Child Sexual Abuse: Consequences and Implications

Gail Hornor, RNC, MS, PNP

ABSTRACT

Sexual abuse is a problem of epidemic proportions in the United States. Given the sheer numbers of sexually abused children, it is vital for pediatric nurse practitioners to understand both short-term and long-term consequences of sexual abuse. Understanding consequences of sexual abuse can assist the pediatric nurse practitioner in anticipating the physical and mental health needs of patients and also may assist in the identification of sexual abuse victims. Sexual abuse typically does not occur in isolation. Implications for practice will be discussed. J Pediatr Health Care. (2010) *24*, 358-364.

KEY WORDS

Sexual abuse consequences

Sexual abuse is a problem of epidemic proportions in the United States. The U.S. Department of Health and Human Services (2008) states that nearly 80,000 American children were victims of sexual abuse in 2006. Based on retrospective studies of adults, it is estimated that only 1 in 20 cases of sexual abuse is identified by or reported to authorities (Kellogg, 2005). Given the sheer numbers of sexually abused children, both detected and undetected, it is vital for pediatric nurse practitioners (PNPs) to understand both short-term and long-term consequences of sexual abuse. Understanding the consequences of sexual abuse can assist the PNP in anticipating the physical and mental health needs of children and also may assist in the identification of undetected sexual abuse victims.

It is important for PNPs to be aware that sexual abuse typically does not occur in isolation. The child who experiences sexual abuse is at high risk for other negative childhood experiences. Dong, Anda, Dube, Giles, and Felitti (2003) found sexual abuse to be strongly associated with multiple other forms of negative childhood experiences. Dong and colleagues analyzed data from the Adverse Childhood Experiences Study, which examined the association of many inter-related adverse childhood experiences to a wide variety of health behaviors and health conditions. The study sample included more than 27,000 adults who were members of the Kaiser Health Plan. Questionnaires mailed to members included detailed questions regarding childhood abuse (sexual, emotional, or physical), neglect, and family dysfunction (domestic violence, parental separation or divorce, mental illness, substance abuse, or crime). Information related to health behaviors also was obtained. Child sexual abuse was reported by nearly one fourth (21%) of participants. Dong and colleagues found a strong relationship between sexual abuse and emotional abuse, physical abuse, battered mother, household substance abuse, household mental illness, parental separation/divorce, criminal household member, emotional neglect, and physical neglect. Especially strong relationships were noted between sexual abuse and emotional abuse, physical abuse, physical neglect, and having a battered mother. Previous studies also have reported a relationship between sexual abuse, neglect, or family dysfunction (Finkelhor & Dziuba-Leatherman, 1994; Madu & Peltzer, 2000). Clearly, when discussing the consequences of sexual

Gail Hornor, Nationwide Children's Hospital, Center for Child and Family Advocacy, Columbus, OH

Conflicts of interest: None to report.

Correspondence: Gail Hornor, RNC, MS, PNP, Nationwide Children's Hospital, Center for Child and Family Advocacy, 655 East Livingston Ave, Columbus, OH 43205; e-mail: gail.hornor@nationwidechildrens.org.

0891-5245/$36.00

Copyright © 2010 by the National Association of Pediatric Nurse Practitioners. Published by Elsevier Inc. All rights reserved.

doi:10.1016/j.pedhc.2009.07.003

abuse, an understanding of the multiple stressors that many sexual abuse victims are or have been exposed to is important when developing a plan of care for the child and for the prevention of further abuse.

Sexual abuse is a complex life experience, not a disorder or diagnosis (Putnam, 2003). Sexual abuse is defined as any sexual conduct or contact of an adult or significantly older child with or upon a child for the purposes of the sexual gratification of the perpetrator. Sexual abuse involves both touching and non-touching behaviors. The behaviors include fondling of breasts, genitalia, or buttocks under or on top of clothing, exposure to pornography or adults engaging in sexual activity, or even oral, anal, or vaginal penetration. The diversity of behaviors included in sexual abuse, along with differences in the age and gender of the child victim, the nature of the relationship between the child and the perpetrator, and the frequency and duration of the sexual abuse, all help to ensure differences in consequences for the child sexual abuse victim. Not every child reacts to sexual abuse in the same manner.

