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MENTAL HEALTH DISORDERS IN SURVIVORS OF CHILD SEXUAL ABUSE.

Dr. Archana Shukla
Dean Faculty of Arts & Director AIBAS
Amity University Haryana,
Panchgaon, Manesar, Gurgaon-122413,
India.
prof.archana.shukla@gmail.com

Athullya S Nair
Research Scholar
AIBAS, Amity University, Haryana,
Panchgaon, Manesar, Gurgaon-122413,
India.
athullyanair@gmail.com

ABSTRACT

Articles and papers were examined thoroughly to see the disturbed psychological outcomes of child sexual abuse. These include, a number of mental health disorders typically identified among individuals like depression, anxiety, post traumatic stress disorder, eating disorders, sleep disorders. The results of each study were found different as they aimed at non-identical aspects of mental health issues. Factors that affected the outcome includes gender, ethnicity, age et al. Severity of the abuse, how harsh the force has been, and victim's relationship to the perpetrator are other components that were keenly studied to understand their effect in triggering the mental health issues. These factors can soften, or exacerbate, the impact of abuse on a child's psychological wellbeing, and the likelihood that they will develop mental illness later in life. A number of mental disorders have been diagnosed among the survivors and a myriad of psychotherapies (focusing on the behavioral, emotional and psychological) have been extensively applied in these individuals in order to help the affected group, overcome the symptoms of these disorders.

General Terms

Paper review, Statistical results, Prevalence rates.

Keywords: Mental Health, Child Sexual Abuse, Depression, Post Traumatic Stress Disorder, Eating disorder, Sleep Disorders**.**

1. INTRODUCTION

1.1 What is Child Sexual Abuse?

The World Health Organization (WHO) defines child sexual abuse as: "the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared, or else that violate the laws or social taboos of society. Children can be sexually abused by adults or other children who are – by virtue of their age or stage of development – in a position of responsibility, trust, or power over the victim (World Health Organisation, 2006: p.10).

For many years, researchers have been focusing and studying how susceptible children and adolescents are to stressful events, but it is only recently that they have been focusing on the intensity of trauma that these children withstand, which is in par with what adults

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undergo. Until recently, it was assumed that any stress reactions that children manifested to traumatic experiences were more likely to be short-lived adjustment reactions rather than major severe disorders (Yule, 1998).

Child sexual abuse is an epidemic, which gains the least of attention .While it may seem easier to live in denial, child abuse happens everywhere irrespective of boundaries and nations. Child sexual abuse knows no barriers — not race, income or religion.

Therapist worldwide acclaim that it is extremely strenuous to treat a child who has been abused as the wounds are deep and beyond repair. As they carry on these traumatic experience with them, they, unconsciously alter from general symptoms to more stressful mental health issues.

Secondary trauma, is the emotional duress, that results when an individual hears about the firsthand **trauma** experiences of another. It has been widely observed that adolescents who realize about their first hand experience as a child, usually defy the secondary trauma.

Its symptoms mimic those of **post-traumatic** stress disorder (PTSD). As part of conglomerating their private experiences with the realities of the outer world, they are battered by the **disbelief, blame and rejection** they experience from adults. This, subsequently affects their image about themselves which leads to even further deterioration of view about their self. The normal coping behavior of the child contradicts the entrenched beliefs and expectations typically held by adults, stigmatizing the child with charges of lying, manipulating or imagining from parents, courts and clinicians. Such abandonment by the very adults most crucial to the child's protection and recovery drives the child deeper into **self-blame, self-hate, alienation and re-victimization**. In this period of time, when an empathetic therapist with a very comfortable environment is brought into picture by the adults associated with the child, can bring in enormous change and validation about themselves in children.

Evaluation of the responses of normal children to sexual assault provides clear evidence that societal definitions of “normal” victim behaviour are inappropriate and procrustean, serving adults as mythic insulators against the child's pain. Within this climate of prejudice, the sequential survival options available to the victim further alienate the child from any hope of outside credibility or acceptance. Ironically, the child's inevitable choice of the “wrong” options reinforces and perpetuates the prejudicial myths.

