturated home environment.

5. Socio-economic deprivation and psychological vulnerability
5.1 Poverty and exposure to violence
Chronic socio-economic deprivation is strongly linked with elevated risk for both victimization and perpetration of violence (Fergusson *et al*., 2008). Families living in extreme poverty often lack stable housing, privacy, and access to protective institutions, amplifying risks of CSA and neglect.

5.2 Overcrowding as a catalyst for boundary erosion
Overcrowded living conditions, as seen in informal settlements, increase the likelihood of children inadvertently witnessing sexual activity or being exposed to inappropriate situations (Evans *et al*., 2000). These exposures can blur internalized boundaries of consent and safety, especially in households with ongoing conflict or mental illness.

5.3 Intergenerational poverty and psychosocial stress
Prolonged poverty fosters chronic stress states in both parents and children, impairing parental responsiveness and child self-regulation (Evans & Kim, 2013).
The intersection of poverty, inadequate housing, and psychosocial stress provided a fertile ground for both the father's untreated psychopathology and the daughter's vulnerability to CSA and later dissociative phenomena.

6. Cultural narratives of supernatural influence in psychopathology
6.1 Role of religious and folk beliefs
In India, supernatural attributions to mental illness such as possession, black magic, or divine intervention are widespread (Srinivasan & Thara, 2001). These beliefs can delay access to psychiatric care, as families may prefer religious healers to medical intervention.

6.2 Supernatural framing of sexual transgression
Cultural scripts sometimes allow perpetrators to rationalize sexual misconduct through supernatural narratives, displacing personal responsibility. In cases of psychosis, such narratives can become incorporated into delusional systems (Bhugra & Jacob, 1997).

6.3 Case correlation
The father's claim that his affair with his wife's sister was caused by "Jaadu Tona" reflects a culturally embedded explanatory model that aligns with both psychotic symptomatology and socio-cultural patterns of externalizing blame.
Supernatural explanatory models in mental illness not only influence symptom expression but also shape how abuse is rationalized and remembered within families.

7. Neurodevelopmental impact of childhood trauma
7.1 Brain regions affected by CSA
Neuroimaging studies have documented structural and functional changes in the hippocampus, amygdala, and prefrontal cortex in adults who experienced CSA (Teicher *et al*., 2003). These brain regions are critical for memory integration, emotional regulation, and threat perception.

7.2 Dissociation and neural disconnection
Trauma-induced dissociation is associated with reduced connectivity between limbic and cortical networks, impairing the integration of emotional and cognitive processing (Lanius *et al*., 2010).

7.3 Intergenerational neurobiological effects
Parental trauma-related dysregulation can influence fetal and infant brain development via altered maternal or paternal stress hormones and attachment interactions.
The survivor's dissociative possession experiences may be partially understood as neurobiological consequences of both direct CSA trauma and the inherited dysregulation from a parent with untreated psychosis and trauma history.

8. Family systems and role reversals in dysfunctional homes
8.1 Parentification and boundary confusion
In high-conflict or mentally unstable households, children may take on caregiving or mediating roles, a process known as parentification (Hooper, 2007). This role reversal disrupts normative attachment hierarchies, leading to identity confusion and vulnerability to exploitation.

8.2 Enmeshment and lack of privacy
In enmeshed family systems, personal boundaries are poorly defined. Minuchin's (1974) structural family theory suggests such patterns foster emotional entanglement, where abuse may be hidden under a facade of family unity.

8.3 Case relevance
The survivor's environment characterized by paternal psychosis, narcissistic aggression, and community silence likely entrenched enmeshment, secrecy, and fear, which sustained her silence about the CSA for years.
Understanding the family as a system rather than viewing only the individual pathology illuminates how multiple relational patterns interact to perpetuate trauma.

Table 1: This table highlights intergenerational linkage in between father and daughter under various domains

Domain	Father	Daughter	Intergenerational link
Mental health	Schizophrenia, hallucinations, delusional beliefs	Dissociative possession, PTSD symptoms	Cultural idioms of distress as coping
Personality traits	Narcissistic tendencies, poor empathy	Distrust, emotional withdrawal	Learned interpersonal schemas
Trauma history	Early marriage, extramarital affair under belief of "black magic"	CSA at age 12 by paternal uncle	Normalisation of violation within family
Socio-economic context	Chronic poverty, housing instability	Limited access to safe spaces	Poverty as chronic stressor
Violence exposure	Physical aggression toward spouse	Witnessing violence, emotional abuse	Modelling of aggression

3. Methodology
3.1 Research design
This study employed a qualitative single-case study design (Yin, 2018), chosen for its capacity to provide an in-depth, contextualized exploration of complex psychological, familial, and socio-cultural phenomena. The approach integrated trauma-informed inquiry, narrative analysis, and Interpretive Phenomenological Analysis (IPA) to explore lived experiences, intergenerational trauma transmission, and culturally embedded idioms of distress. This design enabled the triangulation of multiple data sources participant interviews, family member narratives, and historical background records within a coherent theoretical framework.

