Chapter 4
Adult Molested as Child

Namitha Babu

Introduction

Victimology is a multidisciplinary field of research that examines injury, trauma, victimization, victims and survivors of crimes, victims and survivors of noncriminal victimizations such as human rights abuses and societal interactions and responses to victimization (Quinney, 1972). Childhood sexual abuse (CSA) and its long-term effects in the life of an individual are topical public health concerns as well as a human rights issues (Choudhry et al., 2018). It is considered as an activity that provides sexual gratification, pleasure or stimulation to an adult by taking advantage or superiority of a minor (Castro et al., 2019). It includes the involvement of being touched sexually, fondling or inviting the child to touch, exhibitionism, intercourse, causing the child to participate in prostitution or pornography or online persuasion by cyber predators (Putnam, 2003; Wolak et al., 2008).

Adult victims of childhood sexual assault or childhood trauma suffer a slew of setbacks. To mention a few, there is a loss of innocence, a loss of a carefree childhood, a loss of security, and a loss of trust. There could have been a loss of a normal relationship with parental figures, as well as the ability to choose your own sexual experiences and partner, as well as a lack of nurturing (Beitchman et al., 1992). Adults who were abused at younger age, early phases of life may have trouble trusting others. They may believe that if they trust and allow others to approach them, they will be hurt and victimized again. This is a reasonable dread; especially if the person who abused the adult was someone they knew and trusted (Leserman, 2005).

Studies have shown life-long devastating and wide-ranging consequences of child maltreatment on the victim. Exposure to childhood abuse and trauma has cardinal significances on the cognitive, socioemotional, mental, and neurobiological

N. Babu (✉)
THRIVE, Bangalore, India
e-mail: namitha@rewirenthrive.com

R. T. Gopalan (ed.), *Victimology*, https://doi.org/10.1007/978-3-031-12930-8_4

aspects of development at later stages of life especially adulthood (Goodman et al., 2010). According to the dictionary of the American Psychological Association (APA n.d.), 'adulthood is the period of human development in which full physical growth and maturity have been achieved and certain biological, cognitive, social, personality, and other changes associated with the aging process occur. Beginning after adolescence, adulthood is sometimes divided into young adulthood (roughly 20–35 years of age); middle adulthood (about 36–64 years); and later adulthood (age 65 and beyond)'.

Adverse childhood events (ACEs) tend to activate a set of biopsychosocial events that can result in various kinds of dysfunctions and disorders in adulthood which leads to poor life situations and health outcomes. During transition in to adulthood, a number of customary changes happen in the physical, mental, social and spiritual aspects of life in the general population. These events and changes can cause a drastic impact on the psychological, emotional, relationship, health and quality of life aspects during adulthood (Daines et al., 2021). Childhood trauma can culminate in to adulthood symptoms in many areas of life. Survivors of early life abuse and trauma may find it difficult to form intimate bonds or create closeness with others. Intimacy necessitates the qualities of trust, respect, love, and sharing. Because of the imagined vulnerability, these things can be frightening. It has also been found that adults who have been molested, abused or witnessed and directly experienced trauma tend to cling too tightly to a connection that makes them feel safe because of the fear of losing that person. Many survivors find it beneficial to speak with a counsellor who can assist them in developing skills and gaining the confidence necessary to engage in a healthy romantic relationship (DiLillo, 2001). Another potential difficulty is the ability to set limits and boundaries as they may have given up hope of having any control over what occurred with them in the past. It is critical, however, that the adult victims recognize that they are no longer a child who is powerless to resist the abuse committed on them by adults in their life. They have greater power today, but more importantly, they have the right to pick their sexual partners and to control what happens to them (DiLillo, 2001; Smedley, 2012; Ensink et al., 2020).

Individuals may be plagued by disturbing memories of the assault. A flashback is a recurrence of a visual recollection that occurs suddenly. One may not only 'see' what happened during a flashback, but you may also 'feel' all of the emotions and feelings you felt at the time of the assault. A flashback might be terrifying and possibly cause a panic attack. Memories and flashbacks might be triggered by sounds, scents, people, and places linked with the assault (Brown & Kulik, 1977). In general, population studies an association between early adverse effects and psychiatric morbidity has been commonly recorded (Breslau, 2002). Early onset trauma is a strong and substantial predictor of adult psychopathology. Although the specific link is unknown, early life trauma has been associated with issues in adulthood such as mood and anxiety disorders, substance abuse disorders, personality disorders, and psychosis (McElroy et al., 2016).

Due to the lack of clarity in CSA definitions and the differences across areas, research has shown major incongruence in the low number of official reports and

the rates at which CSA is self-reported (Stoltenborgh et al., 2011). Studies corroborate high prevalence of CSA universally. Even the lowest prevalence involves a huge number of early onset abuse victims. A meta-analysis conducted in '2009 in 22 countries estimated a figure of 7.9% males and 19.7% females who was sexually abused before the age of 18 years' (Singh et al., 2014). According to the data provided by UNICEF, a minimum of 120 million girls under the age of 20 years, i.e., 1 in 10 females have been the victims of sexual violence (UNICEF, 2021). The lack of disclosure and reporting due to many factors such as shame, fear, and guilt makes it very difficult to ascertain that a considerable number of adult psychopathologies are based on early onset abuse or trauma.

The impact of early life trauma and its magnitude tends to differ greatly from person to person and case to case. Reports have shown that a wide majority of sexual abuse happens in childhood and incest is the most distressing and common form of abuse (Hall & Hall, 2011). Extensive abuse, higher number of experiences and younger age increases the form and severity of the impact on the victim. Other factors like the individual perspective as well as internal resources and support also play a role in the degree of damage experienced by the victim (Ron, 2020). Studies have revealed that the adverse outcomes of early trauma during childhood affect all areas of the victim's life. Long-term longitudinal research has also thrown light in to seven areas and these effects are not experienced over short term but can persist throughout the survivor's lifetime (Fisher et al., 2017). Research has shown that childhood victimization is a serious risk factor that leads to adult sexual assault and the prevalence of trauma and distress is twice likely for survivors of early onset trauma (Elliott et al., 2004).

Despite the large number of adults seeking help for multiple symptoms and researches available discussing the effects of childhood abuse and trauma throughout life, the further paragraphs comprehensively expand the lens by outlining the impact and effects of early life abuse and trauma on adult life at multiple layers/facets of life and the various treatment modalities available to effectively deal with the adult trauma clients.

Effects on Physiological Markers

As outlined in the previous paragraphs, early childhood abuse and trauma impacts the livelihood and other important parameters and markers throughout life. Some of the major markers are listed below:

Overall Risk Factors Associated with CSA

Exposure to an adverse life event like Childhood abuse, trauma, and incest etc. can result in problems in physiological aspects in adulthood. Abuse can cause stress-induced alterations in 'cortisol levels, changes in processes of pro-inflammatory

substances as well as gene expression which in turn has an adverse effect on a person's health'. Early childhood abuse or trauma is an Adverse Childhood Experience (ACE) which greatly impacts an individual's Health-Related Quality of Life (HRQoF) (Downing et al., 2021). Research shows that adults with a history of childhood trauma and victimization have reported severe negative perceptions of their overall health as well as higher somatization symptoms compared to individuals without any abuse history (Irish et al., 2009). Various studies conducted comparing individuals with and without childhood abuse and trauma history on several health themes such as pain, reproductive or gynaecologic health, gastrointestinal health, obesity, cardiopulmonary health and general health found that individuals with early trauma history indicated concerns in each health outcome (Wegman & Stetler, 2009; Afifi et al., 2007; Lepsy et al., 2022). The impact of childhood abuse, molestation and trauma on adults manifested in higher odds of depression, suicide attempts, alcohol problems, drug abuse and issues in family and relationships (Dube et al., 2005; Felitti et al., 2019).

The lack of clear distinction between the mind and body, due to the interrelatedness of the nervous, endocrine and immune systems, early childhood stressful experiences can cause immune dysregulation throughout the lifespan of an individual. A case study by Sigurdardottir and Halldorsdottir (2018) on a 40-year-old female CSA survivor to understand the lived experience indicated devastating effects of trauma throughout lifespan. Anne's case presented severe and complex nature of trauma that was marked by sexual abuse from her father from a very young age of 2 or 3 years old until she was 9 years old. Anne's physical symptoms were reported to have started around the age of four when her parents got divorced. From the age between 9 and 21, Anne was sexually assaulted by various people inside and out of the family circle. The recurrent retraumatization also leads to a sense of dissociation and disconnection from her body. Through the seven interviews that were conducted, the study revealed widespread consequences on her physical, mental and psychiatric health during adulthood. Concerns of sleep issues, widespread and chronic pain, chronic back pain, vaginal and abdominal infections, fibromyalgia, cervical dysplasia, recurrent urinary tract infections, cervical dysplasia, musculoskeletal problems, menorrhagia, ovarian cysts, ectopic pregnancies, endometrial hyperplasia, chlamydia, ovarian cancer, adhesions and other uterus problems were reported. This study shows the widespread array of potential disorders and difficulties caused to an adult with a history of childhood abuse and trauma. Even though this is reported as a unique case study, the aforementioned problems and the nature of comorbidity reflects the severity of the impact early onset trauma can have across the lifespan in mainly female survivors.

Gastroenterology and Gynaecological Difficulties Associated with Childhood Abuse

A marked difference in adverse physical health was also observed among individuals who reported CSA with intercourse and without intercourse (Felitti et al., 2019). Other physiological markers identified in adults who have experienced trauma and abuse in childhood are related to abdominal discomfort, peptic ulcers, chronic pain, lung disease, arthritis, high levels of cholesterol, low density lipoprotein were reported. And these were adults who reported early onset trauma with more number of doctor and hospital visits compared to those without the history of childhood abuse and trauma (Kamiya et al., 2015).