The most typical reactions of children are classified in this paper as the **child sexual abuse accommodation syndrome.** The term was coined by Roland C. Summit. There are five categories in the above mentioned syndrome, of which two define basic childhood vulnerability and three are sequentially contingent on sexual assault:

1)secrecy, (2) helplessness, (3) entrapment and accommodation, (4) delayed, unconvincing disclosure, and (5) retraction.

This was predominantly coined in order to make it easier for the clinician to empathise better and to extend maximum support to the child who is engulfed in this complexity of victimisation. Application of the syndrome, tends to challenge entrenched myths and prejudice, providing credibility and advocacy for the child within the home, the courts, and throughout the treatment process.

Adult women with a history of childhood sexual abuse show greater evidence of sexual disturbance or dysfunction, homosexual experiences in adolescence or adulthood, depression, and are more likely than non abused women to be re victimized. Anxiety, fear, and suicidal ideas and behaviour have also been associated with a history of childhood sexual abuse but force and threat of force may be a necessary concomitant. As yet, there is insufficient evidence to confirm a relation between a history of childhood sexual abuse and a post sexual abuse syndrome and multiple or borderline personality disorder. Sexually abused subjects report higher levels of general psychological distress and higher rates of both major psychological disorders and personality disorders than non abused subjects. In addition, child sexual abuse survivors report higher rates of substance abuse, binge eating, somatisation, and suicidal behaviours than non abused subjects.

Male victims of child sexual abuse show disturbed adult sexual functioning. The relation between age of onset of abuse and outcome is still equivocal. Greater long-term harm is associated with is associated with greater impact, and the use of force or threat of force is associated with greater harm.

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2. INCIDENCE AND PREVALENCE

2.1 Male/female prevalence and incidence

The global prevalence of child sexual abuse has been estimated at 19.7% for females and 7.9% for males. ***(*Pereda, N.; Guilera, G.; Forns, M. & Gómez-Benito, J. (2009). "The prevalence of child sexual abuse in community and student samples: A meta-analysis". Clinical Psychology Review.*)***

Few studies have been published about the incidence of child sexual abuse, whether nationally or internationally, and their number is considerably less than that of prevalence studies regarding the same problem. Incidence refers to the number of cases reported to or detected by the authorities (as hospitals, social services, and the courts) during a given period of time, usually one year **(Runyan, 1998; Wynkoop, Capps, & Priest,1995).** This however, doesn't establish the real incidence of the child sexual abuse rates.

Factors such as the secrecy which surrounds the abusive situation, the shame felt by the victim when speaking about what has happened, the criminal penalties to which the abuser may be subject, and the young age of victims combined with their dependence upon adults mean that very few victims come forward at the time of abuse, it therefore being highly probable that official statistics underestimate the true extent of the problem **(Finkelhor,1994; Goldman & Padayachi, 2000; Widom & Morris,1997).**

The feasibility and the accuracy of various tests has been questioned. **(Bruck, & Ceci, 1999).** The downside of the self-reports is that the results could be negative and not feasible at all. (**Oates et al., 2000)**. However, this risk is much greater than the relatively small number of victims who would make false allegation, something that will always interfere in coming up with accurate statistics **(Fergusson, Horwood, & Woodward, 2000),** and therefore, at all events, prevalence findings would be conservative. The research carried out to date varies in terms of the procedures used for sample selection, the type of questionnaire or interview employed, the age limit set for classifying subjects as a child victim and, especially, the criteria used to define whether or not a behaviour should be classified as sexual abuse (**Leventhal, 1998).** The methods that hs been adopted to study differ, that the difference in the populations, which can be pinned down as one of the reasons to why there might be discrepancies in the results.(**Finkelhor, 1994; Wynkoop et al., 1995).**

2.2 The global scenario

The WHO in 2002 estimated that 73 million boys and 150 million girls under the age of 18 years had experienced various forms of sexual violence. The Centre's for Disease Control and the US Department of Justice conducted a study in the US and reported prevalence of being forced to have sex at some point of time in their lives as 11% and 4% of the high-school girls and boys, respectively.A meta-analysis conducted in the year 2009 analyzed 65 studies in 22 countries and estimated an "overall international figure."