3.2 Aim
The aim of this study was to investigate the psychological sequelae of Childhood Sexual Abuse (CSA) in the context of intergenerational psychopathology, socio-economic adversity, and cultural constructs of possession states. Specifically, the research sought to understand how paternal psychosis, narcissistic personality traits, and culturally embedded belief systems influenced the development, expression, and persistence of dissociative-possession symptoms in the daughter.

3.3 Objectives
- To explore the survivor's subjective experience of CSA and its impact on her psychosocial functioning.
- To examine the intergenerational transmission of trauma and psychopathology within the family.
- To identify the role of socio-economic deprivation and overcrowded living conditions in shaping vulnerability.
- To investigate the cultural and religious frameworks contributing to symptom expression (e.g., "Mata Aati Hai" phenomenon).
- To propose a culturally competent, trauma-informed intervention framework.

3.4 Sample selection
This study utilized purposive sampling (Palinkas *et al*., 2015) to select the case. The participant met the following inclusion criteria:
- Female, aged 23, self-reported survivor of CSA at age 12.
- Persistent culturally interpreted dissociative symptoms.
- Family history of untreated severe mental illness (father diagnosed with schizophrenia, presenting with hallucinations, delusional beliefs, and narcissistic traits).
- Residing in socio-economically disadvantaged settlement with high exposure to domestic conflict and cultural ritual practices.

Table 2: This table indicates the specification of information of victim

Criteria category	Specification
Age & gender	Female, 23 years old.
History of abuse	Survivor of child sexual abuse (CSA) at age 12 by a paternal uncle.
Clinical presentation	Persistent culturally framed dissociative symptoms (episodes of "Mata Aana").
Family psychiatric history	Father with untreated schizophrenia, hallucinations, delusional beliefs, and narcissistic traits.
Socio-economic background	Lives in disadvantaged urban settlement; exposure to overcrowding, poverty, and domestic conflict.
Cultural context	Embedded in community with strong ritual/religious practices influencing illness interpretation.

The father was included as a secondary informant to provide historical, relational, and psychosocial context. No random sampling was applied, as the focus was on depth of analysis rather than generalizability.

3.5 Pilot study

A pilot phase was conducted with two comparable cases from the same community to test the cultural sensitivity and appropriateness of the interview guide, trauma timeline mapping, and genogram elicitation methods. Adjustments included:

- Simplified wording for trauma timeline prompts to avoid retraumatization.
- Inclusion of a symbol-based response card set to help participants articulate dissociative experiences.
- Added culturally sensitive probes for understanding spiritual possession narratives.

These refinements ensured the methodology respected participant safety, cultural beliefs, and emotional boundaries.

Table 3: This table gives detailed pilot study plan

Method tested	Adjustment made	Rationale/outcome
Trauma timeline mapping	Simplified wording of prompts	Reduced risk of retraumatization; improved participant comfort and engagement
Interview guide (Narrative elicitation)	Added culturally sensitive probes regarding spiritual possession experiences	Enhanced validity of responses by aligning with local explanatory models of distress
Genogram elicitation	Incorporated symbol-based response card set to describe dissociative experiences	Allowed participants to express complex emotional states non-verbally and safely

3.6 Ethical considerations

Ethical protocols adhered to APA Ethical Principles of Psychologists and Code of Conduct (2017) and the Indian Council of Medical Research (ICMR) National Ethical Guidelines (2017). Key measures:

- Informed consent obtained from the participant and verbal consent from the father for his narrative contributions.
- Confidentiality maintained through pseudonyms and removal of identifying details.
- Right to withdraw communicated and respected at all stages.
- Minimization of harm via the use of trauma-informed questioning, with immediate referral to mental health support if distress was observed.
- A distress protocol was activated when the participant showed signs of dissociation during interviews, including grounding techniques and session breaks.

3.7 Data collection

Data were collected over six in-depth sessions:

1. **Session 1:** Rapport building, informed consent, and socio-demographic profiling.
2. **Session 2:** Elicitation of trauma timeline from childhood to present.
3. **Session 3:** Life history interview focusing on family relationships and father's mental health.
4. **Session 4:** Cultural idioms and spiritual possession narratives.
5. **Session 5:** Construction of a three-generation genogram highlighting psychiatric, trauma, and relational patterns.
6. **Session 6:** Validation of data with participant and member checking.