Studies conducted on gastroenterology patients found that '53% of the population diagnosed with gastro intestinal disorders reported to have experienced CSA compared to the total population' (Fullwood & Drossman, 1995, p. 483–496). Several researches have also reported that individuals with CSA history are twice as likely to experience Irritable Bowel Syndrome (IBS) (Hashemi et al., 2020). There were two types of chronic pain syndromes associated with past abuse – fibromyalgia and irritable bowel syndrome (Kendall-Tackett, 2009). Fibromyalgia syndrome (FMS) is characterized by pervasive musculoskeletal pain, decreased threshold for pain, sleep problems, and marked psychological distress (Boisset-Pioro et al., 1995). Studies have also shown that individuals with an abuse history in the past, primarily during their childhood experienced more severe indications of symptoms and stronger functional disabilities (Taylor et al., 1995). Irritable bowel syndrome (IBS) is a disorder of the lower gastrointestinal tract. Severe abdominal cramping, altered bowel habits with either diarrhoea or constipation, passage of mucus, bloating and abdominal distension are some of the symptoms of IBS (American Gastroenterological Association, 1997). Physicians in the past has written off pain symptoms as neuroticism or somatization without knowing the physiological basis of the symptoms as well as lowered pain threshold in victims and survivors of childhood abuse (Kendall-Tackett, 2009).

Furthering the understanding of effects on physiology, gynaecological studies corroborate strong links between CSA and chronic pelvic pain (CPP) (Walker et al., 2004). Early onset trauma and abuse were also related to higher risks in reproductive characteristics in women which includes early menarche (menstrual period occurring before the age of 11 years) as well as adolescent pregnancy (Wosu et al., 2015). Early life trauma has consistently proven to increase various stressors in childhood that also leads to biological influences on the endocrine development which in turn results in early onset of menarche (Henrichs et al., 2014). Early menarche were also found to be associated with health risks such as metabolic dysfunction, cardiovascular disease, depression and cancer and in some cases late menarche (menstrual periods after the age of 15 years) was associated with depression and low bone mineral density (Boynton-Jarrett et al., 2013). Amid pregnant women, the effect of early trauma was a manifestation of psychiatric disorders, prolonged abuse, and risk behaviours such as smoking and drinking. Research also suggests that early

life stress also leads to preterm birth (PTB) which is birth without completing the gestation period of 37 weeks (Wosu et al., 2015).

Orthopaedic and Neurology-Related Issues in Early Onset Trauma

Some of the other known physical consequences of childhood trauma are adult onset arthritis (Newton et al., 2009), long-term fatigue and diabetes (Sigurdardottir & Halldorsdottir, 2018; Romans et al., 2002), circulatory problems (Kendall-Tackett, 2009), digestive and respiratory problems (Wegman & Stetler, 2009; Dube et al., 2009) and neurological problems (Paras et al., 2009). Early abuse survivors can also develop medically unexplained symptoms which were recognized through greater number of hospital outpatient and emergency department visits, speciality and primary care as well as pharmacy visits compared to those without the experience childhood sexual abuse (Bonomi et al., 2008).

Obesity and Body Mass Index (BMI) Problems in Adults with Abuse History

Adult survivors who experienced early life trauma with intercourse were found to have two times the chances of being obese (McCarthy-Jones & McCarthy-Jones, 2014). Body mass index (BMI) is considered to be a significant mediator for heart disease in individuals who has experienced childhood abuse (Williamson et al., 2002; McCarthy-Jones & McCarthy-Jones, 2014). Adults who fall in to the obese range tend to develop physical health problems such as cardiac disease, as a consequence of increased blood pressure, higher probabilities of atherosclerosis and insulin resistance and the occurrences of low grade chronic inflammatory disease (Muntner, 2004; Siervo et al., 2012; Willett, 1995). Studies conducted to explore the causal factors other than the traditional pathways which include smoking, diabetes and the rest of Ischemic heart disease (IHD) strongly indicate that adverse childhood experiences (ACEs), especially CSA is directly linked to a higher risk of IHD. It was also shown that psychological factors which are caused mainly due to ACEs appear to be more significant factors than the traditional risk factors in the increased risk of IHD in adulthood. The study comprised of a cluster of possible mediators which included BMI as a mediator to IHD (Dong et al., 2004). Animal as well as human studies have revealed that ACEs cause inflammatory responses. Chronic stress associated with early trauma also leads to the development of inflammation which reduces the inhibitory effects of cortisol which otherwise has the ability to supress inflammation (Danese et al., 2009; Hennessy et al., 2010; Raison et al., 2006).

Survivors and victims of early life trauma often experience distorted perceptions body and self-image. These include dissatisfaction about body, body shape and appearance due to the disgust and shame caused by the abuse. Many individuals who have experienced early onset trauma also uses these body perceptions and

distortions as an escape from the debilitating emotional and cognitive effects of the traumatic event. Body oriented self-harm, binge eating, purging behaviours, reducing or increasing the size of the body which subsequently reduces attractiveness to avoid any future abuse are all coping mechanisms used to gain back the loss of control over oneself and their body as a coping mechanism towards the interpersonal and intrapsychic conflicts which includes shame, guilt and powerlessness (Karr et al., 2012).

Mental Health Concerns

Early onset sexual abuse is considered to be one of the highest risk factor in contributing to psychological trauma in adulthood and is proven to have a negative impact on the brain development and functionality (Heim et al., 2013). Childhood abuse is also a strong determinant in lifetime psychopathology in adults who have experienced early onset trauma (Lev-Wiesel et al., 2018). Depending on the age, the consequences of sexual abuse symptoms can be varied. Some of the symptoms exhibited by children early on can be maladjustment in school, social isolation behaviour, somatic problems like enuresis, developmental delays, neurobiological changes, sexual behaviour problems, PTSD, behavioural concerns, and poor self-esteem (Paolucci et al., 2001). While in adults the symptomatology can be different. Growing up, individuals with the experience of an early onset trauma can exhibit high-risk sexual behaviours, early sexual initiation, unwanted pregnancies, sexually transmitted diseases, PTSD, depression, neurobiological changes, distrust, anxiety, fear, eating disorders, self-harming or self-destructive behaviours, strained relationships, lack of emotional commitments, revictimization, etc. are some of the most commonly reported symptoms (Putnam, 2003).

Neuropsychological Findings (Structural and Functional Changes)

Childhood trauma is a strong forecaster of psychopathology. Studies suggest that adverse early childhood effects like sexual abuse contributes to long lasting and permanent structural brain alterations such as neurohumoral and neurotransmitter effects which manifests in the poor development of the hippocampus, amygdala, corpus callosum, cerebral cortex and the cerebellar vermis These brain alterations explain the difficulties associated with communication, memory retrieval, development of psychiatric disorders, emotional processing and regulation. Childhood trauma, especially sexual abuse trauma is a major contributor to the later development of serious mental health concerns. The change in the structure of the brain along with severe stress and impacts of the trauma causes serious emotional and physical implications in the life of an individual (Lev-Wiesel et al., 2018; Frodl et al., 2010; Rinne-Albers et al., 2013; Tomoda et al., 2009). The abnormalities in the brain that signifies psychological trauma caused by early trauma entails

comparable neurobiological pathogenies to the damage caused by traumatic brain injury (TBI) (Hadanny & Efrati, 2016). Depending on an individual's background and social and personal resources, adverse childhood experiences can have detrimental long-term consequences on the mental health of an adult which manifests in various forms of impairments such as anxiety disorders, depression, posttraumatic stress disorder (PTSD), recall and memory problems, dissociative disorders, personality disorders and psychosis (Bremner et al., 1997; Wolf & Nochajski, 2013; Hovens et al., 2015).

Studies have reported consistent findings in the 'structural abnormalities in the development of the corpus callosum, amygdala, hippocampus, cerebral cortex and cerebral vermis of the brain in children and adolescents who have experienced ACEs' (Rinne-Albers et al., 2013, p. 745–755; Lev-Wiesel et al., 2018). Research has also revealed that CSA is associated with changes in brain morphology in the stress-sensitive regions of the brain. It was found that there was a reduction in the grey matter volume due to the exposure to early life trauma which also has a significant influence on the developing mammalian visual cortex (Tomoda et al., 2009). Adults who experienced adverse childhood experiences also displayed higher occurrences of lifetime major depression, substance abuse, sexual dysfunction and somatization (Harrop-Griffiths et al., 1988) and was found to have more than three times the chances of having mental health disorders, more than four times the chances of being alcohol dependent, five times the likelihoods of being drug dependant and more than six times the odds of attempting suicide compare to individuals with no history of childhood abuse (McCarthy-Jones & McCarthy-Jones, 2014).

Posttraumatic Stress Disorder (PTSD) in Adults with Sexual Abuse Trauma

One of the most prominent long-term effects of childhood abuse is posttraumatic stress disorder that carries on in to adulthood (Briggs & Joyce, 1997). Traumatic stress is a mental health condition that is classified under anxiety disorders and is developed as a response to a traumatic situation. 'PTSD is characterised by the symptoms of reliving the traumatic experience(s) called "flashbacks", avoidance of any reminders of the unpleasant event(s), emotional dysregulation, startled responses' (McLean et al., 2014). Posttraumatic stress disorder includes symptoms such as nightmares, flashbacks and re-experiencing the traumatic event. Dissociation which involves losing track of time and place or having experiences of depersonalization and derealization as well as flashback which is primarily emotional which manifests as feeling fearful, distressed and anxious without any apparent reason are also symptoms of PTSD. Some other debilitating effects of traumatic stress disorder are vivid and intrusive memories, altered attention and consciousness, problems in affect regulation, difficulty in making and maintaining interpersonal relationships, distorted belief systems, feeling of being defeated or worthless, strong physical sensations and somatic symptoms and hypervigilance with persistent feelings of threat (Su & Stone, 2020). Self-harm in childhood abuse victims is a form of emotional

avoidance and numbing as well as posttraumatic dissociation, and individuals also develop memory issues related to the event. Stress disorder is an alarming factor and is a strong manifestation of sexual abuse trauma. PTSD is the result of re-experiencing the trauma even after a month of the occurrence of the incident. Traumatic events causes dysregulation in the body that can be observed in the major systems of the body such as endocrine, immune and the neural systems (Brunello et al., 2001). For some people, traumatic stress can occur after 3 months of the occurrence of an event and for some after a year or more.

Abuse-related PTSD in children manifests in losing interest in pleasurable activities, regressions to thumb sucking, bedwetting and age inappropriate behaviours, outbursts, emotion dysregulation, unusual fears, attachment issues, learning, attention and concentration problems, inability to talk and disrespectful attitudes (Batchelder et al., 2018). Early onset abuse manifestation in PTSD in adults has been associated with problems in sexuality, emotional dysregulation, lack of self-esteem and boundaries, anxiety, difficulty in relationships, distorted body image and engaging in risky behaviours (The Ranch TN, 2021). Complex trauma which has higher chances of becoming PTSD results in an adult losing core capabilities such as self-regulation, increased impairment in mental, behavioural and emotional functioning, interpersonal relatedness as well as legal, family and vocational problems (Cook et al., 2005).