The main findings of the study were:

- An estimated 7.9% of males and 19.7% of females universally faced sexual abuse before the age of 18 years
- The highest prevalence rate of CSA was seen in Africa (34.4%)
- Europe, America, and Asia had prevalence rate of 9.2%, 10.1%, and 23.9%, respectively
- With regards to females, seven countries reported prevalence rates as being more than one fifth i.e., 37.8% in Australia, 32.2% in Costa Rica, 31% in Tanzania, 30.7% in Israel, 28.1% in Sweden, 25.3% in the US, and 24.2% in Switzerland.
- The lowest rate observed for males may be imprecise to some extent because of under reporting.Noteworthy in this regard is the review by Finkelhor (1994) who, after analysing reported prevalence rates for 21 countries, concluded that between 7% and 36% of women and between 3% and 29% of men had suffered sexual abuse during childhood.

  The estimation is that one in three girls and one in six boys are sexually abused in North America. The exact number is hard to determine because many cases are not reported to authorities. Of adults who receive mental health services, it's thought that as many as 50% of women and 25% of men have experienced childhood sexual abuse

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2.3 The Indian scenario

Among the world's children,19% are here in India. As per the 2001 census, about 440 million individuals in India were below 18 years of age and constitute 42% of total population. A total of 33,098 cases of sexual abuse in children were reported in the nation during the year 2011 when compared to 26,694 reported in 2010 which increased by 24%. A total of 7,112 cases of child rape were reported during 2011 as equated to 5,484 in 2010 depicting a growth by 29.7%. The increase in the number of cases reported has been found alarming. But , there has been very little evidence to illustrate what measures have been taken to ensure the well being of these children. In a shocking revelation, a government commissioned survey has found that more than 53% of children in India are subjected to sexual abuse, but most don't report the assaults to anyone fearing the negative consequences that they may have to face. According to the women and child development ministry-sponsored report, which assumes greater significance in the backdrop of the Nithari killings that brought into focus the issue of children's safety, those in the age group of 5-12 years reported higher levels of abuse.

In a survey, that was carried out in 13 states and with a sample size of 12,447, revealed that 53.22% of children reported having faced one or more forms of sexual abuse, with Andhra Pradesh, Bihar, Assam and Delhi reporting the highest percentage of such incidents. In 50% of child abuse cases, the abuser is a person known to the child, an individual they trust which in return made it difficult for them to open up to and report to any authority(Women and child welfare ministry, 2007).

3. PSYCHOLOGICAL DISORDERS IN VICTIMS OF CHILD SEXUAL ABUSE

Child sexual abuse has been considered as one of the most serious public health problems that the society has been facing and, above all, children and young people themselves (MacMillan, 1998). Data from published research illustrate that, to a greater or lesser extent, child abuse is a historical constant that occurs in all cultures and societies and irrespective of the social class/levels (Walker, Bonner, & Kaufman, 1988). Child sexual abuse is therefore not an isolated, sporadic or distant reality, but rather a complex and universal problem, one which results from the interaction of individual, family, social and cultural factors (Brown, Cohen, Johnson, & Salzinger, 1998; Fleming, Mullen, & Bammer, 1997). The silence, so intense revolving around the subject matter, makes it difficult for the families and the immediate acquaintances to acknowledge the impacted psychological disorders.

The realisation that child sexual abuse was a common form of maltreatment with significant and lasting psychological effects in both the short and long term, **(Beitchman, Zucker, Hood, DaCosta, & Akman, 1991; KendallTackett, Meyer, & Finkelhor, 1993) (Beitchman et al., 1992; Flitter, Elhai, & Gold, 2003; Jumper, 1995)** has led to burgeoning social and professional interest being shown over the last decade.

