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Emotional Disturbances and Child Sexual Abuse: A Psychosocial Perspective

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ABSTRACT:

Child abuse has many forms: physical, emotional, sexual, neglect, and exploitation. Any of these that are potentially or actually harmful to a child's health, survival, dignity and development are abuse. Violence against children can be "physical and mental abuse and injury, neglect or negligent treatment, exploitation and sexual abuse". Research conducted over the past decade indicates that a wide range of psychological and interpersonal problems are more prevalent among those who have been sexually abused children than among individuals with no such experiences. This article summarizes what is currently known about these potential impacts of child sexual abuse. Various problems and symptoms described in the literature on child sexual abuse are reviewed in a series of broad categories including; Child sexual abuse, variety of sexual offenses, indications of sexual abuse in children and adolescents in terms of emotional and behavioural signs. In conclusion importance of psychotherapies have been mentioned as psychological intervention and was discussed few laws against child sexual abuse in the United States and India.

Keywords: *Child, emotional disturbances, psychosocial perspectives, sexual abuses*

Violence against children can be "physical and mental abuse and injury, neglect or negligent treatment, exploitation and sexual abuse. Violence may take place in homes, schools, orphanages, residential care facilities, on the streets, in the workplace, in prisons and in places of detention". Such violence can affect the normal development of a child impairing their mental, physical and social being. In extreme cases abuse of a child can result in death. Child abuse has many forms: physical, emotional, sexual, neglect, and exploitation.

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Any of these that are potentially or actually harmful to a child's health, survival, dignity and development are abuse. Physical abuse is when a child has been physically harmed due to some interaction or lack of interaction by another person, which could have been prevented by any person in a position of responsibility, trust or power. Emotional abuse can be seen as a failure to provide a supportive environment and primary attachment figure for a child so that they may develop a full and healthy range of emotional abilities. Emotional abuse is also the act of causing harm to a child's development, when they could have been within reasonable control of a person responsible for the child. Examples of these acts are restricting movement, threatening, scaring, discriminating, ridiculing, belittling, etc. A rising concern is the pressure, children feel to perform well in school and college examinations, which can be seen as a form of emotional stress and abuse. Sexual abuse is engaging a child in any sexual activity that he/she does not understand or cannot give informed consent for or is not physically, mentally or emotionally prepared for. Abuse can be conducted by an adult or another child who is developmentally superior to the victim. This includes using a child for pornography, sexual materials, prostitution and unlawful sexual practices. Neglect or negligent treatment is purposeful omission of some or all developmental needs of the child by a caregiver with the intention of harming the child. This includes the failure of protecting the child from a harmful situation or environment when feasible.

Child sexual abuse or **child molestation** is a form of child abuse in which an adult or older adolescent uses a child for sexual stimulation (Child Sexual Abuse [CSA], 2008; APA Board of Professional Affairs", 1999). Forms of child sexual abuse include asking or pressuring a child to engage in sexual activities (regardless of the outcome), indecent exposure (of the genitals, female nipples, etc.) to a child with intent to gratify their own sexual desires or to intimidate or groom the child, physical sexual contact with a child, or using a child to produce child pornography ("CSA", 2014; Martin, Anderson, Romans, Mullen., & O'Shea, 1993).

Child sexual abuse includes a variety of sexual offenses

a) *Sexual assault* – a term defining offenses in which an adult uses a minor for the purpose of sexual gratification; for example, rape (including sodomy), and sexual penetration with an object (Finkelhor, David, Ormrod & Richard, 2001).

b) *Sexual exploitation* – a term defining offenses in which an adult victimizes a minor for advancement, sexual gratification, or profit; for example, prostituting a child and creating or trafficking in child pornography (Finkelhor, David, Ormrod., & Richard, 2004).

c) *Sexual grooming* – defines the social conduct of a potential child sex offender who seeks to make a minor more accepting of their advances, for example in an online chat room.

d) *Incest* - A child sexual abuse offense where the perpetrator is related to the child, either by blood or marriage, is a form of incest described as intrafamilial child sexual abuse (Fridell,