Attachment-Related Findings with People with Early Onset Trauma

Research also suggests a reciprocal relationship between attachment and trauma in adulthood. Attachment is a subjective sense of security that one may have that other people will react to their needs of support, belonging and comfort. Trauma activates the attachment system and the need to feel protected (Lieberman et al., 1997). Secure attachment patterns can have restorative effects on trauma since the feelings of safety can eliminate the feelings of danger or threat and help in the neurobiological rewiring of the brain after a traumatic experience (Maunder & Hunter, 2001). Studies have also shown that adult CSA survivors with a secure attachment representation were at lower risk of PTSD compared to early life abuse survivors with an insecure attachment pattern.

The attachment pattern becomes very evident in trauma-related symptoms especially because these patterns manifested in considerably more depressive, anxiety, dissociative and somatic symptoms in adults. Those with an insecure attachment style were also found to display more trauma-related anger later in their life (Briere et al., 2008). Research also suggests that maltreatment, especially childhood abuse often co-occurs in adverse family conditions and environments.

Poor parenting and a generally maltreating nature of environment has shown to have reported higher rates of child abuse. Studies have also revealed a strong relation between household instability and parenting variables to increased suicide ideation in adult early onset trauma survivors and victims. There is also a variance in how household instability affects men and women; parenting variables and

household instability is seen to have a higher impact on the suicidal ideation and attempts in women than in men (Li et al., 2012). Most victims and survivors of early life abuse trauma, especially men, tend to exhibit an array of externalizing behaviours in their adult life such as addictions, confusion in sexual identity, anger and aggression at themselves and others, self-harm and suicidal ideation as a result of the emotional dysregulation caused by the trauma. These maladaptive coping strategies are considered as a way of relief from distressing emotions and also contribute to a distortion in self-perception (Fisher et al., 2017; Nelson et al., 2011). These destructive coping strategies which includes self-destructive and avoidant behaviours used by survivors are also a result of the availability of social and personal resources available. This link between early life abuse and negative coping strategies increases the likelihood to sexual revictimization in adulthood (Astbury, 2013).

Personality Pathology Among Adults with Sexual Abuse History

A study comparing men's and women's experiences on childhood abuse found that men were more prone to anger, aggression and fear which lead to physical and emotional disconnection. As a result men who experienced early life trauma was reported to be hyperactive, have gone through indisposition and bullying, had learning difficulties, misused alcohol and drugs, addictions and displayed criminal behaviours. They also had poor interpersonal relationships as well as broken self-image and self-identity (Karr et al., 2012). Most men also reported to have endured the pain and trauma silently due to prejudice and were unable to seek help later in life (Sigurdardottir et al., 2012).

In females, CSA trauma had severe consequences on physical and mental health, especially incestuous abuse. A lack of trauma-informed care was also identified in females with the history of early onset abuse. Poor self-identity, body image and self-esteem also lead to revictimization during adulthood in large number of females. Women also reported multiple chronic complaints, mental and physical health comorbidities, pregnancy, and birth-related issues as well as severe relationship concerns (Bachmann et al., 1988a).

Sexual abuse trauma affects many facets of the victim's life and can leave long-term impacts that not only affect the self but people around them. For many victims of early onset trauma, mental health concerns also stem from a lack of trust and inability to create and maintain healthy intra and interpersonal relationships.

Interpersonal Relationships

CSA is correlated to reduced social adjustment and relationship-related problems in adults. It is also associated with violence in intimate relationships, adult sexual assault, disturbed sexual functioning and poor relationship satisfaction (Heiman &

Heard-Davison, 2004; DiLillo, 2001; Messman-Moore & Long, 2003). A large number of early abuse survivors also reported difficulty in maintaining stable and safe intimate relationships in their adulthood due to increased levels of sexually risky behaviours (Testa et al., 2005). A lot of early onset sexual abuse cases have been found to be unreported even during adulthood of the victims. Reporting childhood abuse is also linked to a decline in socioeconomic status, sexual problems, issues with trust and disruption in intimate relationships (Montigny Gauthier et al., 2018).

Early life trauma survivors tend to naturally perceive their partners as controlling and uncaring. The families or couples that reported emotional and physical abuse and violence had childhood abuse as a more common history (Mullen et al., 1994). 'More than one third female victims, which is 35.2% who were victims of early onset abuse and trauma reported rape or sexual assault as adults' (Messman-Moore et al., 2010, p. 967). Intimate partner violence (IPV) is also a common reported problem among childhood abuse victims (Messman-Moore et al., 2010). Risky sexual behaviours, poor risk assessment and recognition, dissociation, and drug and alcohol misuse might act as mediators of early life abuse and adult revictimization. Emotion dysregulation, dissociation, and poor attachment styles lead to problems in interpersonal difficulties which increases the complexity of intimate relationships (Messman-Moore & Long, 2003).

The psychological trauma inflicted by abuse can be categorized in to 'four trauma genic dynamics during adulthood- stigmatization, betrayal, traumatic sexualization and powerlessness' (Finkelhor & Browne, 1985, p. 530). The dynamic of powerlessness results in an inability in saying 'no' (Gelinas, 1983). Along with the learned helplessness, this dynamic of powerlessness is internalized to minimize the injury as a result of which the seriousness of the abuse is denied (Auerbach Walker & Browne, 1985). The stigmatization and betrayal dynamics- both internal and external, leads to shame and self-blame which affects the peer acceptance and friendship and closeness perceptions. This also results in making the victim feel less capable of satisfying relationships with peers and romantic partners (Feiring et al., 2000). This disrupts interpersonal relationships and results in fewer friends and trustworthy relationships in the life of an early life abuse survivor. Due to the impairment in perceptual abilities and the feelings of powerlessness and lack of boundaries, childhood abuse victims often tend to fulfil others' needs at the expense of their wellbeing and have poor understanding of a healthy balance in relationships as adults (Gelinas, 1983).

Issues with relationships flags a number of concerns such as loneliness, isolation, lack of support and vulnerability. This also leads to development of thought and behavioural patterns that can impact the personality of an individual with an early life trauma (Hemmati et al., 2020).

Behavioural and Personality-Related Concerns

Behavioural concerns on adults with the history of early onset abuse manifests as inappropriate and risky sexual behaviours. Research has corroborated the effects of early onset abuse on satisfaction and sexual relationship with intimate partners. In women with the history of early onset abuse, experiencing very intense ambivalent feelings such as devaluation, hostility, disillusionment, idealization and mistrust are common occurrences compared to women without the history of abuse (Briere, 1996).

Research interview data also suggests that a general dissatisfaction in couple relationships, fear of partners, marital and relationship discord is a general pattern due to the trauma caused by the abusive event(s). Revictimization or later life victimization from partner or intimate relationships in the form of sexual or physical assault is also reported in a lot of individuals with the history of childhood abuse due to the disturbed dynamics and perceptions. In many studies, two general patterns of sexual behaviours are observed in victims and survivors of childhood abuse. One reveals the relation of early life sexual abuse to high-risk sexual behaviours and activities such as increased number of relationships and frequencies, taking part in prostitution or commercialized sexual activities and poor use of risk reducing contraceptives. The second reveals a high association with sexual victimization early in life and behavioural symptoms of poor sexual satisfaction. This is generally manifested in the form of copulatory pain, sexual arousal disorders or repressed orgasms (Najman et al., 2005).

Survivors and victims of early onset abuse often experience distorted perceptions body and self-image. These include dissatisfaction about body, body shape and appearance due to the disgust and shame caused by the abuse. Many individuals who have experienced childhood trauma also uses these body perceptions and distortions as an escape from the debilitating emotional and cognitive effects of the traumatic event. Body oriented self-harm, binge eating, purging behaviours, reducing or increasing the size of the body which subsequently reduces attractiveness to avoid any future abuse are all coping mechanisms used to gain back the loss of control over oneself and their body as a coping mechanism towards the interpersonal and intrapsychic conflicts which includes shame, guilt and powerlessness (Karr et al., 2012). Self-harm in childhood sexual abuse victims is a form of emotional avoidance and numbing as well as posttraumatic dissociation, and individuals also develop memory issues related to the event (Jacobs-Kayam & Lev-Wiesel, 2019).

Personality traits of an adult are not the result of genetic predisposition alone. It can also be attributed to an individuals lived personal experiences. Children who have been maltreated and abused continue to show heightened risks in psychiatric comorbidities and personality disorders in adulthood (Fletcher & Schurer, 2017). Many victims of early life trauma experiences complex PTSD which tends to be diagnosed as Borderline Personality Disorder (BPD) because of the crossover of the symptomatology and as a result of which they experience the stigma associated with a personality disorder (Cloitre et al., 2014). PTSD is also comorbid with many other mental health disorders such as substance abuse disorders, personality disorders,

major depressive disorder and eating disorders. Bipolar disorder is also an additional mental illness that is associated with CSA. Individuals who have experienced severe physical and sexual abuse in their childhood experience severe manic episodes (Brietzke et al., 2012). The repeated depression that hinders a successful treatment process is later diagnosed as bipolar disorder. Sexual abuse trauma is associated with higher number of mood episodes in individuals with the diagnosis of bipolar disorder (Larsson et al., 2013).

Socioeconomic/Environmental Context

The impact of early onset trauma and abuse significantly extends to other areas of life such as the socioeconomic wellbeing, career, achievements and social status. The functional domains of education is greatly affected which results in underachievement and failure (Boden et al., 2007). Research conducted by Zielinski (2015) found that adults who were physically and sexually abused as children were markedly on the possibility to be living below the poverty line, unemployed compared to adults who did not experience abuse in their life. A study on the gap between early trauma experiences and socioeconomic wellbeing in adulthood indicated growing rates of poor economic productivity, over spending, diminished tax revenue, poor socioeconomic status as well as transmission of violence through generations (Zielinski, 2009). CSA is correlated with poor educational outcomes, unemployment, reduced income and financial instability during adulthood. As a result of this poor socioeconomic backwardness, also causes homelessness in many adult victims of early onset trauma (Henny et al., 2007).