However, epidemiological studies on this topic remain few and far between and tend to lack methodological rigor; furthermore, most of the research that has been conducted presents conflicting results which, as they cannot be unified, make it impossible to present clear figures regarding the extent of the problem.

The disorders that has been narrowed down for the present paper, discerned to child sexual abuse from among the plethora of mental health issues are depression, anxiety, phobia, PTSD, eating disorders and sleep disorders.

3.1 Depression

The very commonly tabulated disorders among the many mental health disorders is Depression, and it isn't a novel knowledge among the researchers**.** A review, covering 60,000 participants from 160 studies, concluded that while CSA is a risk factor for depression, it is also significantly related to other forms of psychopathology, with which it may interact, and so cannot be identified as a specific risk factor. Some traumatic experiences can "alter people's psychological, biological and social equilibrium to such a degree that the memory of one particular event comes to taint all other experiences"50.
Approximately 35% of those with major depressive disorder (MDD) have a history of childhood
maltreatment **(Young, Abelson, Curtis, & Nesse, 1997**), which portends greater illness severity, chronicity, and co morbidity **(Harkness & Monroe, 2002; Harkness & Wildes, 2002),** as well as a poorer response to psychotherapy.

3.2 Post traumatic stress disorder (ptsd)

PTSD has long been associated with war, but exposure to traumatic events during and after puberty is also associated with increased risk of the disorder with 30–50 per cent of sexually abused children meeting full criteria for a PTSD diagnosis and many more exhibiting at least some.

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Guilt and shame are part of a constellation of emotions that may be experienced in relation to a traumatic event, which also include **fear, anger and sadness**. Guilt and shame in particular have been found to be components of the post-traumatic state among CSA survivors. Fear has been found to be heightened during trauma, with emotional responses such as guilt, shame, anger and sadness being heightened afterwards and increasing over time, particularly for those who have experienced sexual assault. Such emotions can interact dynamically with other symptoms. One study found that where shame had been addressed effectively during treatment, PTSD symptoms reduce. Guilt and shame can however be more resistant to treatment than other symptoms such as depression, anxiety and anger.

3.3 Eating Disorder

A disturbed childhood with a history of child sexual abuse has been indicated in individuals diagnosed with major Eating Disorders (CSA). A particular pattern that has been noticed among the individuals with a non-eating behaviour is very similar to individuals with eating disorders which includes impediments like feelings of shame, low self-esteem, and body image disparagement. Many researches state that there has been relationship between eating disorders and sexual abuse, but it isn't very clear on how much does it contribute in the diagnosis of the psychopathology of eating disorders(Oppenheimer, Howells, Palmer, & Chaloner, 1985).

Reviews of the research on the association between CSA and eating disorders have noted variation across studies in the estimated prevalence rate of sexual abuse in both eating disorder and control populations (Thompson & Wonderlich, 2004). Such inconsistencies may reflect differences in the samples studied (e.g., clinic vs. community samples), methodological differences, as well as differences in the definitions used for sexual abuse (Wyatt & Peters, 1986a, 1986b).

The use of face-to-face interviews has been found to be associated with higher prevalence estimates than self-report questionnaires (Wyatt & Peters, 1986a). Broader definitions of sexual abuse (e.g., abuse with or without physical contact) also produce higher prevalence rates than more restrictive definitions (Wyatt & Peters, 1986b).

To include child sexual abuse with eating disorders, the definition to the term has to be large and wide. More than eating disorder being identified as the only disorder post CSA, it was always found to be comorbid with other psychological issues. With two exceptions, studies to date have found no evidence that sexual abuse is associated with more severe eating disorder psychopathology in patients with eating disorders. A study by Fullerton, Wonderlich, and Gosnell (1995) found that sexual abuse was associated with higher scores on a self-report measure of eating disorder attitudes and behaviours. Another study by Waller (1992a, 1992b) showed that a history of sexual abuse was associated with more frequent episodes of binge eating and vomiting. Several studies have shown that CSA is associated with the presence of binge eating and purging behaviors in patients with eating disorders **(Bulik, Sullivan, Fear, & Joyce, 1997; Deep, Lilenfeld, Plotnicov, Pollice, & Kaye, 1999; Oliosi & Dalle Grave, 2003; Waller, Halek, & Crisp, 1993)**. Given these findings, it is possible that the association between CSA and the eating disorder may be different in AN-R versus AN-BP. To our knowledge, only two studies have examined whether a history of sexual abuse affects response to treatment for an eating disorder.