Social support also influences the development of sequelae to child sexual abuse. Experiencing sexual abuse within the context of a positive family or social environment may be associated with a lower risk for adverse mental health outcomes (Kinnally et al., 2009). Familial support, especially parental belief in the sexual abuse allegation and support, can act as a strong buffer against the development of negative consequences for sexual abuse victims (Tremblay, Hebert, & Piche, 1999).

The majority of children who are sexually abused will be moderately to severely symptomatic at some point in their life. Experiencing sexual abuse creates a feeling of powerlessness in the child and leaves the child with the perception of having little control over what happens (Dube et al., 2005). This lack of a sense of control acts as a stressor that has effects on the neurodevelopment of both male and female victims. Boys and girls cope differently with the stressor of sexual abuse. Girls are more likely to exhibit internalizing behaviors, such as depression and disordered eating (anorexia, bulimia, or obesity). Externalizing behaviors such as delinquency and heavy drinking are more likely exhibited by boys. Understanding the underlying feelings of powerlessness and loss of control experienced by children who are sexually abused helps in understanding the behaviors and consequences that some sexual abuse victims exhibit.

SEXUALIZED BEHAVIORS

All forms of child abuse have been linked with the development of a variety of behavioral problems in children. Sexualized behaviors in children have been linked most closely with child sexual abuse (Putnam, 2003). Children who exhibit sexualized behavior tend to be younger and to have been sexually abused at a younger age (Mullers & Dowling, 2008; Putnam). Many sexual behaviors exhibited by children are a part of normal development; however, numerous studies have found that sexually abused children exhibit more sexualized behaviors when compared with other non-abused children (Friedrich, Fisher, & Dittner, 2001; Paolucci, Genuis, & Violato, 2001). Sexual behavior in children can become a cause for concern due to particular aspects of the behavior such as frequency of the behavior, the child's demeanor while engaged in the behavior, or continuing to engage in the behavior after being asked to stop (Hornor, 2004). It is particularly alarming when a child demonstrates age-inappropriate sexual knowledge; for instance, when a 5-year-old child attempts to place his penis in the mouth, anus, or vagina of another child. Such behavior raises strong concern that the child has either observed explicit sexual behavior or has been sexually abused. A child who exhibits age-inappropriate knowledge of sex needs to be assessed for possible sexual abuse and should be reported to child protective services (CPS).

Girls are more likely to exhibit internalizing behaviors, such as depression and disordered eating (anorexia, bulimia, or obesity). Externalizing behaviors such as delinquency and heavy drinking are more likely exhibited by boys.

OTHER BEHAVIORAL CONCERNS

Child sexual abuse has been linked to the development of problematic behaviors. Symptoms of attention deficit hyperactivity disorder (ADHD) can develop as a result of sexual abuse, and the child may be misdiagnosed as having ADHD (Mullers & Dowling, 2008). The symptoms are actually the result of the trauma of sexual abuse and are more accurately diagnosed as post-traumatic stress disorder (PTSD) or anxiety. Briscoe-Smith and Hinshaw (2006) reported that girls with ADHD were at increased risk of having been sexually abused. This is not to state that every child, male or female, diagnosed with ADHD has been sexually abused, but the possibility of sexual abuse should be explored in children, especially girls, diagnosed with ADHD.

Mullers and Dowling (2008) report a link between child sexual abuse and violent behavior, especially in adolescent males. The violent behaviors include the use of weapons and fighting. Violent behaviors are exhibited by male sexual abuse victims more frequently than female victims and are an example of an externalizing behavior to cope with the stress of sexual abuse.

Cyr, McDuff, and Wright (2006) state that adolescent female victims of sexual abuse may vent their feelings through anger and aggression and accept relationships with these elements.

PSYCHIATRIC DISORDERS

Child sexual abuse has been linked with a variety of psychiatric disorders in childhood and continuing into adulthood. Martin, Bergen, and Richardson (2004) report that the incidence of psychiatric diagnoses occurring over a lifetime is 56% for women and 47% for men who have disclosed a history of child sexual abuse. However, when no history of child sexual abuse is reported, the rates of psychiatric disorders are much lower, at 32% for women and 34% for men. Depression, suicidal ideation, substance abuse, and PTSD appear to be associated with sexual abuse and will be discussed more completely. However, other psychiatric disorders also have been linked to sexual abuse such as borderline personality disorder, dissociative identity disorder, and bulimia nervosa (Putman, 2003). The development of pain disorders has also been found to be related to child sexual abuse (Sapp, 2005).