Social Issues of CSA Disclosure

Disclosure of CSA is an extremely difficult and complex process due to the detected and experienced incongruities. '60–70% of childhood abuse survivors fail to disclose the event until they become adults and 27.8% of them do not share the incident at all'. Most of the time, children do not understand what they are being exposed to, since they do not have any preconditioning to the event (Halvorsen et al., 2020, p. 1). This makes disclosure a problem even during adulthood due to the conflicts it can create in their personal and interpersonal lives (Halvorsen et al., 2020, p. 1). The psychological consequences for a someone exposed to a traumatic event includes fear, shock, denial, nervousness and anxiety, confusion, withdrawal, guilt, isolation and grief. These chronic effects can have severe impact on their adjustments and thoughts throughout their adult lives (De Sousa et al., 2017). Most individuals who are exposed to an early life abuse incident tend to feel guilty after the exposure to a traumatic event as they feel responsible for what happened (Paul, 2019). Through disclosure and from the perpetrator being a family member, most familial

relationships tend to suffer and the survivors may feel responsible for the changes in the family dynamics.

A disclosed event of sexual abuse has been observed to also affect the parents and close ones of survivors and victims of the trauma since they feel greatly responsible and feel powerless for the inability in protecting the person exposed to the event (IICSA, 2018). There is also an innate urge to keep things normal in victims and survivors due to the negative self-representation caused by early onset abuse as staining. Due to the lack of self-respect and devaluation of one's own needs, individuals fear disclosure due to the feeling that it would take away their identity and be marked as different even as an adult (Halvorsen et al., 2020). Research also throws light in to the fact that victims of an abusive event fail to disclose and seek help and tend to blame themselves for the events and experiences they do not necessarily understand. They try to not put themselves through any trouble by keeping a secret or maintaining silence since their dependence on the perpetrator (Turkus, 1994; Herman, 1998; Alaggia et al., 2017; Solberg et al., 2021).

Early onset abuse disclosure is understood as a reiterative and interactive process rather than an isolated one-time event. Childhood abuse is now recognized as a multidimensional and carefully assessed matter rather than a single event (Alaggia et al., 2017). The revolutionary proposition by Summit (1983), on the Child Sexual Abuse Accommodation Syndrome (CSAA) lead to this understanding of early life abuse which mentioned a five stage model of sexual victimization dynamic. 'The proposed contingencies that are sequential to a sexual assault incident were (1) secrecy (2) helplessness (3) accommodation and entrapment (4) tentative, delayed and unconvincing disclosure (5) denial or recantation'. Although this model was developed to help therapists improve the therapy outcomes as a clinical opinion, this has also served in advanced understanding of the process of disclosure (Summit, 1983, p. 1). Childhood sexual abuse is the most universal public health concern and is the most hidden form of violence that is under reported. The shame and social stigma associated with childhood abuse is why it remains the most underreported crime (Human Rights Watch, 2013). Most newspapers and media fail to report the necessary and crucial details and includes unwarranted details, not maintaining ethical standards. This consequently adds on to the shame and psychological and social burden experienced by the victims (Collings et al., 2005). The International Federation of Journalists (IFJ) and UNICEF has adopted guidelines on maintaining accuracy and sensitivity while reporting on issues that involve children. A lack of knowledge about children's rights along with the sensationalism and news worthiness of early life abuse are major reason in unethical news reporting of sexual abuse which leads to shame in disclosing an incident (Anik et al., 2021).

Studies on early life trauma has shown that some children are able to disclose and report the abuse soon after the event and some are not able to tell anyone and they may remain silent for years and sometimes over their lifetime (Alaggia et al., 2017). Disclosure is also depends greatly on the kind of abuse, the perpetrator being a stranger or a family member or a known person, the age of the child and the availability of a trusted person (Collin-Vézina et al., 2015; Lemaigre et al., 2017). Collin-Vézina et al. (2015) indicates that there are a few barriers that inhibits the reporting

of an abusive incident. Barriers with the self like self-blame, attempts of protecting the self, age and maturity at the time of the traumatic event, shame, guilt, poor cognitive development; difficulties related to others such as dysfunctional family dynamics, power dynamics, poor social network, judgements, fear of consequences; factors connecting to the social world such as culture, societal taboo around sexuality, labelling, name calling.

Gender plays an important role in the disclosure (Easton, 2012). Men experience more fear, guilt and embarrassment when it comes to reporting an abusive experience. They also experience a fear of being perceived as a potential perpetrator following the disclosure (Fontes & Plummer, 2010). The social and cultural perceptions of masculinity also impact the disclosure and reporting of early onset abuse. Masculinity equates abuse and victimization as weakness and it leads to anger, shame and withdrawal in male survivors (Easton et al., 2014).

Studies have also identified several cultural factors that prevent disclosure of abuse. These factors include accusation of women for being abused, beliefs that men cannot be victimized, the sexual scripts assigning gender roles, beliefs that virginity affects the dignity of the person and the family as well (Fontes & Plummer, 2010). Existing quantitative and qualitative research shows that several of the aforementioned factors affect the disclosure of an early life traumatic and abusive event (Lemaigre et al., 2017).

One other factor that affects disclosure is intrafamilial abuse (London et al., 2005). In such cases, the perpetrator may or may not be related to the victim. From the child's point of view, if an individual is considered as family, then it is classified under intrafamilial abuse. More than two thirds of childhood abuse reported was found to be involving a perpetrator close to the victim. Research has also recorded majority of perpetrators being males and below the age of 18 years. Intrafamilial abuse has very rarely been an isolated event. The abuse may go on for years with the victim being fearful of the abuser, worrying that the perpetrator might get in to trouble, a sense of responsibility for what happened as well as the dignity of the family being affected. Intrafamilial abuse also involves a great amount of secrecy, stigma and a sense of betrayal (McNeish & Scott, 2018).

Survivors or victims experience a great deal of shame, guilt, shame, fear of stigmatization, fear of the perpetrator, worries about the future, worries about losing dignity and the fear of not being believed. Fear of being unsafe and fear of others' reactions and judgements as well as being neglected at the attempt of disclosure are also major contributing factors to disclosure (or nondisclosure) (Hershkowitz et al., 2007; McElvaney & Culhane, 2015). Another factor that contributes to the rate of disclosure is the time-period when the victim or the survivor grew up. An understanding about how safe it is to discuss and reveal their experience and the listeners being open enough to create a safe space is greatly depended on the time-period and the environment which considers topics alongside sexual activities as a taboo or not (McRobert, 2022).

All of the above-mentioned factors lead to lack of self- respect and devaluation of the self which in turn affects the self-expression and perceptions about oneself. It

takes enormous strength and courage to let others and the world know about the incident.

Forensic and Legal Aspects of Sexual Abuse

The forensic focus to aid the conviction of the enforcer has been on the thorough documentation, collection of evidences and the resetting the crime to help with the prosecution of the case. In cases of abuse, forensic examinations play a major role in the court proceedings and the legal management of suspected traumatic abusive incident. A forensic examination is conducted using a forensic kit to collect the biological evidences that is usually only handled by the clinician, nurse or police handling the case. The principles that are followed using and holding the kit throws light at the relevance of the kit at the time the individual decides to press charges against the perpetrator. The collection of forensic evidence is also time bound (Niec, 2002). Due to the possible transfer of secretions in sexual abuse, forensic kits and DNA traces facilitates the identification of the perpetrator (Kaur et al., 2021). A study conducted by Christian et al. (2000), on identifying forensic evidences on prepubertal sexual assault victims found that timely collection of evidences was mandatory such as clothes and linens to be given predominance. All other evidences such as body swab collection, blood and sperm/semen collected after 24 hours were unnecessary. DNA analysis is seen to have an exceptional effect on the criminal justice system due to the high reliance on the validation of a case. Most lawyers and jurors expect DNA evidence to convict a case. This also raises concerns as DNA in sexual assault cases becomes a major part in conviction and the cases without the probatory DNA evidences may lose stance (Waltke et al., 2017). In the medico-legal examinations post assault, forensic samples along with genital examinations are the most important components of assessments. To determine the components of the forensic testing, a standard method of assessment of sexual maturity is also adopted to aid the understanding of the physical maturity of the victim (Niec, 2002).

When collecting forensic evidences, any bruises, bite marks, injury, seminal fluids, pubic hair, any damage to the mouth and oral cavity, nail clippings, finger prints, blood or urine samples, body, breasts, vaginal and anal swabs are some of the best suited components to be included in the kit (Christian et al., 2000; Kaur et al., 2021). Another important factor that aids forensic examination in the case of a sexual assault crime is the informed consent from the victim. The victims must be informed of what can be expected and what procedures will be carried out during the examination. In case of victims younger than 16 years of age, the consent is to be obtained from the parent or guardian accompanying the victim only after the individual agrees to undergo the assessment. In case of a minor who is unaccompanied by an adult, they are usually termed as ‘mature minor’ and is qualified to provide consent. In any case, the victim should be given ample information about the procedures, protocols and limitations of the examination before the decision to give the consent is made (Niec, 2002).

Science is about facts and it is nonjudgemental. This is the very reason that sexual assault crimes can rely on forensic evidences for case convictions. Hence, criminal justice systems can get great help from DNA and non-DNA samples. Although, identifying, collecting, processing, analysing and preserving the evidences being done in a timely manner is most critical (Waltke et al., 2017). The legal issues around reporting of sexual assault is found to be the lack of testing of the forensic kits as well as the police not submitting the Sexual Assault Kits (SAKs) due to the doubts on the value of evidence these kits provide and the credibility of the people that have been assaulted. This impacts the criminal proceedings as well as the arrest decisions (Campbell et al., 2015).