Supplementary data sources:

- Observational field notes during home visits.
- Archival family information from community records.
- Researcher reflexive journal documenting interpretive process

3.8 Procedure

The procedure followed a sequential, layered exploration:

- **Phase 1 - Contextual grounding:** Establish rapport, explain research purpose, and engage in informal conversations to reduce mistrust.
- **Phase 2 - Narrative elicitation:** Use semi-structured, open-ended questions to elicit a chronological account of key life events, with optional drawing activities for emotional distancing.
- **Phase 3 - Multi-perspective integration:** Cross-reference the participant's narrative with the father's account, noting convergences and divergences.
- **Phase 4 - Visual mapping:** Construct genograms and trauma timelines collaboratively.
- **Phase 5 - Thematic coding:** Apply inductive coding in NVivo, identifying themes such as intergenerational beliefs, trauma scripts, and socio-cultural vulnerability.
- **Phase 6 - Closure and support:** Provide debriefing, psychoeducation about trauma and dissociation, and connect the participant with ongoing counselling services.

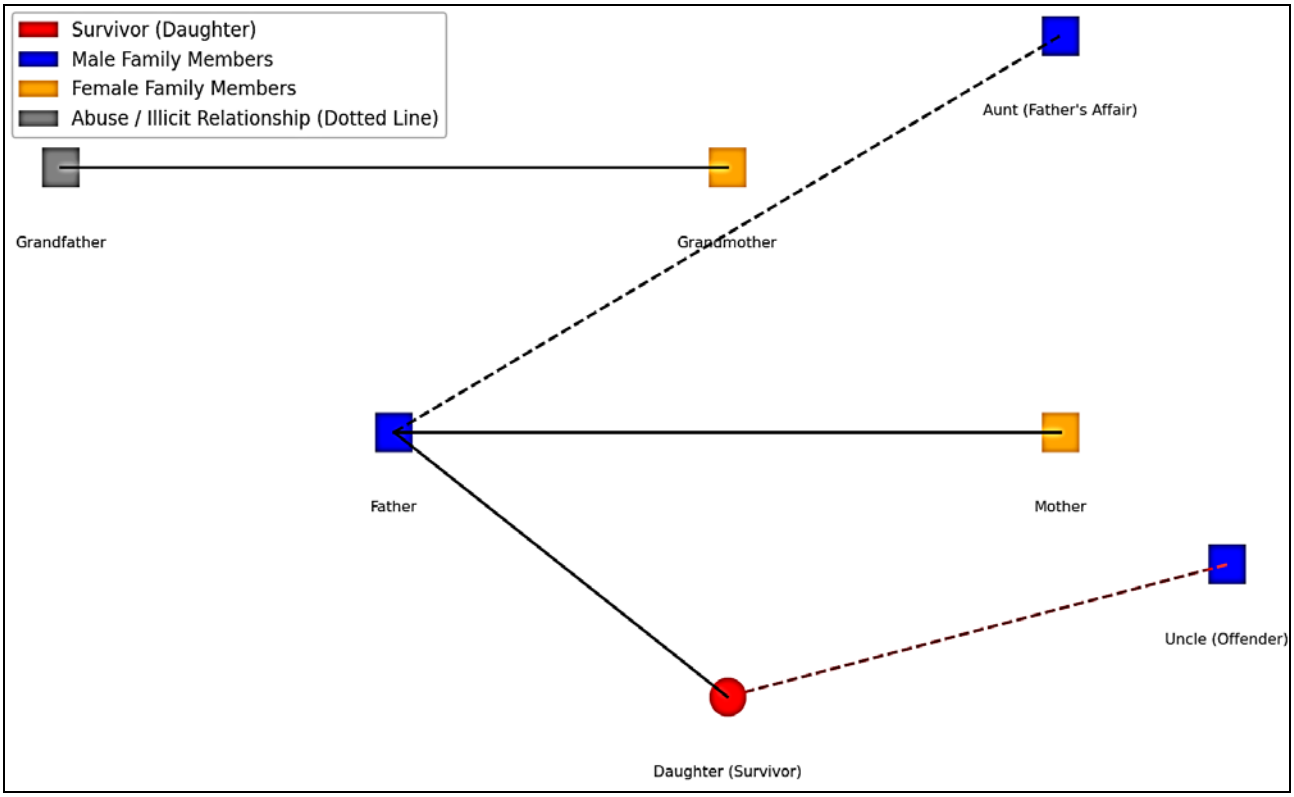

Fig 2: Genogram of survivor's family dynamics

Table 4: Activities carried out in different phases and the purpose

Phase	Activity	Purpose
Phase 1	Rapport building & contextual briefing	Establish trust and explain purpose in culturally sensitive language.
Phase 2	Survivor narrative elicitation	Capture detailed account of abuse, family history, and personal meaning-making.
Phase 3	Father's narrative & psychopathology mapping	Understand psychiatric history, beliefs, and behavioural patterns.
Phase 4	Triangulation	Cross-verify survivor's account with father and community sources.
Phase 5	Visual mapping (genogram, trauma timeline)	Identify intergenerational trauma patterns and life events.