1990). Incest between a child or adolescent and a related adult has been identified as the most widespread form of child sexual abuse with a huge capacity for damage to a child. It is also known as child incestuous abuse (Courtois & Christine, 1988). When a prepubescent child is sexually abused by one or more other children or adolescent youths, and no adult are directly involved, it is defined as child-on-child sexual abuse. The definition includes any sexual activity between children that occurs without consent, without equality, or due to coercion (Shaw et al., 2000) whether the offender uses physical force, threats, trickery or emotional manipulation to compel cooperation. When sexual abuse is perpetrated by one sibling upon another, it is known as "intersibling abuse", a form of incest (Caffaro & Conn-Caffaro, 2005). Unlike research on adult offenders, a strong causal relationship has been established between child and adolescent offenders and these offenders' own prior victimization, by either adults or other children (Bromberg, Johnson., & Blair, 2001).

e) The term *pedophilia* refers to persistent sexual feelings of attraction in an adult or older adolescent toward prepubescent children, whether the attraction is acted upon or not. A person with this attraction is called a pedophile.

f) *Commercial sexual exploitation of children (CSEC***)** is defined by the Declaration of the First World Congress against Commercial Sexual Exploitation of Children, held in Stockholm in 1996, as "sexual abuse by an adult accompanied by remuneration in cash or in kind to the child or third person(s). CSEC usually takes the form of child prostitution or child pornography, and is often facilitated by child sex tourism. CSEC is particularly a problem in developing countries of Asia. In recent years, new innovations in technology have facilitated the trade of Internet child pornography (UNICEF, 2006).

g) *Child marriage* is one of the main forms of child sexual abuse; UNICEF has stated that child marriage "represents perhaps the most prevalent form of sexual abuse and exploitation of girls" (UNICEF, 2006).

h) Even seemingly less serious sexual behaviors are damaging to children and are considered abusive. For instance:-fondling or kissing a child in a sexual manner, making a child watch pornographic movies or observe sexual activities, exhibiting one's sexual organs to a child or making the child display his or her own genitals, taking sexually explicit photographs of a child, talking with a child in a sexual or seductive manner.

INCIDENCE AND PREVALENCE

Child sexual abuse can occur in a variety of settings, including home, school, or work (in places where child labor is common). Up to two-thirds of females and one-third of males may be sexually abused at some time in their lives. Sexual abuse is present in all classes, races and religions. Females are two to three times more likely than males to be sexually abused.

The global prevalence of child sexual abuse has been estimated at 19.7% for females and 7.9% for males, according to a 2009 study published in *Clinical Psychology Review* that examined 65 studies from 22 countries. Using the available data, the highest prevalence rate of child sexual abuse geographically was found in Africa (34.4%), primarily because of high rates in South Africa; Europe showed the lowest prevalence rate (9.2%); America and Asia had prevalence rates between 10.1% and 23.9%("Prevalence of Child Sexual Abuse in Community and Student Samples: A Meta-Analysis").

Most sexual abuse offenders are acquainted with their victims; approximately 30% are relatives of the child, most often brothers, fathers, uncles or cousins; around 60% are other acquaintances, such as "friends" of the family, babysitters, or neighbors; strangers are the offenders in approximately 10% of child sexual abuse cases (Julia, 2007). Most child sexual abuse is committed by men; studies show that women commit 14% to 40% of offenses reported against boys and 6% of offenses reported against girls (Julia, 2007).

The most-often reported form of incest is father–daughter and stepfather–daughter incest, with most of the remaining reports consisting of mother/stepmother–daughter/son incest (Turner, 1996). Father–son incest is reported less often; however it is not known if the actual prevalence is less or it is under-reported by a greater margin (Meyer & Michel, 2002). Similarly, some argue that sibling incest may be as common, or more common, than other types of incest: Goldman and Goldman (Goldman & Padayachi, 1997) reported that 57% of incest involved siblings; Finkelhor reported that over 90% of nuclear family incest involved siblings (Finkelhor, 1979) while Cawson, Wattam and Brooker, (2000) show that sibling incest was reported twice as often as incest perpetrated by fathers/stepfather.

In 2007 the Ministry of Women and Child Development published the "Study on Child Abuse: India, (2007) main findings of these study included 53.22% of children reported having faced sexual abuse". Among them 52.94% were boys and 47.06% girls. Andhra Pradesh, Assam, Bihar and Delhi reported the highest percentage of sexual abuse among both boys and girls, as well as the highest incidence of sexual assaults. 21.90% of child respondents faced severe forms of sexual abuse, 5.69% had been sexually assaulted and 50.76% reported other forms of sexual abuse. Significant underreporting of sexual abuse of boys by both women and men is believed to occur due to sex stereotyping, social denial, the minimization of male victimization, and the relative lack of research on sexual abuse of boys (Watkins & Bentovim, 1992).