The other legal and forensic issues in cases of CSA are related to the disclosure discrepancies between the reported, experienced and identified incidents (Stoltenborgh et al., 2014). A major forensic and legal concern of sexual assault cases is the delay in disclosure which has serious implications in the outcomes of these cases. The clarity in remembering incidents and the reality and honesty of the cases disclosed within forensic interviews merits further attention (Alaggia et al., 2017). In forensic interviews that are carried out in courtrooms, the strategies used by the defence lawyers imply lack of credibility and dishonesty from the victims. The nature of questions asked by the defence and the prosecution as well as the tactics used to interview greatly affects the response given by the victim. Most individuals fail to disclose and report and abusive incident due to the shame and fear attached to such a disclosure. Due to the delay in disclosing a traumatic event, the nature of trauma involved and factors like PTSD or dissociation or effects on the memory can affect the clarity with which a person can report the event. From a prosecution standpoint, these aspects greatly influence the indictment or conclusion of the case (Skinner, 2020). Through adult surveys of sexual abuse disclosure, it has been found that delays in disclosure and nondisclosure have great impacts on child protection, social justice and mental and physical health outcomes. Studies conducted on adult survivors as well as adolescents who experienced early life trauma revealed that forensic and interrogatory interactions lead to high nondisclosures in children even in cases with medical evidences. In adults, a disclosure delayed by 20–50 years was found (McElvaney, 2013). While CSA disclosures are delayed, researchers agree that the delay is due to repressed memories due to the traumatic events. These memories maybe repressed or forgotten due to the impact the abusive incident has on the individual. These repressed memories may come back or surface only in therapy as part of addressing distressful emotions or feelings (Loftus & Davis, 2006). Research has also showed individuals' conscious effort in forgetting or avoiding the memories of trauma since they cause distress. Hence, these memories are labelled horrible and frightening and are pushed out of their minds (Edwards et al., 2007). Infantile amnesia, a condition characterized by the loss or absence of early life memories, could be a reason for the lack of disclosure and clarity of events. Polyvictimization which is caused due to multiple traumatic experiences in childhood is found to be another reason for lack of memory retrieval due to the intensity of distress caused by repeated trauma. Individuals with avoidant coping

mechanisms due to attachment issues caused by early onset trauma are found to have greater loss of memory detail (Goodman et al., 2018).

Management of CSA

There are various treatment models that have been proposed to treat victims and survivors of CSA. The most widely used and studied method is the cognitive behavioural therapy (CBT). CBT used for trauma survivors is termed as trauma-focused cognitive behavioural therapy (TF-CBT) which is designed to address issues related to the traumatic incident. TF-CBT focuses on the trauma narrative that helps in addressing the fears and anxieties and to psycho-educate and equip the individuals with relaxation, healthy coping and self-regulation skills (Cohen & Mannarino, 2008). Another therapy model that is proposed to be very effective on trauma is Eye Movement Desensitization and Reprocessing (EMDR). Studies suggest that EMDR therapy has shown similar positive effects to that of CBT in adults with a few benefits on reducing behavioural issues (Jaberghaderi et al., 2004). Additionally, self-reports from groups that were treated with CBT and EMDR favoured EMDR due to rapid recovery as well as fewer number of sessions compared to CBT (Nijdam et al., 2012). However, the effectiveness of EMDR therapy on abuse trauma survivors is not clear due to the very few numbers of studies conducted on the success of EMDR.

Individual and group therapies are another form of evidence-based models that are used in treatment of trauma. Group therapy has shown more effect in improving self-concept, appropriate social skills and building trust while individual therapy has shown to reduce anxiety and depressive symptoms. Group therapy tends to be widely used and preferred due to the economic advantages as well as the benefits of belonging to a group (Knittle & Tuana, 1980; Kruczek & Vitanza, 1999).

Studies have proven play therapy and related treatment modalities to be effective for younger children. Since play therapy do not rely rigidly on verbal communication, children tend to enjoy and be able to work through their problems through play (Pifalo, 2006). Additionally, play therapy also aids in effective childhood abuse disclosure due to a difficulty in appropriately verbally reporting the incident (Paine & Hansen, 2002). Studies have also corroborated the efficiency of play therapy due to the reduction in externalized behaviours such as anger, aggression, conduct issues, antisocial as well as sexually inappropriate behaviours. Children who attended play therapy was also observed to have decreased internalizing concerns such as anxiety, self-blame, shame, guilt and nightmares (Greenspan et al., 2013).

A study conducted on combining psychotherapy and Hyperbaric Oxygen Treatment (HBOT) has shown to induce neuroplasticity and improves connectivity between the impacted areas of the brain, thus restoring the brain function. This mode of treatment which is carried out in three phases is proven to decrease levels of dissociation and elevate cognitive and emotional coping abilities. The three stages were designed in a way for a trauma survivor to recall and recollect the painful experiences and negative cognitions followed by reduction in distressing

symptoms such as hypervigilance, anxiety, nightmares, and depression and were taken over by an emotional and physical relaxed state of being. In the third phase, newer physical and emotional energy and outlook instilled where participants tend to take on a future orientation shedding the past orientation. The findings of the study leads to a new understanding of treatment which focuses on a dual modality of treatment focusing the mind, brain and body and not merely reducing symptoms (Lev-Wiesel et al., 2018).

The aforementioned evidence-based trauma-focused interventions are widely used to treat survivors and victims of early abuse. Nonetheless, for individuals displaying severe distressing and persistent symptoms, alongside psychotherapy, medications in the form of antipsychotic drugs or mood stabilizers are provided to aid in ameliorating the symptoms as well as for a more optimistic treatment response to psychotherapy (McLaren et al., 2018). The American Academy of Child and Adolescent Psychiatry (AACAP) advises in the practice parameters the use of selective serotonin reuptake inhibitors (SSRIs) only after ineffective trials of evidence-based psychotherapies. AACAP also recommends pharmacotherapy with conjunction with psychotherapy in treatment of comorbid presentations (Cohen, 2010).

Treatment for adults who has disclosed and is experiencing the distress of early onset abuse includes factors that are specific and nonspecific to therapy approaches. Unconditional positive regard, attention, a trusted therapist-client relationship are some on the nonspecific factors that help mediate and regulate the therapy process (Jensen et al., 2005). The most common therapeutic approaches used to treat adults with sexual abuse trauma are cognitive behavioural therapy (CBT), cognitive processing therapy (CPT), supportive therapy, EMDR, exposure therapy and psychodynamic psychotherapy. These approaches help clients address the memories that are stuck and distressing and help change the trauma narrative (Wilen et al., 2017). Of the various types of treatment the above mentioned therapies have proven to be effective on many levels. There is no one best method of intervention that the literature suggests. There is some evidence in the effectiveness of each treatment type. More research is required on the treatment components that will help in advancing the treatment for early onset abuse victims and survivors (Tichelaar et al., 2020).

Conclusion

CSA still remains to be a major public health concern. Abuse of any kind has significant impact through the lifespan of an individual. It is shown to have debilitating effects on the physical, mental, emotional, sexual, personal and interpersonal aspects of an individual's life. Despite the precautionary measure taken by individuals, families and the social justice systems, sexual abuse is highly prevalent among children and youth. It is important to continue research on the topic of early life abuse and its long-term effects to better understand the severity and implications as well as to better the treatment outcomes and the modalities used by the healthcare

professionals. The statistics and prevalence of childhood trauma throws light in to the importance of educating the public and especially adolescents and youth with ample information and normalization of disclosure and intervention to help work towards promoting better health outcomes. Improving disclosure facilitation and strengthening the disclosure resources has become the need of the hour due to the alarming rates at which traumatic incidences occur and the reason why victims and survivors remain silent. Awareness from a young age on the adverse effects of early onset trauma can help deal with the physical, emotional, psychological, cognitive, and socioeconomic factors in adulthood. Safer systems to support, disclose, and report an event as well as ameliorating the screening and intervention methods will help delineating the tremendous darkness associated with sexual abuse trauma. Educating individuals in families, society and other institutions on how to respond to and support disclosure of abuse will have far reaching effects in aiding better disclosure and awareness.

References

Afifi, T. O., Enns, M. W., Cox, B. J., de Graaf, R., ten Have, M., & Sareen, J. (2007). Child abuse and health-related quality of life in adulthood. *The Journal of Nervous and Mental Disease, 195*(10), 797–804.

Alaggia, R., Collin-Vézina, D., & Lateef, R. (2017). Facilitators and barriers to child sexual abuse (CSA) disclosures: A research update (2000–2016). *Trauma, Violence, & Abuse, 20*(2), 260–283.

American Psychological Association. (n.d.). *APA dictionary of psychology*. American Psychological Association. Retrieved March 19, 2022.

American Gastroenterological Association. (1997). American Gastroenterological Association medical position statement: Irritable bowel syndrome. *Gastroenterology, 112*, 2118–2137.

Anik, A. I., Towhid, M. I., Islam, S. S., Mallik, M. T., Azim, S., Rahman, M. G., & Haque, M. A. (2021). Deviance from the ethical standard of reporting child sexual abuse in daily newspapers of Bangladesh. *Humanities and Social Sciences Communications, 8*(1), 1–11.

Astbury, J. (2013). *Violating children's rights: The psychological impact of sexual abuse in childhood*. APS. Retrieved February 26, 2022.

Auerbach Walker, L. E., & Browne, A. (1985). Gender and victimization by intimates. *Journal of Personality, 53*(2), 179–195.

Bachmann, G. A., Bennet, J., & Moeller, T. p. (1988a). Consequences of childhood sexual abuse. *Journal of Nurse-Midwifery, 33*(5), 235–236.

Batchelder, A. W., Safren, S. A., Coleman, J. N., Boroughs, M. S., Thiim, A., Ironson, G. H., Shipherd, J. C., & O'Cleirigh, C. (2018). Indirect effects from childhood sexual abuse severity to PTSD: The role of avoidance coping. *Journal of Interpersonal Violence, 36*(9–10), NP5476–NP5495.

Beitchman, J. H., Zucker, K. J., Hood, J. E., DaCosta, G. A., Akman, D., & Cassavia, E. (1992). A review of the long-term effects of child sexual abuse. *Child Abuse & Neglect, 16*(1), 101–118.

Boden, J. M., Horwood, L. J., & Fergusson, D. M. (2007). Exposure to childhood sexual and physical abuse and subsequent educational achievement outcomes. *Child Abuse & Neglect, 31*(10), 1101–1114.

Boisset-Pioro, M. H., Esdaile, J. M., & Fitzcharles, M.-A. (1995). Sexual and physical abuse in women with fibromyalgia syndrome. *Arthritis and Rheumatism, 38*(2), 235–241.

Bonomi, A. E., Anderson, M. L., Rivara, F. P., Cannon, E. A., Fishman, P. A., Carrell, D., Reid, R. J., & Thompson, R. S. (2008). Health Care Utilization and costs associated with childhood abuse. *Journal of General Internal Medicine, 23*(3), 294–299.