Phase 6	Closure & resource provision	Emotional containment, psychoeducation, and referral.

4. Results

4.1 Introduction

This chapter presents the results of the case study in a structured manner, integrating the participant's narrative, observational data, and supplementary sources. To enhance clarity, findings are presented thematically, supported by tables, genograms, trauma timelines, and conceptual diagrams. The aim is to illustrate how CSA, dissociative/ possession phenomena, paternal psychopathology, and socio-cultural contexts intersect to shape the participant's experiences.

4.2 Childhood trauma and CSA

The participant described repeated sexual abuse by her paternal uncle at age 12, in the context of an overcrowded one-room household. Silence and denial by the family prevented disclosure, leading to long-term emotional and psychological distress.

Table 5: Childhood trauma exposure

Trauma type	Age of onset	Perpetrator	Context	Consequences
Sexual abuse (CSA)	12	Paternal uncle	Within home	Fear, shame, withdrawal, self-blame, nightmares
Witnessing domestic violence	Childhood	Father vs mother	Household	Hypervigilance, anxiety, mistrust of men
Poverty & deprivation	Birth onward	Structural issue	Slum settlement	Malnutrition, low self-esteem, unsafety

4.3 Dissociative and possession experiences

Episodes of possession (locally described as *mata aana*) emerged in adolescence. These included trance states, chanting, and altered awareness. While the community interpreted them as divine possession, they clinically resembled dissociation (detachment, amnesia, altered identity).

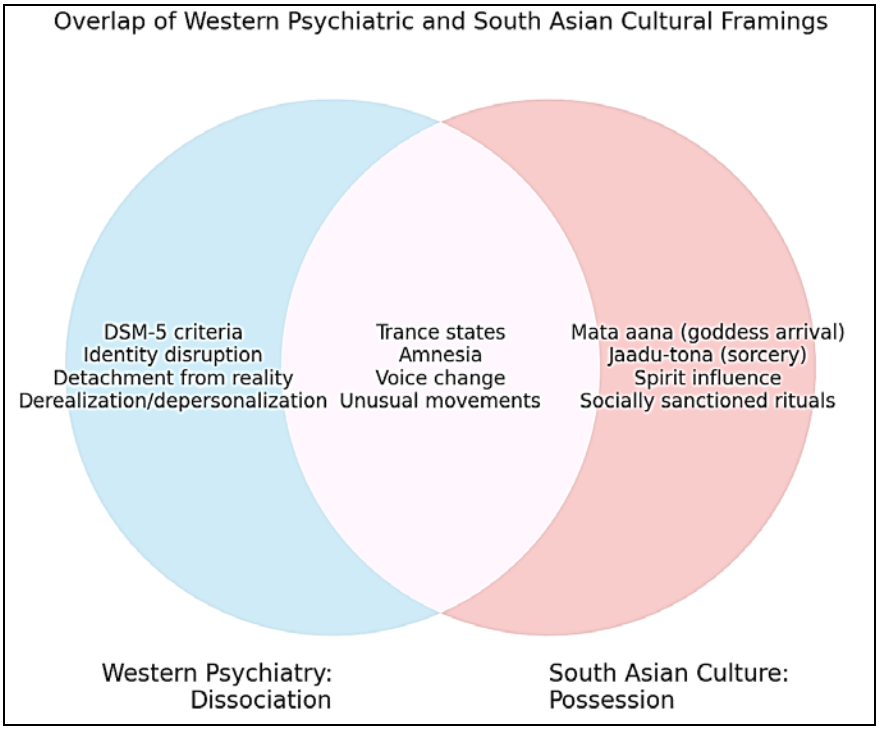

Fig 4.1: Symptom overlap between dissociation and possession

4.4 Intergenerational transmission of psychopathology

The participant's father exhibited chronic psychosis with narcissistic traits. His delusions and violence created a chaotic family environment. His untreated illness represented a major intergenerational risk factor.