Post-traumatic Stress Disorder

Sexual abuse can result in the emergence of PTSD. PTSD can affect the pre-adolescent, adolescent, and adult victim of sexual abuse. The American Psychiatric Association's 1994 *Diagnostic and Statistical Manual* (DSM–IV) lists diagnostic criteria for PTSD. The criteria include exposure to a traumatic event (sexual abuse) in which the person witnessed or experienced an event that involved actual or threatened death or serious injury to self or others with the individual's response involving intense fear, helplessness, horror, or, in children, disorganized or agitated behavior. Hornor (2005) states that PTSD also involves the persistent re-experience of the traumatic event by recurrent and intrusive recollections of the event, repetitive play expressing a theme of the trauma, repetitive dreams of the event or frightening dreams without recognizable content, flashbacks of the traumatic event or acting or feeling as if the traumatic event was recurring, and/or intense psychological distress or physiologic reactions at exposure to cues to the trauma. Persistent avoidance of stimuli associated with the trauma and numbing of responsiveness also may be exhibited. PTSD also can be associated with persistent symptoms of increased arousal such as difficulty staying or falling asleep, anger outbursts or irritability, difficulty concentrating, or hypervigilance. Clearly, PTSD can result in behaviors that are detrimental to the individual's life. Symptoms of PTSD may not develop immediately following sexual abuse; rather, symptoms may become apparent months or even years following sexual abuse. Certain developmental milestones also can trigger emergence or re-emergence of PTSD symptoms such as initiation of sexual activity or the birth of a child. Cohen, Deblinger, Mannarino, and Steer (2004) suggest that trauma-focused cognitive behavioral therapy can be utilized successfully by clinicians to assist victims of sexual abuse, especially those exhibiting symptoms of PTSD.

Depression

Depression can be present in pre-adolescent children, adolescents, and adults who have been sexually abuse (Mullers & Downing, 2008). Numerous studies have linked major depression and dysthymia with sexual abuse (Paolucci et al., 2001). Both boys and girls who have been sexually abused are at increased risk for the development of depression, and this risk continues into adulthood (Dube et al., 2005). Putnam (2008) suggests that a history of sexual abuse may change the clinical presentation of major depression with reversal of neuro-vegetative signs such as increased appetite, weight gain, and hypersomnia when compared with depressed individuals without a history of sexual abuse. A history of sexual abuse has been associated with earlier onset of depressive episodes and an altered response to standard treatments for depression. The type of sexual abuse (touching vs. non-touching; penetration vs. non-penetration) and relationship to the perpetrator (closer relative vs. non-related) appears to affect the development and severity of depression (Trickett, Noll, Reiffman, & Putnam, 2001). However, Chapman and colleagues (2004) found emotional abuse to pose the greatest risk for the development of depression in childhood and/or adulthood, greater than sexual or physical abuse. PNPs should explore the possibility of sexual abuse as well as other forms of child abuse when a child or adolescent presents with depression.

Suicide

A history of sexual abuse places the individual at increased risk of suicide throughout the life span—childhood, adolescence, and adulthood (Dube et al., 2001). Sapp and Vandeven (2005) state that adolescent boys (grades 8 through 10) who have been sexually abused are at significantly increased risk of suicide, and are at even greater risk than girls who have been sexually abused. Any child or adolescent who expresses suicidal ideation or a suicide attempt must be assessed for all psychosocial risk factors, including sexual abuse.

Substance Abuse

Cigarette smoking usually is initiated in adolescence. The relationship between adult cigarette smoking and childhood sexual abuse was explored by Nichols and Harlow (2004) by conducting a retrospective study on 722 women aged 36 to 45 years. Nearly half (41%) of participants were identified as smokers, with a mean and median age of beginning smoking at age 16 years.

Physical abuse was reported by 17% of the participants, and 6% reported sexual abuse. Findings included a 3.5-fold increased risk of smoking in women who gave a history of both physical and sexual abuse and a two-fold increase in women who gave a history of sexual abuse only. Sapp and Vandeven (2005) state that smoking may be initiated during adolescence to help the individual cope with the trauma of the abuse and that continued adult smoking is complicated by nicotine addiction and adult stressors.