Types of offenders*:* Early research in the 1970s and 1980s began to classify offenders based on their motivations and traits. Groth and Birnbaum (1978) categorized child sexual offenders into two groups, "fixated" and "regressed". Fixated were described as having a primary attraction to children, whereas regressed had largely maintained relationships with other adults, and were even married. This study also showed that adult sexual orientation was not related to the sex of the victim targeted, e.g. men who molested boys often had adult relationships with women.

Holmes and Stephen (2002) expanded on the types of offenders and their psychological profiles. They are divided as follows.

I. Situational – does not prefer children, but offend under certain conditions.

- *Regressed* – Typically has relationships with adults, but a stressor causes them to seek children as a substitute
- *Morally Indiscriminate* – All-around sexual deviant, who may commit other sexual offenses unrelated to children.
- *Naive/Inadequate* – Often mentally disabled in some way, finds children less threatening.

II. Preferential – has true sexual interest in children.

- *Mysoped* – Sadistic and violent, target strangers more often than acquaintances.
- *Fixated* – Little or no activity with own age, described as an "overgrown child."

INDICATIONS OF SEXUAL ABUSE IN CHILDREN AND ADOLESCENTS

1) Behavioral Signs

- Sexualized behavior, for instance, children engaging in sexual play with dolls, or adolescents engaging in indiscriminate sexual activity
- Acting-out behaviors such as running away or temper tantrums
- Regressive behaviors such as thumb sucking, baby talk or curling up in fetal position
- Poor school performance
- Drug and/or alcohol abuse
- Self-mutilating behaviors, cutting self or hurting self in other ways
- Radical behavior change in any direction. For example, suddenly becoming a model child or suddenly beginning to act rebellious or unruly
- Eating disturbances
- Sleep disturbances, especially nightmares or insomnia
- Difficulty concentrating

2) Emotional Signs

- Depressed or sad mood
- Feeling anxious in general or having fears of specific settings or circumstances, often related to the abusive situation
- Perfectionism
- Aggression
- Withdrawal
- Low self-esteem
- Guilt, self-blame

3) Physical Signs

- Abdominal pain
- Genital, urethral or rectal pain, bleeding or abrasions
- Sexually transmitted diseases
- Recurrent urinary tract infections
- Bed-wetting

- Bed-soiling
- Pregnancy

EMOTIONAL DISTURBANCES DUE TO SEXUAL ABUSE ON CHILDREN

Child sexual abuse can result in both short-term and long-term harm, including psychopathology in later life (Dinwiddie, Heath, & Dunne, 2000, Nelson, Heath, & Madden, 2002). A study funded by the USA National Institute of Drug Abuse found that "Among more than 1,400 adult females, childhood sexual abuse was associated with increased likelihood of drug dependence, alcohol dependence, and psychiatric disorders". A well-documented, long-term negative effect is the repeated or additional victimization in adolescence and adulthood (Messman-Moore., & Long, 2000). A causal relationship has been found between childhood sexual abuse and various adult psychopathologies, including crime and suicide (Julia, 2007; Freyd, Putnam., & Lyon, 2005) in addition to alcoholism and drug abuse (Zickler & Patrick, 2002). Males who were sexually abused as children more frequently appear in the criminal justice system than in a clinical mental health setting. Intergenerational effects have been noted, with the children of victims of child sexual abuse exhibiting more conduct problems, peer problems, and emotional problems than their peers (Roberts, o'Connor, Dunn, & Golding, 2004). The social stigma of child sexual abuse may compound the psychological harm to children (Holguin, Hansen, & David, 2003) and adverse outcomes are less likely for abused children who have supportive family environments (Romans, Martin, Anderson, O'Shea., & Mullen, 1995).

Indicators and effects include depression, somatization (Widom DuMont, Czaja, 2007; Arnow, 2004), anxiety, (Levitan, Rector, Sheldon., & Goering, 2003), eating disorders, poor self-esteem (Walsh., & DiLillo, 2011), sleep disturbances (Steine & Krystal, 2012), and dissociative and anxiety disorders including post-traumatic stress disorder (Arehart-Treichel., & Joan, 2005). Victims may withdraw from school and social activities and exhibit various learning and behavioural problems including cruelty to animals (Ascione, Friedrich, William, Heath, Hayashi., & Kentaro, 2003; Ascione & Frank, 2005) attention deficit/hyperactivity disorder (ADHD), conduct disorder, and oppositional defiant disorder (ODD) (Walsh & DiLillo, 2011). Teenage pregnancy and risky sexual behaviors may appear in adolescence (Tyler, 2002). Child sexual abuse victims report almost four times as many incidences of self-inflicted harm (Noll, 2003).