Table 6: Father's symptom profile

Symptom cluster	Manifestation	Cultural framing	Impact on family
Hallucinations & delusions	Spirits, black magic, death predictions	Bhoot-Pret influence	Instability, fear
Personality traits	Narcissistic entitlement, aggression	Seen as Mardangi (masculinity)	Violence, neglect
Domestic violence	Physical & emotional abuse	Normalized as stress	Trauma for children

4.5 Genogram analysis

A three-generation genogram revealed a pattern of mental illness, trauma, and relational conflict.

- **Grandfather:** Alcohol dependence
- **Father:** Schizophrenia, narcissistic traits
- **Participant:** CSA survivor, dissociative possession
- **Intergenerational theme:** Untreated mental illness, violence, silence around trauma

4.6 Cultural idioms of distress

The participant and her family framed psychological symptoms as spiritual phenomena (e.g., black magic, spirit possession). Community rituals during Navratri provided a sanctioned outlet for her possession episodes. This dual framing (medical vs cultural) created a gap in accessing psychiatric help.

Table 7: Cultural vs psychiatric interpretations

Phenomenon	Cultural framing	Psychiatric framing
Participant's trance	Divine possession (*mata aana*)	Dissociation, altered consciousness
Father's delusions	Black magic, spirit influence	Schizophrenia, psychosis
Family silence	Respect for elders, taboo	Trauma silencing, re-victimization

4.7 Trauma timeline

Table 8. Structural Vulnerabilities

Age	Event	Impact
0-6	Exposure to violence, poverty	Fear, insecurity
12	CSA by paternal uncle	Withdrawal, shame
13-18	Onset of possession states	Relief + stigma
19-23	Continued possession + CSA memories	Dissociation, avoidance

4.8 Socio-economic context

Overcrowding, poverty, and cultural silence amplified vulnerability.

Table 9: Structural vulnerabilities

Domain	Manifestation	Effect on participant
Housing	One-room household	Exposure to parental sexuality, no privacy
Poverty	Limited resources	Malnutrition, poor education
Cultural silence	Taboo on CSA disclosure	Internalized guilt, isolation

4.9 Triangulated findings

- CSA at age 12 was central to trauma.
- Dissociation was culturally reframed as possession.
- Father's untreated psychosis created intergenerational

vulnerability
- Poverty and silence amplified trauma impact.

4.10 Summary
The results reveal a complex web of CSA, dissociation/possession, intergenerational psychopathology, cultural idioms of distress, and socio-economic marginalization. Together, they explain the persistence of the participant's symptoms and her limited access to mental health services.

5. Discussion
5.1 Introduction to the discussion
The present case study illustrates how individual trauma cannot be understood in isolation but rather in connection with intergenerational psychopathology, socio-economic deprivation, and cultural meaning-making systems. The survivor's experiences of child sexual abuse (CSA), dissociative possession states, and long-term emotional disturbances are interwoven with her father's untreated psychosis, narcissistic tendencies, and belief in supernatural causation. This chapter unpacks these complexities, linking the findings to established psychological theories, empirical research, and contextual realities.

5.2 Intergenerational trauma transmission
Trauma does not end with the individual; it often spills into subsequent generations through biological, relational, and cultural channels (Yehuda *et al*., 2016). In this case, the father's psychosis and maladaptive relational patterns contributed directly to the daughter's vulnerability.
- **Relational modelling:** The father's abusive behaviour, combined with delusional justifications for infidelity and violence, modelled distorted relational norms where abuse and coercion were normalised.
- **Biological vulnerability:** Research suggests that children of parents with psychotic disorders may inherit altered stress-response systems, leading to heightened vulnerability to trauma-related symptoms (Weinberg *et al*., 2021).
- **Cultural pathways:** The father's reliance on "Jaadu Tona" explanations for his own misconduct blurred accountability, perpetuating silence and secrecy in the household.

Implication*:* The daughter's CSA and later dissociative states can be interpreted as both a direct consequence of her father's condition and an *outcome of maladaptive family dynamics shaped by his illness.

5.3 Dissociation as a coping strategy and idiom of distress
The survivor's episodes of possession during Navratri described as "Mata Aati Hai" mirror dissociative phenomena recognised in clinical psychology, but expressed in a culturally acceptable idiom.
- **Psychodynamic lens:** Freud's (1920/2018) theory of repression helps explain how unbearable trauma may be channelled into symbolic forms such as possession states.
- **Trauma theory:** Van der Kolk (2014) [7] emphasises that dissociation is a way of preserving psychological functioning when faced with unbearable intrusions of trauma memories.
- **Cultural psychiatry:** Fernando (2012) documents how spirit possession is often an accepted language for articulating distress in South Asian societies, especially among women with limited autonomy.