Anderson et al. (1997) found that bulimia nervosa patients with a history of sexual abuse demonstrated lower rates of abstinence from binge eating and purging behaviors at the end of treatment as compared with patients without a history of abuse.

However, this study was limited by the use of a self-report questionnaire to assess sexual abuse history and eating disorder status as well as a low (52%) response rate. The aim of the present study was to examine the association between CSA and clinical presentation as well as premature termination of treatment in anorexia nervosa (AN-R and AN-BP). It was hypothesized that a history of CSA would be associated with: (1) more severe eating disorder symptoms; (2) more severe general psychopathology; (3) having the binge-purge subtype of AN; and (4) an increased rate of premature termination of treatment.

3.4 Sleep Disorders

Insomnia Definition and prevalence In the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994) the main diagnostic criteria for insomnia are difficulties initiating and/or maintaining sleep, or non-restorative sleep, that has lasted for at least one month, and that causes clinically significant distress or impairment in social, occupational or other

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important areas of functioning. Insomnia or sleeplessness is considered to be one of the most disturbing forms of psychological impairments as it in general affects your wellbeing and quality of life.

The major cognitive facets that get affected are concentration, attention, memory difficulties etc. Psychological distress and quality of life impairment seem to increase with insomnia severity **(LeBlanc et al., 2007; Leger et al., 2001; Schubert et al., 2002),** but this relationship is Sexual abuse and sleep difficulties most likely complex and bidirectional. For example, insufficient sleep may amplify a person's intrapersonal, social, and work related problems, which in turn may cause additional sources of distress, which consequently may lead to even more sleep difficulties for the individual, creating a vicious cycle of deterioration **(Dahl, 1999; Vgontzas & Kales, 1999).** Sleep difficulties in sexually abused A general finding is that sleep disturbances are common after traumatic events **(Caldwell & Redeker, 2005).** It is therefore not a surprise that sleep complaints are frequently reported by victims of sexual abuse **(Bader et al., 2007; Beichtman et al., 1991; Beichtman et al., 1992; Briere & Runtz, 1987; Calam et al., 1998; Caldwell & Redeker, 2005; Krakow et al., 2000; Krakow et al., 2001; Sarkar & Sarkar, 2005).**

In a representative sample of Swedish youth, sexually abused girls reported more sleep disturbance than non-abused girls **(Edgardh & Ormstad, 2000).** Similarly, rape victims reported more nightly awakenings, tiredness, and poor sleep quality compared to non-victims in a national representative sample of French secondary school children **(Choquet et al., 1997**). In a study by **Noll et al. (2006),** sexually abused adolescents reported higher rates of sleep disturbances than non-abused comparisons. In addition, the sleep disturbances were independent of any co-morbid PTSD or depression, in which sleep difficulties comprises one of several diagnostic criteria. Nisith et al. (2001) found moderate sleep difficulties in almost all areas of sleep functioning in rape victims, reflected in their Pittsburg Sleep Quality Index (**PSQI; Buysse, Reynolds, Monk, Berman, & Kupfer, 1989**) scores. The PSQI scores of sexually assaulted women have also been found to be at the same level or worse than scores of patients with specific types of sleep disorders **(Krakow et al., 2001) Wells et al. (1995, 1997)** found parents of sexually abused teenagers to report their children to have more difficulties falling asleep than did parents of matched non-abused teenagers. Similar findings were reported by **Rimsza, Berg and Locke (1988).**

Using actography measurements, Glod, Teicher, Hartman and Sexual abuse and sleep difficulties(**Harakal (2001**) found longer sleep latency, more nocturnal activity, and lower sleep efficiency in sexually abused children compared to non- abused children. Goldston, Turnquist and Knutson (1989) studied the clinical records of girls receiving consecutive admissions to psychiatric services, and found more sleep disturbances among sexually abused compared to non-abused patients. Consequences of sleep difficulties in sexually abused. Though there are so many kinds of sleep disturbances mentioned here, The real reason for why these kinds of disturbances occur in children who have been sexually assaulted hasn't been able to been exactly discovered.