Numerous studies have linked child sexual abuse and illicit drug use (Bensley, Eenwyk, & Simmons, 2000; Dube et al., 2003). Child sexual abuse can produce feelings of helplessness, chaos, and impermanence in children and adolescents, and illicit drug use may serve as a way to escape or dissociate from these feelings (Dube et al., 2003). Sexual abuse, along with other forms of abuse and neglect, has been linked with drug initiation from early adolescence into adulthood and the problems with drug use, drug addiction, and parenteral drug use. Both men and women with a history of child sexual abuse demonstrate an increased risk of alcohol problems and marrying an alcoholic (Dube et al., 2003).

Alcohol use in adolescence is higher among teens who have been sexually abused. Sexual abuse, as well as other forms of child abuse or neglect, should be considered when an individual presents with a substance abuse problem.

OBESITY

Noll, Trickett, Harris, and Putnam (2008) note an association between child sexual abuse and the later development of obesity. Both child sexual abuse and obesity often occur in conjunction with depression, behavioral impulsivity, drug and alcohol use, difficulties with peers, and poor self-esteem. Obese children most often become obese adults, which places their children at increased risk for the development of childhood obesity and diabetes. Childhood obesity places the child at risk for a host of social, relationship, and emotional difficulties (Trickett et al., 2001).

ADULT REVICTIMIZATION

A history of sexual abuse places an individual at increased risk for sexual re-victimization in adolescence and adulthood, especially for women. Fillipas and Ullman (2006) found adult sexual abuse to be almost four times more likely for individuals who suffered sexual abuse as a child. Significantly higher PTSD symptoms have been found in victims who have experienced both child and adult sexual assault. Dubowitz and associates (2001) speculate that the effects of early abuse and the subsequent mental health problems that may develop, including depression and PTSD, place the woman at increased risk for dysfunctional and sexually violent relationships in adulthood.

EFFECTS ON PARENTING

Given the preceding discussion linking sexual abuse with the development of multiple behavioral and psychiatric disorders including depression, substance abuse, and PTSD, it is no wonder that a history of child sexual abuse can negatively affect the individual's ability to parent and thus have negative effects on their offspring. Children born to mothers with a history of sexual abuse are more likely to be born pre-term, have a teenage mother, and be involved with CPS (Noll et al., 2008). Children born to sexually abused mothers are at increased risk to be abused (physically, emotionally, and sexually) by their mothers or by other individuals who are allowed access to vulnerable children. Dubowitz and associates (2001) describe the cumulative risk affect of childhood abuse. Mothers who were both sexually *and* physically abused were more likely to suffer from depressive symptoms and use harsh parenting techniques (verbal aggression and minor violence) than were mothers who were either sexually abused or physically abused. Mothers suffering only sexual or physical abuse were both more likely then mothers who experienced no form of childhood abuse to display depressive symptoms and use harsh parenting techniques. Children of mothers who were sexually abused or physically abused were more likely to exhibit internalizing behaviors such as withdrawal and depression than were children of mothers reporting no history of abuse. Children of mothers who were both sexually and physically abused or physically abused only were more likely to exhibit externalizing behaviors, aggression, and delinquency than were children of non-abused mothers.

Children born to sexually abused mothers are at increased risk to be abused (physically, emotionally, and sexually) by their mothers or by other individuals who are allowed access to vulnerable children.

Inter-generational transmission of physical abuse is thought to develop as a result of patterning parental behavior experienced as a child; that is, a child who experiences physical abuse as a child is at risk to repeat this behavior as an adult (Zuravin, McMillin, DePanfilis, & Risley-Curtiss, 1996). Sexual abuse is uniquely different in that the majority of sexual abuse is perpetrated by males on females, so the likelihood of inter-generational transmission of sexual abuse is low (i.e., a female victim of child sexual abuse growing up to sexually abuse her own or other children as an adult). However, although female perpetrators of sexual abuse are much less common than male perpetrators of sexual abuse, when a woman does commit sexual abuse, she most

BOX 1. Sexual abuse screening questions for children and parents

Children (ask questions in a developmentally appropriate format)