Table 10: Comparison of "Western psychiatric framing (dissociation)" vs. "South Asian cultural framing (possession)" to illustrate overlapping meanings

Dimension	Western psychiatric framing (Dissociation)	South Asian cultural framing (Possession / "Mata Aana")
Core concept	Dissociation: disruption in consciousness, memory, identity, or perception (APA, 2013).	Spirit possession: control of body/mind by external divine/spiritual force (Kakar, 1982; de Zoysa, 2011) [17].
Etiology	Linked to trauma (CSA, violence, neglect); defense mechanism against overwhelming experiences.	Triggered by family misfortune, stress, trauma, or ancestral/cosmic imbalance.
Symptoms	Amnesia, trance states, altered identity, depersonalization, derealization.	Shaking, chanting, speaking in altered voice, "trance" during festivals (e.g., Navratri).
Explanatory model	Psychological: maladaptive coping; neurobiological trauma imprint (van der Kolk, 2014).	Religious-cultural: divine visitation, goddess/mata entering the body, seen as sacred power.
Family/community reaction	Often stigmatized, labeled as "mental illness" needing treatment.	Socially tolerated, sometimes revered; seen as auspicious or sign of divine connection.
Treatment approach	Psychotherapy (CBT, trauma therapy, grounding, medication if comorbid psychosis).	Ritual healing: puja, exorcism, shamanic practices, religious intervention.
Meaning for survivor	Pathology needing regulation and integration of trauma memories.	Spiritual agency and recognition; paradoxically may provide voice/status to otherwise silenced girl.
Risks	Risk of misdiagnosis, under-treatment if only seen culturally.	Risk of untreated trauma, further victimization if only seen as possession.
Overlap	Both recognize altered states of consciousness as linked to overwhelming stress/trauma.	Both provide frameworks for legitimizing otherwise "unexplainable" experiences.

4.4 Developmental vulnerability trajectory
A longitudinal mapping of the survivor's life reveals how vulnerability accumulated across stages of development:
- **Early childhood (0-5 years):** Exposure to father's untreated psychosis → emotional neglect.
- **Middle childhood (6-10 years):** Limited peer interaction, unsafe home environment → social withdrawal.
- **Adolescence (12-13 years):** CSA by paternal uncle → emergence of dissociation.
- **Late adolescence (14-18 years):** Escalation of possession episodes, internalised shame.
- **Adulthood (19-23 years):** Chronic symptoms, limited access to therapy, reliance on spiritual idioms.

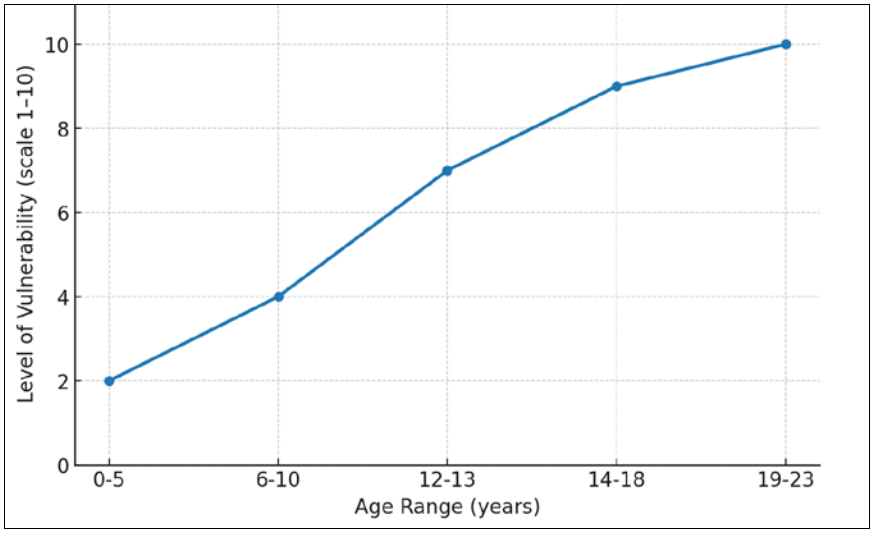

Fig 3: Trajectory of accumulated risk across developmental stages

4.5 Father-daughter psychological linkages

The father's psychopathology and the daughter's symptoms form a mirror pattern that underscores intergenerational trauma.