Boynton-Jarrett, R., Wright, R. J., Putnam, F. W., Lividoti Hibert, E., Michels, K. B., Forman, M. R., & Rich-Edwards, J. (2013). Childhood abuse and age at menarche. *Journal of Adolescent Health, 52*(2), 241–247.

Bremner, J. D., Randall, P., Vermetten, E., Staib, L., Bronen, R. A., Mazure, C., Capelli, S., McCarthy, G., Innis, R. B., & Charney, D. S. (1997). Magnetic resonance imaging-based measurement of hippocampal volume in posttraumatic stress disorder related to childhood physical and sexual abuse—A preliminary report. *Biological Psychiatry, 41*(1), 23–32.

Breslau, N. (2002). Psychiatric morbidity in adult survivors of childhood trauma. *Seminars in Clinical Neuropsychiatry, 7*(2), 80–88.

Briere, J. (1996). Treating adults severely abused as children: The self-trauma model. In *Child abuse: New directions in prevention and treatment across the lifespan* (pp. 177–204).

Briere, J., Kaltman, S., & Green, B. L. (2008). Accumulated childhood trauma and symptom complexity. *Journal of Traumatic Stress, 21*(2), 223–226.

Brietzke, E., Sant'anna, M. K., Jackowski, A., Grassi-Oliveira, R., Bucker, J., Zugman, A., Mansur, R. B., & Bressan, R. A. (2012). Impact of childhood stress on psychopathology. *Revista Brasileira de Psiquiatria, 34*(4), 480–488.

Briggs, L., & Joyce, P. R. (1997). What determines post-traumatic stress disorder symptomatology for survivors of childhood sexual abuse? *Child Abuse & Neglect, 21*(6), 575–582.

Brown, R., & Kulik, J. (1977). Flashbulb memories. *Cognition, 5*(1), 73–99.

Brunello, N., Davidson, J. R. T., Deahl, M., Kessler, R. C., Mendlewicz, J., Racagni, G., Shalev, A. Y., & Zohar, J. (2001). Posttraumatic stress disorder: Diagnosis and epidemiology, comorbidity and social consequences, biology and treatment. *Neuropsychobiology, 43*(3), 150–162.

Campbell, R., Greeson, M. R., Fehler-Cabral, G., & Kennedy, A. C. (2015). Pathways to help. *Violence Against Women, 21*(7), 824–847.

Castro, Á., Ibáñez, J., Maté, B., Esteban, J., & Barrada, J. R. (2019). Childhood sexual abuse, sexual behavior, and revictimization in adolescence and youth: A mini review. *Frontiers in Psychology, 10*, 2018.

Choudhry, V., Dayal, R., Pillai, D., Kalokhe, A. S., Beier, K., & Patel, V. (2018). Child sexual abuse in India: A systematic review. *PLoS One, 13*(10), e0205086.

Christian, C. W., Lavelle, J. M., De Jong, A. R., Loiselle, J., Brenner, L., & Joffe, M. (2000). Forensic evidence findings in prepubertal victims of sexual assault. *Pediatrics, 106*(1), 100–104.

Cloitre, M., Garvert, D. W., Weiss, B., Carlson, E. B., & Bryant, R. A. (2014). Distinguishing PTSD, Complex PTSD, and borderline personality disorder: A latent class analysis. *European Journal of Psychotraumatology, 5*(1), 25097.

Cohen, J. A. (2010). Practice parameter for the assessment and treatment of children and adolescents with posttraumatic stress disorder. *Journal of the American Academy of Child & Adolescent Psychiatry, 49*(4), 414–430.

Cohen, J. A., & Mannarino, A. P. (2008). Trauma-focused cognitive behavioural therapy for children and parents. *Child and Adolescent Mental Health, 13*(4), 158–162.

Collings, S. J., Griffiths, S., & Kumalo, M. (2005). Patterns of disclosure in child sexual abuse. *South Africa Journal of Psychology, 35*(2), 270–285.

Collin-Vézina, D., De La Sablonnière-Griffin, M., Palmer, A. M., & Milne, L. (2015). A preliminary mapping of individual, relational, and social factors that impede disclosure of childhood sexual abuse. *Child Abuse & Neglect, 43*, 123–134.

Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Cloitre, M., DeRosa, R., Hubbard, R., Kagan, R., Liautaud, J., Mallah, K., Olafson, E., & van der Kolk, B. (2005). Complex trauma in children and adolescents. *Psychiatric Annals, 35*(5), 390–398.

Daines, C. L., Hansen, D., Novilla, M. L., & Crandall, A. A. (2021). Effects of positive and negative childhood experiences on Adult Family Health. *BMC Public Health, 21*(1), 651.

Danese, A., Moffitt, T. E., Harrington, H., Milne, B. J., Polanczyk, G., Pariante, C. M., Poulton, R., & Caspi, A. (2009). Adverse childhood experiences and adult risk factors for age-related dis-

ease: depression, inflammation, and clustering of metabolic risk markers. *Archives of Pediatrics & Adolescent Medicine, 163*(12), 1135–1143. https://doi.org/10.1001/archpediatrics.2009.214

De Sousa, A. A., Shrivastava, A. K., Karia, S. B., & Sonavane, S. S. (2017). Child sexual abuse and the development of psychiatric disorders: A neurobiological trajectory of pathogenesis. *Industrial Psychiatry Journal, 26*(1), 4. https://doi.org/10.4103/ipj.ipj_38_15

DiLillo, D. (2001). Interpersonal functioning among women reporting a history of childhood sexual abuse: Empirical findings and methodological issues. *Clinical Psychology Review, 21*(4), 553–576.

Dong, M., Giles, W. H., Felitti, V. J., Dube, S. R., Williams, J. E., Chapman, D. P., & Anda, R. F. (2004). Insights into causal pathways for ischemic heart disease. *Circulation, 110*(13), 1761–1766.

Downing, N. R., Akinlotan, M., & Thornhill, C. W. (2021). The impact of childhood sexual abuse and adverse childhood experiences on adult health related quality of life. *Child Abuse & Neglect, 120*, 105181.

Dube, S., Andra, R., Whitefield, C., Brown, D., Felitti, V., Dong, M., & Giles, W. (2005). Long-term consequences of childhood sexual abuse by gender of victim. *American Journal of Preventive Medicine, 28*(5), 430–438.

Dube, S. R., Fairweather, D. L., Pearson, W. S., Felitti, V. J., Anda, R. F., & Croft, J. B. (2009). Cumulative childhood stress and autoimmune diseases in adults. *Psychosomatic Medicine, 71*(2), 243–250.

Easton, S. D. (2012). Disclosure of child sexual abuse among adult male survivors. *Clinical Social Work Journal, 41*(4), 344–355.

Easton, S. D., Saltzman, L. Y., & Willis, D. G. (2014). "Would you tell under circumstances like that?": Barriers to disclosure of child sexual abuse for men. *Psychology of Men & Masculinity, 15*(4), 460–469.

Edwards, V. J., Dube, S. R., Felitti, V. J., & Anda, R. F. (2007). It's OK to ask about past abuse. *American Psychologist, 62*(4), 327–328. https://doi.org/10.1037/0003-066x62.4.327

Elliott, D. M., Mok, D. S., & Briere, J. (2004). Adult sexual assault: Prevalence, symptomatology, and sex differences in the general population. *Journal of Traumatic Stress, 17*(3), 203–211.

Ensink, K., Borelli, J. L., Normandin, L., Target, M., & Fonagy, P. (2020). Childhood sexual abuse and attachment insecurity: Associations with child psychological difficulties. *American Journal of Orthopsychiatry, 90*(1), 115–124. https://doi.org/10.1037/ort0000407

Feiring, C., Rosenthal, S., & Taska, L. (2000). Stigmatization and the development of friendship and romantic relationships in adolescent victims of sexual abuse. *Child Maltreatment, 5*(4), 311–322.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (2019). Reprint of: Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine, 56*(6), 774–786.

Finkelhor, D., & Browne, A. (1985). The traumatic impact of child sexual abuse: A conceptualization. *American Journal of Orthopsychiatry, 55*(4), 530–541.

Fisher, C., Goldsmith, A., Hurcombe, R., & Soares, C. (2017). (rep.). *The impacts of child sexual abuse: A rapid evidence assessment.*

Fletcher, J., & Schurer, S. (2017). Origins of adulthood personality: The role of adverse childhood experiences. *The B.E. Journal of Economic Analysis & Policy, 17*(2).

Fontes, L. A., & Plummer, C. (2010). Cultural issues in disclosures of child sexual abuse. *Journal of Child Sexual Abuse, 19*(5), 491–518.

Frodl, T., Reinhold, E., Koutsouleris, N., Reiser, M., & Meisenzahl, E. M. (2010). Interaction of childhood stress with hippocampus and prefrontal cortex volume reduction in major depression. *Journal of Psychiatric Research, 44*(13), 799–807.

Fullwood, A., & Drossman, D. A. (1995). The relationship of psychiatric illness with gastrointestinal disease. *Annual Review of Medicine, 46*(1), 483–496.

Gelinas, D. J. (1983). The persisting negative effects of incest. *Psychiatry, 46*(4), 312–332.

Goodman, G. S., Quas, J. A., & Ogle, C. M. (2010). Child maltreatment and memory. *Annual Review of Psychology, 61*(1), 325–351.

Goodman, G. S., Gonzalves, L., & Wolpe, S. (2018). False memories and true memories of childhood trauma: Balancing the risks. *Clinical Psychological Science, 7*(1), 29–31. https://doi.org/10.1177/2167702618797106

Greenspan, F., Moretzsohn, A. G., & Silverstone, P. H. (2013). What treatments are available for childhood sexual abuse, and how do they compare? *International Journal of Advances in Psychology, 2*(4), 232.

Hadanny, A., & Efrati, S. (2016). Treatment of persistent post-concussion syndrome due to mild traumatic brain injury: Current status and future directions. *Expert Review of Neurotherapeutics, 16*(8), 875–887.

Hall, M., & Hall, J. (2011). *The long-term effects of childhood sexual abuse: Counseling implications*.

Halvorsen, J. E., Tvedt Solberg, E., & Hjelen Stige, S. (2020). "to say it out loud is to kill your own childhood." – an exploration of the first person perspective of barriers to disclosing child sexual abuse. *Children and Youth Services Review, 113*, 104999.