1. Have children identify their body parts.
2. Determine the words the child uses for body parts, including vagina/penis, breasts, and anus.
3. Educate the child regarding the concept of private parts. Have a developmentally appropriate discussion with the child regarding private body parts. Does anyone touch, tickle, kiss, or hurt your vagina? (Use the word identified by the child and ask each action separately.) Ask regarding breasts and anus, also using the appropriate word.
4. If the child answers yes to any aspect of No. 3, try to identify simply who, what, and where. Who touched your vagina? What did they do? (What body part was touched, etc., and what was it touched with, etc.) Where were you when it happened? This information is important to determine the context of the touching, tickling, or hurting to aide in differentiating between innocent touching with hygiene care and inappropriate touching.
5. Discuss consensual sexual activity with adolescents including safe sex practices. How old is the person/persons you have had sex with?
6. Also discuss nonconsensual sexual activity. Have you ever been forced into sexual activity? Have you ever had sex when you did not want to? Tell me about it.

Parents

1. Do you have any concerns that your child has been sexually abused? If yes, what are your concerns?
2. Were you or your partner ever sexually abused as a child? If so, by whom? Does your child have contact with that individual?
3. Does your child ever have contact with anyone who has sexually abused a child or has been accused of sexually abusing a child?

likely was a victim of sexual abuse as a child. The intergenerational aspect of sexual abuse appears to be more closely related to the negative effects of her own sexual abuse, which impedes the mother's emotional and mental health, limiting her ability to make good parenting decisions to keep her children safe from sexual abuse. Woman who have been sexually abused may form relationships with individuals who then sexually abuse their children, leave the children in the care of individuals who sexually abuse them, and may be less aware of sexual abuse occurring within the family.

It also is important to note that experiencing sexual abuse as a child may make a parent, especially a mother, hyper-vigilant regarding the potential sexual abuse of his or her child. Parental sexual abuse hyper-vigilance affects the ability to make good parenting decisions and potentially can expose the child to unnecessary sexual abuse investigations and examinations and have a negative effect on the parent-child relationship.

A parental history of child sexual abuse also may have the positive effect of making the parent more empathetic to the child when sexual abuse occurs. The parent may feel responsible for the abuse, feel they have failed the child, and be strongly supportive of the child.

IMPLICATIONS FOR PRACTICE

Recognition of sexual abuse is crucial for PNPs. Prompt recognition of sexual abuse coupled with reporting of concerns to the appropriate CPS agency can assure safety for the child. All well-child appointments should include a few developmentally appropriate screening questions for sexual abuse. Children and parents should be separated for the screening questions if possible. See the Box 1 for examples of questions to ask children and parents concerning sexual abuse. The well-child examination always should include a thorough ano-genital inspection. The PNP should provide education regarding private parts and that no one should touch, tickle, kiss, or hurt their private parts. One should explain to the child that it is only all right to be examining their genitals today because they are having a check-up and their parent is present. Screening parents for a history of child sexual abuse provides valuable information regarding potential increased risk of sexual abuse for the child, especially if the child has contact with the individual who sexually abused their parent, but also should alert the PNP to potential negative effects on parenting.

If a child discloses a history of sexual abuse or has a physical examination finding that is concerning for sexual abuse, the PNP must report concerns of suspected sexual abuse to the appropriate CPS agency and/or law enforcement agency. CPS is then responsible for the determination of a safety plan for the child and deciding if the child can be discharged home with the accompanying parent/adult. An open, honest discussion should ensue between the PNP and the parent regarding the sexual abuse concerns and the need to report to CPS. Caution should be heeded in this discussion if there are concerns regarding parental support of the allegation or especially if the child has been accompanied to the visit by the alleged perpetrator. PNPs should rely on the guidance of CPS and/or law enforcement when confronted with such a situation.

Only a small portion of child sexual abuse is ever identified; therefore, PNPs must consider the possibility of sexual abuse when a child or adolescent presents with a behavioral or psychiatric disorder that can

develop as a result of sexual abuse. I certainly am not implying that every child diagnosed with ADHD or depression has been sexually abused or should be reported to CPS. Rather, when a child presents with depression, suicidal ideation, substance abuse, or PTSD, the possibility of sexual abuse should be explored. These children should be asked a few screening questions regarding sexual abuse.