Table 11: It illustrates how psychopathology cascades across generations through modelling, neglect, and cultural narratives

Father's traits	Daughter's outcomes
Delusional thinking (Bhoot, Jaadu Tona)	Spiritual possession states (Mata Aana)
Narcissistic lack of empathy	Low self-worth, external dependency
Violent, abusive relational style	Vulnerability to CSA, fear-based relationships
Predicting death, persecutory hallucinations	Hypervigilance, mistrust of safety in environment

4.6 Ecological systems analysis

Using Bronfenbrenner's ecological systems theory (1979), the survivor's distress is seen as a product of interacting systems:

- **Microsystem:** Dysfunctional family, direct abuse.
- **Mesosystem:** Lack of school/community support.
- **Exosystem:** Socio-economic hardship, unsafe housing.
- **Macrosystem:** Cultural silence around CSA, patriarchal norms.
- **Chronosystem:** Life events (father's affair, CSA, puberty, continued poverty).

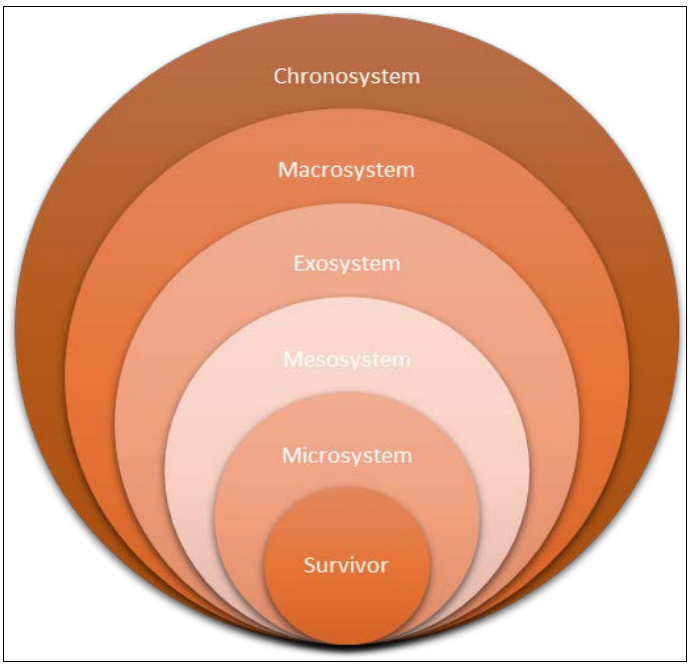

Fig 4: A layered ecological circle diagram placing the survivor at the centre

4.7 Integration with trauma theory and psychoanalysis

The case aligns with complex trauma theory, which emphasises:

- Fragmentation of self-due to repeated trauma (Herman, 1992) [5].
- Identity disturbance manifesting as possession episodes.
- Attachment dysregulation, where both fear and dependence on caregivers coexist.

From a psychoanalytic lens, the father's projection of blame onto external forces (e.g., Jaadu Tona) can be seen as a defence mechanism to avoid guilt. The daughter's possession states serve as a symbolic re-enactment of both disempowerment and resistance.