Harrop-Griffiths, J., Hickok, L., Russo, J., Holm, L., Walker, E., & Katon, W. (1988). Relationship of chronic pelvic pain to psychiatric diagnoses and childhood sexual abuse. *American Journal of Psychiatry, 145*(1), 75–80.

Hashemi, S. M., Yousefichaijan, P., Salehi, B., Almasi-Hashiani, A., Rafiei, M., Zahedi, S., Khedmati Morasae, E., & Maghsoudlou, F. (2020). Comparison of child abuse history in patients with and without functional abdominal pain: A case-control study. *BMC Psychiatry, 20*(1), 1–7.

Heim, C. M., Mayberg, H. S., Mletzko, T., Nemeroff, C. B., & Pruessner, J. C. (2013). Decreased cortical representation of genital somatosensory field after childhood sexual abuse. *American Journal of Psychiatry, 170*(6), 616–623.

Heiman, J. R., & Heard-Davison, A. R. (2004). Child sexual abuse and adult sexual relationships: Review and perspective. In *From child sexual abuse to adult sexual risk: Trauma, revictimization, and intervention* (pp. 13–47). American Psychological Association.

Hemmati, A., Newton-Howes, G., Falahi, S., Mostafavi, S., Colarusso, C. A., & Komasi, S. (2020). Personality pathology among adults with history of childhood sexual abuse: Study of the relevance of DSM-5 proposed traits and psychobiological features of temperament and character. *Indian Journal of Psychological Medicine, 43*(2), 135–143. https://doi.org/10.1177/0253717620928813

Hennessy, M. B., Deak, T., & Schiml-Webb, P. A. (2010). Early attachment-figure separation and increased risk for later depression: Potential mediation by Proinflammatory Processes. *Neuroscience & Biobehavioral Reviews, 34*(6), 782–790.

Henny, K. D., Kidder, D. P., Stall, R., & Wolitski, R. J. (2007). Physical and sexual abuse among homeless and unstably housed adults living with HIV: Prevalence and associated risks. *AIDS and Behavior, 11*(6), 842–853.

Henrichs, K. L., McCauley, H. L., Miller, E., Styne, D. M., Saito, N., & Breslau, J. (2014). Early menarche and childhood adversities in a nationally representative sample. *International Journal of Pediatric Endocrinology, 2014*(1), 14.

Herman, J. L. (1998). Recovery from psychological trauma. *Psychiatry and Clinical Neurosciences, 52*(S1).

Hershkowitz, I., Lanes, O., & Lamb, M. E. (2007). Exploring the disclosure of child sexual abuse with alleged victims and their parents. *Child Abuse & Neglect, 31*(2), 111–123.

Hovens, J. G., Giltay, E. J., Spinhoven, P., van Hemert, A. M., & Penninx, B. W. (2015). Impact of childhood life events and childhood trauma on the onset and recurrence of depressive and anxiety disorders. *The Journal of Clinical Psychiatry, 76*(07), 931–938.

Human breaking the silence - human rights watch. Human Rights Watch. (2013). Retrieved March 1, 2022.

IICSA. (2018, August 20). *3.2 the effects of child sexual abuse*. IICSA. Retrieved February 27, 2022.

Irish, L., Kobayashi, I., & Delahanty, D. L. (2009). Long-term physical health consequences of childhood sexual abuse: A meta-analytic review. *Journal of Pediatric Psychology, 35*(5), 450–461.

Jaberghaderi, N., Greenwald, R., Rubin, A., Zand, S. O., & Dolatabadi, S. (2004). A comparison of CBT and EMDR for sexually-abused Iranian girls. *Clinical Psychology & Psychotherapy, 11*(5), 358–368.

Jacobs-Kayam, A., & Lev-Wiesel, R. (2019). In limbo: Time perspective and memory deficit among female survivors of sexual abuse. *Frontiers in Psychology, 10*, 912.

Jensen, P. S., Weersing, R., Hoagwood, K. E., & Goldman, E. (2005). What is the evidence for evidence-based treatments? A hard look at our soft underbelly. *Mental Health Services Research, 7*(1), 53–74. https://doi.org/10.1007/s11020-005-1965-3

Kamiya, Y., Timonen, V., & Kenny, R. A. (2015). The impact of childhood sexual abuse on the mental and physical health, and healthcare utilization of older adults. *International Psychogeriatrics, 28*(3), 415–422.

Karr, T. M., Simonich, H., & Wonderlich, S. A. (2012). Psychological trauma and body image. In *Encyclopedia of body image and human appearance* (pp. 700–706). Academic Press.

Kaur, S., Kaur, S., & Rawat, B. (2021). Medico-Legal Evidence Collection in child sexual assault cases: A forensic significance. *Egyptian Journal of Forensic Sciences, 11*(1), 1–6.

Kendall-Tackett, K. (2009). Psychological trauma and physical health: A psychoneuroimmunology approach to etiology of negative health effects and possible interventions. *Psychological Trauma: Theory, Research, Practice, and Policy, 1*(1), 35–48.

Knittle, B. J., & Tuana, S. J. (1980). Group therapy as primary treatment for adolescent victims of intrafamilial sexual abuse. *Clinical Social Work Journal, 8*(4), 236–242.

Kruczek, T., & Vitanza, S. (1999). Treatment effects with an adolescent abuse survivor's group. *Child Abuse & Neglect, 23*(5), 477–485.

Larsson, S., Aas, M., Klungsøyr, O., Agartz, I., Mork, E., Steen, N. E., Barrett, E. A., Lagerberg, T. V., Røssberg, J. I., Melle, I., Andreassen, O. A., & Lorentzen, S. (2013). Patterns of childhood adverse events are associated with clinical characteristics of bipolar disorder. *BMC Psychiatry, 13*(1), 97.

Lemaigre, C., Taylor, E. P., & Gittoes, C. (2017). Barriers and facilitators to disclosing sexual abuse in childhood and adolescence: A systematic review. *Child Abuse & Neglect, 70*, 39–52.

Lepsy, N., Dering, M.-R., Fuge, J., Meltendorf, T., Hoeper, M. M., Heitland, I., Kamp, J. C., Park, D.-H., Richter, M. J., Gall, H., Ghofrani, H. A., Ellermeier, D., Kulla, H.-D., Olsson, K. M., & Kahl, K. G. (2022). Childhood maltreatment, mental well-being, and healthy lifestyle in patients with chronic thromboembolic pulmonary hypertension. *Frontiers in Psychiatry, 13*, 821468.

Leserman, J. (2005). Sexual abuse history: Prevalence, health effects, mediators, and psychological treatment. *Psychosomatic Medicine, 67*(6), 906–915.

Lev-Wiesel, R., Bechor, Y., Daphna-Tekoah, S., Hadanny, A., & Efrati, S. (2018). Brain and mind integration: Childhood sexual abuse survivors experiencing hyperbaric oxygen treatment and psychotherapy concurrently. *Frontiers in Psychology, 9*, 2535.

Li, N., Ahmed, S., & Zabin, L. S. (2012). Association between childhood sexual abuse and adverse psychological outcomes among youth in Taipei. *Journal of Adolescent Health, 50*(3 Suppl), S45–S51.

Lieberman, A. F., Van Horn, P., Grandison, C. M., & Pekarsky, J. H. (1997). Mental health assessment of infants, toddlers, and preschoolers in a service program and a treatment outcome research program. *Infant Mental Health Journal, 18*(2), 158–170.

Loftus, E. F., & Davis, D. (2006). Recovered memories. *Annual Review of Clinical Psychology, 2*(1), 469–498. https://doi.org/10.1146/annurev.clinpsy.2.022305.095315

London, K., Bruck, M., Ceci, S. J., & Shuman, D. W. (2005). Disclosure of Child Sexual Abuse: What does the research tell us about the ways that children tell? *Psychology, Public Policy, and Law, 11*(1), 194–226.

Maunder, R. G., & Hunter, J. J. (2001). Attachment and psychosomatic medicine: Developmental contributions to stress and disease. *Psychosomatic Medicine, 63*(4), 556–567.

McCarthy-Jones, S., & McCarthy-Jones, R. (2014). Body mass index and anxiety/depression as mediators of the effects of child sexual and physical abuse on physical health disorders in women. *Child Abuse & Neglect, 38*(12), 2007–2020.

McElroy, E., Shevlin, M., Elklit, A., Hyland, P., Murphy, S., & Murphy, J. (2016). Prevalence and predictors of axis I disorders in a large sample of treatment-seeking victims of sexual abuse and incest. *European Journal of Psychotraumatology, 7*(1), 30686.

McElvaney, R. (2013). Disclosure of Child Sexual Abuse: Delays, non-disclosure and partial disclosure. What the research tells us and implications for practice. *Child Abuse Review, 24*(3), 159–169. https://doi.org/10.1002/car.2280

McElvaney, R., & Culhane, M. (2015). A retrospective analysis of children's assessment reports: What helps children tell? *Child Abuse Review, 26*(2), 103–115.

McLaren, J. L., Barnett, E. R., Concepcion Zayas, M. T., Lichtenstein, J., Acquilano, S. C., Schwartz, L. M., Woloshin, S., & Drake, R. E. (2018). Psychotropic medications for highly vulnerable children. *Expert Opinion on Pharmacotherapy, 19*(6), 547–560.

McLean, C. P., Morris, S. H., Conklin, P., Jayawickreme, N., & Foa, E. B. (2014). Trauma characteristics and posttraumatic stress disorder among adolescent survivors of childhood sexual abuse. *Journal of Family Violence, 29*(5), 559–566.

McNeish, D., & Scott, S. (2018, June). *Key messages from research on intra-familial child sexual abuse*. www.csacentre.org.uk. Retrieved March 7, 2022.

McRobert, K. (2022). Childhood sexual abuse (CSA): Moving past the taboo and into the postcolonial. *Society Register, 6*(2), 17–34. https://doi.org/10.14746/sr.2022.6.2.02

Messman-Moore, T. L., & Long, P. J. (2003). The role of childhood sexual abuse sequelae in the sexual revictimization of women. *Clinical Psychology Review, 23*(4), 537–571.

Messman-Moore, T. L., Walsh, K. L., & DiLillo, D. (2010). Emotion dysregulation and risky sexual behavior in revictimization. *Child Abuse & Neglect, 34*(12), 967–976.