Nightmares are long, frightening dreams involving threats to survival or security from which the sleeper awakens. These occur during the REM state, hence the dreamer is able to recollect every detail about the dream.The prevalence of monthly nightmares is estimated to be 8-25% **(Bearden, 1994; Bixler, Kales, Soldatos, Kales, & Healey, 1979),** while the corresponding prevalences are 0.9-5.8% for weekly nightmares **(Janson et al., 1995).** In a comparison study it has been noticed that these occur more women than in men**(Nielsen, Stenstrom & Levin, 2006)** and higher in younger than in older age groups **(Chivers & Blagrove, 1999; Nielsen et al., 2006; Salvio, Wood, Schwarz & Eichling, 1992).**

However there is a significant difference between night terror and nightmare. Night terror usually is accompanied by abrupt awakenings in the middle of the night (non-REM) that includes 2.2**% (Ohayon, Guilleminault, & Priest, 1999)**

To what extent is the intensity of the nightmares is still an unexplored arena. However in a comparison study it was found that the Nightmares were more frequent among the sexually abused sample than the non sexually abused sample. And these disturbances include nightmares, sleep terrors **(Choquet et al., 1997).**

On the other hand, **Wells et al. (1995, 1997)** did not find a significant increase in nightmare frequency among sexually abused compared to non abused and concluded that nightmares reported by abuse victims were not necessarily attributable to the abuse. **Argagun et al. (2002)** found higher rates of childhood traumatic experiences in Sexual abuse and sleep difficulties students who suffered from nightmares compared to students who did not. However, in that study trauma included sexual as well as physical and emotional stressors.

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It has been a subject that has been majorly understudied, but there has been no major evidences which prove that the symptoms are worse in sexually abused adolescents than the non sexually abused ones.**Heath, Bean and Feinauer (1996)** The severity of the abuse has always been the core reason for sleeplessness .In contradiction**, Noll et al. (2006)** found that a subgroup of sexually abused adolescents who had experienced relatively less severe forms of sexual abuse (defined as shorter duration, older age of onset, little physical violence, or by a single perpetrator who was not their biological father) reported higher levels of long-term sleep difficulties and shorter sleep duration than subgroups who had experienced relatively more severe forms of abuse **(defined as longer duration, physical violence, multiple perpetrators or the perpetrator being their biological father)**

4. CONCLUSION

The deep wounds from child sexual abuse that gets implanted in the child can remain for longer than a certain time frame. There are various ongoing researches conducted across various ethnicities, region and genders, that has been mediated to establish a protocol by the clinicians to improve the wellbeing and nourish the individual to lead a more positive and healthy life ahead. The multitudinal levels at which abuse gets affected range from a distorted self-image to convoluted relationships. However, these are checked only at a peripheral level while diagnosing for more severe mental disorders. Furthermore, severe issues has been already discussed in this particular paper. Disorders like depression, PTSD, eating disorders and sleep disorders have been keenly observed from various references.

The incidence and prevalence rates have also been discussed at a global and national level which shows that women are affected on a larger scale than men. The statistics on the age group also reveals that the older the children become victim to abuse, the harder it is to work towards their disbelief, shame and guilt. The memory gets wedged so deep as they are much grown up children, that the therapist has to begin to open layer by layer of the individuals personality to begin working with what led them to have a negative approach towards life. Each approach will differ from issue to issue, as the psychopathology of each disorder differ with having comorbidity of other issues coming into picture. However, this leads to further investigation on the physiological facet of these disorders, that is, how different parts of the brain is getting affected and does a pharmacological approach need to be combined with psychotherapy for better and faster improvement in the person.

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