Dissociation and posttraumatic stress disorder (PTSD): Child abuse, including sexual abuse, especially chronic abuse starting at early ages, has been found to be related to the development of high levels of dissociative symptoms, which includes amnesia for abuse memories (Chu, Frey, Ganzel., & Matthews,1999).When severe sexual abuse (penetration, several perpetrators, lasting more than one year) had occurred, dissociative symptoms were even more prominent (Draijer & Langeland,1999). Besides dissociative identity disorder (DID) and posttraumatic stress disorder (PTSD), child sexual abuse survivors may present borderline personality disorder (BPD) and eating disorders such as bulimia nervosa (Hornor, 2010)

Neurological damage: Research has shown that traumatic stress, including stress caused by sexual abuse, causes notable changes in brain functioning and development (Maia, Perry & Bruce, 2006).Various studies have suggested that severe child sexual abuse may have a deleterious effect on brain development. Ito, Teicher, Glod., and Ackerman (1998) found "reversed hemispheric asymmetry and greater left hemisphere coherence in abused subjects;" (Ito et al.,1993) found that an increased likelihood of "ictal temporal lobe epilepsy-like symptoms" in abused subjects. Anderson et al. (2002) recorded abnormal transverse relaxation time in the cerebellar vermis of adults sexually abused in childhood. Teicher et al. (1993) found that child sexual abuse was associated with a reduced corpus callosum area; various studies have found an association of reduced volume of the left hippocampus with child sexual abuse and Ito et al. (1993) found increased electrophysiological abnormalities in sexually abused children. Some studies indicate that sexual or physical abuse in children can lead to the over excitation of an undeveloped limbic system, Teicher, (2002); Teicher et al. (1993) used the "Limbic System Checklist-33" to measure ictal temporal lobe epilepsy-like symptoms in 253 adults. Reports of child sexual abuse were associated with a 49% increase to LSCL-33 scores, 11% higher than the associated increase of self-reported physical abuse. Reports of both physical and sexual abuse were associated with a 113% increase. Male and female victims were similarly affected (Arehart-Treichel., & Joan, 2001).

Navalta et al. (2006) found that the self-reported math Scholastic Aptitude Test scores of their sample of women with a history of repeated child sexual abuse were significantly lower than the self-reported math SAT scores of their non-abused sample. Because the abused subjects verbal SAT scores were high, they hypothesized that the low math SAT scores could "stem from a defect in hemispheric integration." They also found a strong association between short term memory impairments for all categories tested (verbal, visual, and global) and the duration of the abuse (Navalta Polcari, Webster, Boghossian., & Teicher, 2006).

PHYSICAL EFFECTS

Injury: Depending on the age and size of the child, and the degree of force used, child sexual abuse may cause internal lacerations and bleeding. In severe cases, damage to internal organs may occur, which, in some cases, may cause death (Anderson et al. 2004).

Infections: Child sexual abuse may cause infections and sexually transmitted diseases (De Jong, 1985). Depending on the age of the child, due to a lack of sufficient vaginal fluid, chances of infections are higher. Vaginitis has also been reported (De Jong, 1985).

Treatment: The initial approach to treating a person who has been a victim of sexual abuse is dependent upon several important factors: age at the time of presentation, circumstances of presentation for treatment and co-morbid conditions. The goal of treatment is not only to treat current mental health issues, but to prevent future ones.

Children often present for treatment in one of several circumstances, including criminal investigations, custody battles, problematic behaviors, and referrals from child welfare agencies (Cynthia, Anthony., & Urquiza, 2004). The three major modalities for therapy with children and teenagers are family therapy, group therapy, and individual therapy, which course is used depends on a variety of factors that must be assessed on a case by case basis. For instance, treatment of young children generally requires strong parental involvement and can benefit from family therapy. Adolescents tend to be more independent; they can benefit from individual or group therapy. The modality also shifts during the course of treatment, for example group therapy is rarely used in the initial stages, as the subject matter is very personal and/or embarrassing (Cynthia, Anthony., & Urquiza, 2004).

Major factors that affect both the pathology and response to treatment include the type and severity of the sexual act, its frequency, the age at which it occurred, and the child's family of origin. Roland C. Summit, a medical doctor, defined the different stages the victims of child sexual abuse go through, called *Child Sexual Abuse Accommodation Syndrome*. He suggested that children who are victims of sexual abuse display a range of symptoms that include secrecy, helplessness, entrapment, accommodation, delayed and conflicted disclosure and recantation (Summit, 1983).