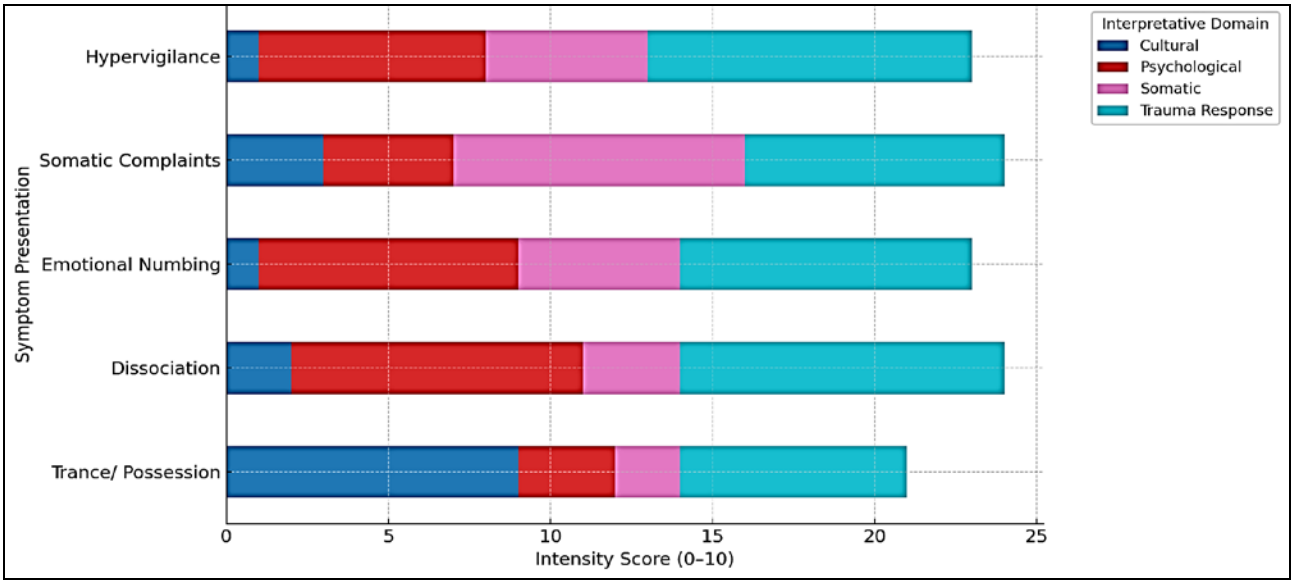

Fig 5: Multidimensional interpretation of survivor's symptom

4.8 Clinical and societal implications

- **Therapeutic need:** Trauma-informed care that respects cultural idioms.
- **Community interventions:** Bridging psychiatric and spiritual healers to avoid misdiagnosis.
- **Policy implications:** Safe housing, community centres, and accessible counselling in low-income settlements.

4.9 Limitations of the study

- Single-case design limits generalisability.
- Cultural interpretations may vary regionally.
- Survivor's recall of CSA may be influenced by memory reconstruction

4.10 Conclusion of discussion

This case demonstrates how CSA, dissociation, and intergenerational psychopathology are intertwined within a socio-cultural context of poverty and silence. It underscores the urgent need for multidimensional approaches that combine trauma psychology, cultural psychiatry, and community-based interventions. The discussion highlights not only individual suffering but also systemic failures, making this study both clinically and socially significant.

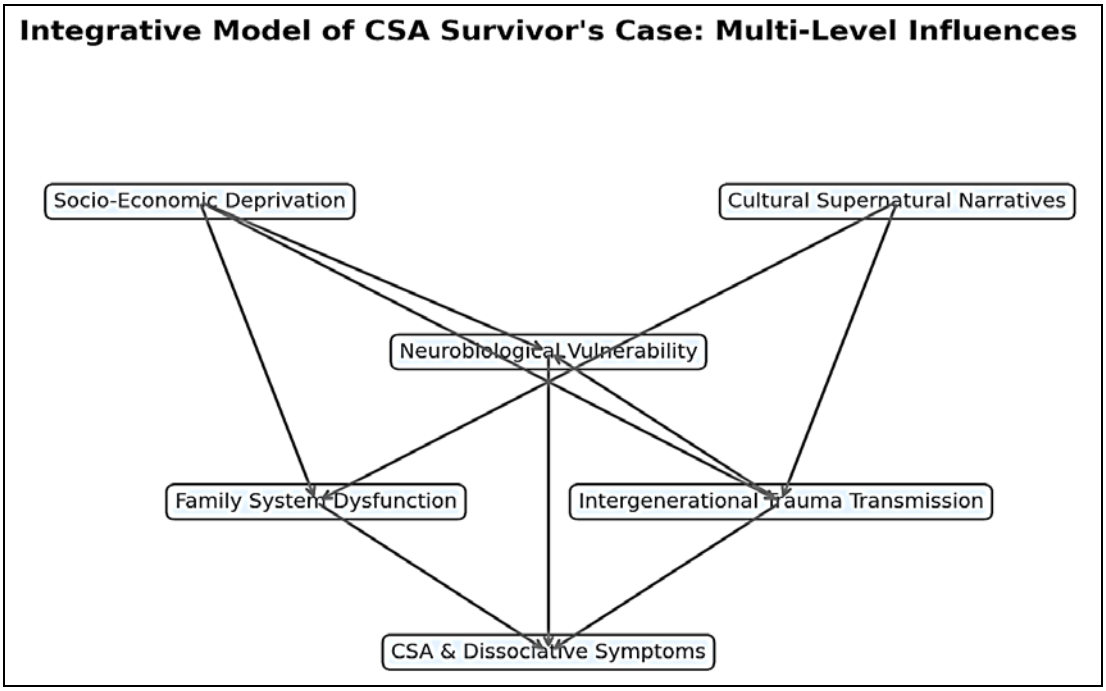

Fig 6: Intergenrative model of CSA survivor's case

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