Every child is an individual, and not every child who is sexually abused will require ongoing mental health therapy. Infants and toddlers who are sexually abused would not be expected to have lasting memories of their sexual abuse and obviously are too young for mental health therapy. Preschool-aged, school-aged, and adolescent children who have been sexually abused should be referred to a mental health therapist with expertise in working with children who have been sexually abused for an assessment to determine the need for ongoing therapy. Asymptomatic children can benefit from therapeutic intervention and education designed to prevent repeated sexual abuse, to normalize and clarify their feelings, and to educate regarding healthy sexual/personal boundaries. The majority of sexually abused children are moderately to seriously symptomatic at some point (Putman, 2003). King, Tonge, and Mullen (2000), as well as Celano, Hazzard, Webb, and McCall (1996), found trauma-focused cognitive-based therapy for the symptomatic child coupled with similar treatment for the non-offending parent to be the most effective treatment for child sexual abuse.

Families of both asymptomatic and symptomatic children should be assessed for the presence of other risk factors such as substance abuse, mental illness, domestic violence, or other dysfunction. Identified risk factors must be addressed and appropriate treatment initiated. Recovery for children can be facilitated by optimizing the strengths of their families and identifying and then addressing their weaknesses.

Noll and colleagues (2008) suggest revisiting mental health therapy at various development points, especially if the developmental task becomes reminiscent of the sexual abuse. Potential trauma invoking developmental changes include forming romantic relationships, becoming sexually active, and becoming a parent.

Child sexual abuse can result in serious sequelae, especially if unrecognized and untreated. Astute recognition and reporting of sexual abuse by the PNP is vital. Routine screening for sexual abuse by the PNP and all primary care providers should be a standard of care. Realizing that sexual abuse can result in a variety of behavioral and psychiatric symptoms prior to or following disclosure of sexual abuse is essential for the PNP. Appropriate mental health referrals are critical. The PNP plays an essential role in keeping children safe and helping children and their families heal following the trauma of sexual abuse.

REFERENCES

Bensley, L. S., Eenwyk, J. V., & Simmons, K. W. (2000). Self-reported childhood sexual and physical abuse and adult HIV-risk behaviors and heavy drinking. *American Journal of Preventive Medicine, 18*, 151-158.

Briscoe-Smith, A. M., & Hinshaw, S. P. (2006). Linkages between child abuse and attention deficit/hyperactivity disorder in girls: Behavioral and social correlates. *Child Abuse & Neglect, 30*, 1239-1255.

Celano, M., Hazzard, A., Webb, C., & McCall, C. (1996). Treatment of traumagenic beliefs among sexually abuse girls and their mothers: An evaluation study. *Journal of Abnormal Child Psychology, 24*, 1-16.

Chapman, D. P., Whitfield, C. L., Felitti, V. J., Dube, S. R., Edwards, V. J., & Anda, R. F. (2004). Adverse childhood experiences and the risk of depressive disorders in adulthood. *Journal of Affective Disorders, 82*, 217-225.

Cohen, J. A., Deblinger, E., Mannarino, A. P., & Steer, R. A. (2004). A multisite, randomized controlled trial for children with sexual abuse-related PTSD. *Adolescent Psychiatry, 43*, 393-402.

Cyr, M., McDuff, P., & Wright, J. (2006). Prevalence and predictors of dating violence among adolescent female victims of child sexual abuse. *Journal of Interpersonal Violence, 21*, 1000-1017.

Dong, M., Anda, R. F., Dube, S. R., Giles, W. H., & Felitti, V. J. (2003). The relationship of exposure to childhood sexual abuse to other forms of abuse, neglect, and household dysfunction during childhood. *Child Abuse and Neglect, 27*, 625-639.

Dube, S. R., Anda, R. F., Felitti, V. J., Chapman, D. P., Williamson, D. F., & Giles, W. H. (2001). Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the life span. *Journal of the American Medical Association, 286*, 1-21.

Dube, S. R., Anda, R. F., Whitfield, C. L., Brown, D. W., Felitti, V. J., Dong, M., & Giles, W. H. (2005). Long-term consequences of childhood sexual abuse by gender of victim. *American Journal of Preventive Medicine, 28*, 430-438.