PSYCHOLOGICAL INTERVENTIONS

Psychotherapy as psychological intervention can be delivered from a broad range of theoretical perspectives, including, behavioural/ cognitive, existential/humanistic, gestalt, interpersonal, psychoanalytic/ psychodynamic, Rogerian/ person-centred and systemic. Therapists typically employ one of these guiding theories, though integrative approaches, which aim to multiply the benefits of different approaches, are becoming more common (Allnock et al., 2009). Some of the more common integrative approaches within sexual abuse services for children are CBT, eye movement desensitisation and reprocessing, and transactional analysis (Prochaska, 1999).

Disclosure: Children who received supportive responses following disclosure had less traumatic symptoms and were abused for a shorter period of time than children who did not receive support (Gries et al., 2000; Kogan, 2005). In general, studies have found that children need support and stress-reducing resources after disclosure of sexual abuse (Palmer, Brown, Rae-Grant, & Loughlin, 1999). Negative social reactions to disclosure have been found to be harmful to the survivor's well being (Ullman, 2003).One study reported that children who received a bad reaction from the first person they told, especially if the person was a close family member, had worse scores as adults on general trauma symptoms, post traumatic stress disorder symptoms, and dissociation (Roesler, 1994). Another study found that in most cases when children did disclose abuse, the person they talked to did not respond effectively, blamed or rejected the child, and took little or no action to stop the abuse (Palmer, Brown, Rae-Grant, & Loughlin, 1999). Non-validating and otherwise non-supportive responses to disclosure by the child's primary attachment figure may indicate a relational disturbance predating the sexual abuse that may have

been a risk factor for the abuse, and which can remain a risk factor for its psychological consequences (Schechter, Brunelli, Cunningham, Brown., & Baca, 2002).

The American Academy of Child and Adolescent Psychiatry provides guidelines for what to say to the victim and what to do following the disclosure ("Responding to Child Sexual Abuse). Asa Don (2008) has indicated that a minimization of the trauma and its effects is commonly injected into the picture by parental caregivers to shelter and calm the child. It has been commonly assumed that focusing on children's issues too long will negatively impact their recovery. Therefore, the parental caregiver teaches the child to mask his or her issues.

Few Laws against child sexual abuse*:* They vary by country based on the local definition of who is a child and what constitutes child sexual abuse. Most countries in the world employ some form of age of consent, with sexual contact with an underage person being criminally penalized. As the age of consent to sexual behaviour varies from country to country, so too do definitions of child sexual abuse (Overview of the nature and extent of child sexual abuse in Europe).

Child sexual abuse is outlawed nearly everywhere in the world, generally with severe criminal penalties, including in some jurisdictions, life imprisonment or capital punishment (Levesque & Roger, 1999; "United Nations Convention on the Rights of the Child", 1989). An adult's sexual intercourse with a child below the legal age of consent is defined as statutory rape, based on the principle that a child is not capable of consent and that any apparent consent by a child is not considered to be legal consent.

The United Nations Convention on the Rights of the Child (CRC) is an international treaty that legally obliges states to protect children's rights. Articles 34 and 35 of the CRC require states to protect children from all forms of sexual exploitation and sexual abuse. This includes outlawing the coercion of a child to perform sexual activity, the prostitution of children, and the exploitation of children in creating pornography. States are also required to prevent the abduction, sale, or trafficking of children. As of November 2008, 193 countries are bound by the CRC, including every member of the United Nations except the United States and Somalia (Child Rights Information Network, 2008; Amnesty International USA, 2007).

In the United States*:* Child sexual abuse has been recognized specifically as a type of child maltreatment in U.S. federal law since the initial Congressional hearings on child abuse in 1973(Child Abuse Prevention and Treatment Act of 1974, 2003).Child sexual abuse is illegal in every state(State Statutes - Child Abuse and Neglect), as well as under federal law (*Index of Child Welfare Laws,).*Among the states, the specifics of child sexual abuse laws vary, but certain features of these laws are common to all states (*Definitions of Child Abuse and Neglect, Summary of State Laws).*

In India: The Protection of Children Against Sexual Offences Act, 2012 regarding child sexual abuse has been passed by the both the houses of the Indian Parliament in May 2012("Parliament

passes bill to protect children from sexual abuse". NDTV, 2012). The Act came into force from 14 November 2012 ("Tough law on sexual offences against children comes into force", 2013).