Montigny Gauthier, L., Vaillancourt-Morel, M. P., Rellini, A., Godbout, N., Charbonneau-Lefebvre, V., Desjardins, F., & Bergeron, S. (2018). The risk of telling: A dyadic perspective on romantic partners' responses to child sexual abuse disclosure and their associations with sexual and relationship satisfaction. *Journal of Marital and Family Therapy, 45*(3), 480–493.

Mullen, P. E., Martin, J. L., Anderson, J. C., Romans, S. E., & Herbison, G. P. (1994). The effect of child sexual abuse on social, interpersonal and sexual function in adult life. *British Journal of Psychiatry, 165*(1), 35–47.

Muntner, P. (2004). Trends in blood pressure among children and adolescents. *JAMA, 291*(17), 2107.

Najman, J. M., Dunne, M. P., Purdie, D. M., Boyle, F. M., & Coxeter, P. D. (2005). Sexual abuse in childhood and sexual dysfunction in adulthood: An Australian population-based study. *Archives of Sexual Behavior, 34*(5), 517–526.

Nelson, S., Baldwin, N., & Taylor, J. (2011). Mental health problems and medically unexplained physical symptoms in adult survivors of childhood sexual abuse: An integrative literature review. *Journal of Psychiatric and Mental Health Nursing, 19*(3), 211–220.

Newton, E. G., Jewett, L. R., & Thombs, B. D. (2009). Childhood psychosocial stressors and adult onset arthritis: A comment on Von Korff et al. *Pain, 144*(3), 340.

Niec, A. (2002). Forensic issues in the assessment of sexually assaulted adolescents. *Paediatrics & Child Health, 7*(3), 153–159.

Nijdam, M. J., Gersons, B. P., Reitsma, J. B., de Jongh, A., & Olff, M. (2012). Brief eclectic psychotherapy v. eye movement desensitisation and reprocessing therapy for post-traumatic stress disorder: Randomised controlled trial. *British Journal of Psychiatry, 200*(3), 224–231.

Paine, M. L., & Hansen, D. J. (2002). Factors influencing children to self-disclose sexual abuse. *Clinical Psychology Review, 22*(2), 271–295.

Paolucci, E. O. D. D. O. N. E., Genuis, M. L., & Violato, C. (2001). A meta-analysis of the published research on the effects of child sexual abuse. *The Journal of Psychology, 135*(1), 17–36.

Paras, M. L., Murad, M. H., Chen, L. P., Goranson, E. N., Sattler, A. L., Colbenson, K. M., Elamin, M. B., Seime, R. J., Prokop, L. J., & Zirakzadeh, A. (2009). Sexual abuse and lifetime diagnosis of somatic disorders. *JAMA, 302*(5), 550.

Paul, H. A. (2019). Treatment of disorders in childhood and adolescence. *Child & Family Behavior Therapy, 41*(4), 247–255.

Pifalo, T. (2006). Art therapy with sexually abused children and adolescents: Extended research study. *Art Therapy, 23*(4), 181–185.

Putnam, F. R. A. N. K. W. (2003). Ten-year research update review: Child sexual abuse. *Journal of the American Academy of Child & Adolescent Psychiatry, 42*(3), 269–278.

Quinney, R. (1972). Who is the victim? *Criminology, 10*(3), 314–323.

Raison, C. L., Capuron, L., & Miller, A. H. (2006). Cytokines sing the blues: Inflammation and the pathogenesis of depression. *Trends in Immunology, 27*(1), 24–31.

Rinne-Albers, M. A., van der Wee, N. J., Lamers-Winkelman, F., & Vermeiren, R. R. (2013). Neuroimaging in children, adolescents and young adults with psychological trauma. *European Child & Adolescent Psychiatry, 22*(12), 745–755.

Romans, S., Belaise, C., Martin, J., Morris, E., & Raffi, A. (2002). Childhood abuse and later medical disorders in women. *Psychotherapy and Psychosomatics, 71*(3), 141–150.

Ron, P. (2020). The relationship between internal and external resources, coping strategies, posttraumatic symptoms, and death-anxiety of round-the-clock paid Philippine immigrants and local workers taking care for the elderly during and after the Gaza War. *Psychology, 11*(04), 606–623.

Siervo, M., Ruggiero, D., Sorice, R., Nutile, T., Aversano, M., Iafusco, M., Vetrano, F., Wells, J. C., Stephan, B. C., & Ciullo, M. (2012). Body mass index is directly associated with biomarkers of angiogenesis and inflammation in children and adolescents. *Nutrition, 28*(3), 262–266.

Sigurdardottir, S., & Halldorsdottir, S. (2018). Screaming body and Silent Healthcare Providers: A case study with a childhood sexual abuse survivor. *International Journal of Environmental Research and Public Health, 15*(1), 94.

Sigurdardottir, S., Halldorsdottir, S., & Bender, S. S. (2012). Deep and almost unbearable suffering: Consequences of childhood sexual abuse for men's health and well-being. *Scandinavian Journal of Caring Sciences, 26*(4), 688–697.

Singh, M. M., Parsekar, S. S., & Nair, S. N. (2014). An epidemiological overview of child sexual abuse. *Journal of Family Medicine and Primary Care, 3*(4), 430.

Skinner, G. C. (2020). Disclosure of Child Sexual Abuse: A review of factors that impact proceedings in the courtroom. In *Reviewing crime psychology* (pp. 380–399). https://doi.org/10.4324/9780429346927-21

Smedley, L. S. (2012). *CSA survivors: What heals and what hurts in a couple relationship* (UNLV Theses, Dissertations, Professional Papers, and Capstones). 1778.

Solberg, E. T., Halvorsen, J. E., & Stige, S. H. (2021). What do survivors of child sexual abuse believe will facilitate early disclosure of sexual abuse? *Frontiers in Psychiatry, 12,639341*

Stoltenborgh, M., van IJzendoorn, M. H., Euser, E. M., & Bakermans-Kranenburg, M. J. (2011). A global perspective on child sexual abuse: Meta-analysis of prevalence around the world. *Child Maltreatment, 16*(2), 79–101.

Stoltenborgh, M., Bakermans-Kranenburg, M. J., Alink, L. R., & van IJzendoorn, M. H. (2014). The prevalence of child maltreatment across the globe: Review of a series of meta-analyses. *Child Abuse Review, 24*(1), 37–50.

Su, W.-M., & Stone, L. (2020). Adult survivors of childhood trauma: Complex trauma, complex needs. *Australian Journal of General Practice, 49*(7), 423–430.

Summit, R. C. (1983). The child sexual abuse accomodation syndrome. *Child Abuse & Neglect, 7*(2), 177–193.

Taylor, M. L., Trotter, D. R., & Csuka, M. E. (1995). The prevalence of sexual abuse in women with fibromyalgia. *Arthritis and Rheumatism, 38*(2), 229–234.

Testa, M., VanZile-Tamsen, C., & Livingston, J. A. (2005). Childhood sexual abuse, relationship satisfaction, and sexual risk taking in a community sample of women. *Journal of Consulting and Clinical Psychology, 73*(6), 1116–1124.

The Ranch TN. (2021, December 7). *Child sexual abuse as a cause of PTSD (post-traumatic stress disorder)*. The Ranch TN. Retrieved February 25, 2022.

Tichelaar, H. K., Deković, M., & Endendijk, J. J. (2020). Exploring effectiveness of psychotherapy options for sexually abused children and adolescents: A systematic review of randomized controlled trials. *Children and Youth Services Review, 119*, 105519.

Tomoda, A., Navalta, C. P., Polcari, A., Sadato, N., & Teicher, M. H. (2009). Childhood sexual abuse is associated with reduced gray matter volume in visual cortex of young women. *Biological Psychiatry, 66*(7), 642–648.

Turkus, J. A. (1994). Trauma and recovery. by Judith Lewis Herman. Basic books: Glenview, IL, 1992, 276 pages. (hardbound $27.00, paperback $14.00). *Journal of Traumatic Stress, 7*(3), 497–498.

UNICEF. (2021). https://www.unicef.org/protection/sexual-violence-against-children

Walker, J. L., Carey, P. D., Mohr, N., Stein, D. J., & Seedat, S. (2004). Gender differences in the prevalence of childhood sexual abuse and in the development of pediatric PTSD. *Archives of Women's Mental Health, 7*(2), 111–121.

Waltke, H., LaPorte, G., Weiss, D., Schwarting, D., Nguyen, M., & Scott, F. (2017). *Sexual assault cases: Exploring the importance of non-DNA forensic evidence*. National Institute of Justice. Retrieved March 20, 2022.

Wegman, H. L., & Stetler, C. (2009). A meta-analytic review of the effects of childhood abuse on medical outcomes in adulthood. *Psychosomatic Medicine, 71*(8), 805–812.

Wilen, J. S., Littell, J. H., & Salanti, G. (2017). Psychosocial interventions for adults who were sexually abused as children. *Cochrane Database of Systematic Reviews*. https://doi.org/10.1002/14651858.cd010099.pub2

Willett, W. C. (1995). Weight, weight change, and coronary heart disease in women. *JAMA, 273*(6), 461.

Williamson, D. F., Thompson, T. J., Anda, R. F., Dietz, W. H., & Felitti, V. (2002). Body weight and obesity in adults and self-reported abuse in childhood. *International Journal of Obesity, 26*(8), 1075–1082.

Wolak, J., Finkelhor, D., Mitchell, K. J., & Ybarra, M. L. (2008). Online "predators" and their victims: Myths, realities, and implications for prevention and treatment. *American Psychologist, 63*(2), 111–128.

Wolf, M. R., & Nochajski, T. H. (2013). Child sexual abuse survivors with dissociative amnesia: What's the difference? *Journal of Child Sexual Abuse, 22*(4), 462–480.

Wosu, A. C., Gelaye, B., & Williams, M. A. (2015). Maternal history of childhood sexual abuse and preterm birth: An epidemiologic review. *BMC Pregnancy and Childbirth, 15*(1), 174.

Zielinski, D. S. (2009). Child maltreatment and adult socioeconomic well-being. *Child Abuse & Neglect, 33*(10), 666–678.

Zielinski, D. (2015, July 2). *Childhood maltreatment linked to adulthood economic problems*. National Institutes of Health. Retrieved March 20, 2022.