Dube, S. R., Felitti, V. J., Dong, M., Chapman, D. P., Giles, W. H., & Anda, R. F. (2003). Childhood abuse, neglect, and household dysfunction and the risk of illicit drug use: The adverse childhood experiences study. *Pediatrics, 111*, 564-572.

Dubowitz, H., Black, M. M., Kerr, M. A., Hussey, J. M., Morrel, T. M., Everson, M. D., & Starr, R. H., Jr. (2001). Type and timing of mothers' victimization: Effects on mother and children. *Pediatrics, 107*, 728-735.

Fillipas, H. H., & Ullman, S. E. (2006). Child sexual abuse, coping responses, self-blame, post-traumatic stress disorder and adult sexual revictimization. *Journal of Interpersonal Violence, 21*, 652-672.

Finkelhor, D., & Dziuba-Leatherman, J. (1994). Children as victims of violence: A national survey. *Pediatrics, 94*, 413-420.

Friedrich, W., Fisher, J., & Dittner, C. (2001). Child sexual behavior inventory: Normative, psychiatric, and sexual abuse comparisons. *Child Maltreatment, 6*, 37-49.

Hornor, G. (2004). Sexual behavior in children: Normal or not? *Journal of Pediatric Health Care, 18*, 57-64.

Hornor, G. (2005). Domestic violence and children. *Journal of Pediatric Health Care, 19*, 206-212.

Kellogg, N. (2005). The evaluation of sexual abuse in children. *Pediatrics, 25*, 506-512.

King, N. J., Tonge, B. J., & Mullen, P. (2000). Treating sexually abuse children with posttraumatic stress symptoms: A randomized clinical trial. *Journal of the American Academy of Child and Adolescent Psychiatry, 39*, 1347-1355.

Kinnally, E. L., Huang, Y., Haverly, R., Burke, A. K., Galfalvy, H., Brent, D. P., … Mann, J. J. (2009). Parental care moderates the influence of MAOA-uVNTR genotype and childhood stressors on trait impulsivity and aggression in adult women. *Psychiatric Genetics, 19*, 126-133.

Madu, S. N., & Peltzer, K. (2000). Risk factors and child sexual abuse among secondary school students in the Northern Province (South Africa). *Child Abuse & Neglect, 24*, 259-268.

Martin, G., Bergen, H. A., & Richardson, A. S. (2004). Sexual abuse and suicidality: Gender differences in a large community sample of adolescents. *Child Abuse & Neglect, 28*, 491-503.

Mullers, E. S., & Dowling, M. (2008). Mental health consequences of child sexual abuse. *British Journal of Nursing, 17*, 1428-1433.

Nichols, H. B., & Harlow, B. L. (2004). Childhood abuse and risk of smoking onset. *Journal of Epidemiology of Community Health, 58*, 402-406.

Noll, J. G., Trickett, P. K., Harris, W. W., & Putnam, F. W. (2008). The cumulative burden borne by offspring whose mothers were sexually abused as children. *Journal of Interpersonal Violence, 10*, 1-26.

Paolucci, E., Genuis, M., & Violato, C. (2001). A meta-analysis of the published research on the effects of child sexual abuse. *Journal of Psychology, 137*, 17-36.

Putman, F. W. (2003). Ten-year research update review: Child sexual abuse. *Journal of the American Academy of Child & Adolescent Psychiatry, 42*, 269-278.

Sapp, M. V., & Vandeven, A. M. (2005). Update on childhood sexual abuse. *Current Opinion in Pediatrics, 17*, 258-264.

Tremblay, C., Hebert, M., & Piche, C. (1999). Coping strategies and social support as mediators of consequences in child sexual abuse victims. *Child Abuse & Neglect, 23*, 929-945.

Trickett, P. K., Noll, J. G., Reiffman, A., & Putnam, F. W. (2001). Variants of intrafamilial sexual abuse experience: Implications for short- and long-term development. *Development & Psychopathology, 13*, 1001-1019.

U.S. Department of Health and Human Services. (2008). *Child maltreatment 2006.* Retrieved April 1, 2009, from http://www.childwelfare.gov/can/prevalance

Zuravin, S., McMillin, C., DePanfilis, C., & Risley-Curtiss, C. (1996). The intergenerational cycle of child maltreatment: Continuity versus discontinuity. *Journal of Interpersonal Violence, 11*, 315-334.