PLAN OF ACTION

All children deserve childhoods free from all manner of sexual abuse and exploitation. Without this safety, we put our future as a society at risk. Fortunately, when we focus on innovative programming and policies, such as those presented in this plan of action, we lay the foundation for children's healthy growth and development into adults capable of having healthy relationships and thus reduce the potential for child sexual abuse and exploitation. Such as decrease the risk of future perpetration of child sexual abuse and exploitation; increase the engagement of effective bystander actions that can aid in the prevention of child sexual abuse and exploitation; promote norms that support healthy behaviours, images, and messages; promote environments and education that support healthy development, relationships, and sexuality; collaborate with media, businesses, and policymakers to develop and implement strategies to prevent child sexual abuse and exploitation; promote safe, stable, nurturing relationships for children in their homes and broader environments to decrease future risk of sexual abuse perpetration. Further, child sexual abuse and the normalization of such abuse and exploitation for individual or commercial gain, will be socially, economically, politically, and spiritually unacceptable in all of our communities.

CONCLUSION

Research and clinical observation have long suggested that child sexual abuse is associated with both initial and long-term alterations in social functioning. Hence, prevention on multiple levels is the key to the protection of children. Victims of child sexual abuse suffer not only an intolerable violation of their right to physical integrity but also life-long horrific social, emotional and psychological consequences. Preventive measures should be holistic, child-centred and happen as early as possible with a minimum level of intervention.

REFERENCES

1. Allnock, D., Bunting, L., Price, A., Morgan-Klien, N., Ellis, J. & Radford, L. (2009). *Sexual abuse and therapeutic services for children and young people: the gap between provision and need*. London: NSPCC available online at www.nspcc.org.uk/Inform/Research
2. Anderson, C.M., Teicher, M.H., Polcari, A., & Renshaw, P.F. (2002). "Abnormal T2 relaxation time in the cerebellar vermis of adults sexually abused in childhood: potential role of the vermis in stress-enhanced risk for drug abuse". *Psychoneuroendocrinology* 27 (1–2): 231–44. doi:10.1016/S0306-4530(01)00047-6. PMID 11750781.
3. Anderson, J., Mangels, N., & Langsam, A. (2004). "Child Sexual Abuse: A Public Health Issue". *The Justice Professional, 17,*107. doi:10.1080/08884310420001679386.

4. APA Board of Professional Affairs". (1999). *The American Psychologist,* 54 (8): 586–93. doi:10.1037/0003-066X.54.8.586. PMID 10453704.
5. Arehart-Treichel & Joan. (2001). "Psychological Abuse May Cause Changes in Brain". *Psychiatric News* 36 (5): 36.
6. Arehart-Treichel, J. (2005). "Dissociation Often Precedes PTSD In Sexually Abused Children". *Psychiatric News (American Psychiatric Association),40*(15): 34.
7. Arnow, B.A. (2004). "Relationships between childhood maltreatment, adult health and psychiatric outcomes, and medical utilization". *The Journal of Clinical Psychiatry*, 65.12, 10–5. PMID 15315472
8. Ascione, & F.R. (2005). "Child sexual abuse". *Children and Animals: Exploring the Roots of Kindness and Cruelty*. Purdue University Press. p. 46. ISBN 978-1-55753-383-8.
9. Ascione, F. R., Friedrich, William, N. Heath, J., & Hayashi, K. (2003). "Cruelty to animals in normative, sexually abused, and outpatient psychiatric samples of 6- to 12-year-old children: Relations to maltreatment and exposure to domestic violence". *Anthrozoos: A Multidisciplinary Journal of the Interactions of People & Animals, 16*(3), 194. doi:10.2752/089279303786992116.
10. Bromberg, D. S., & Johnson, B.T. (2001). "Sexual interest in children, child sexual abuse, and psychological sequelae for children". *Psychology in the Schools, 38* (4): 343. doi:10.1002/pits.1023.
11. Caffaro, J., & Conn-Caffaro, A. (2005). "Treating sibling abuse families". *Aggression and Violent Behavior, 10* (5): 604. doi:10.1016/j.avb.2004.12.001.
12. Cawson, Pat., Wattam, C., & Brooker, S. (2000). *Child Maltreatment in the United Kingdom: A Study of the Prevalence of Child Abuse and Neglect*. London: National Society for the Prevention of Cruelty to Children. ISBN 978-1-84228-006-5.
13. Child Rights Information Network (2008). *Convention on the Rights of the Child*. Retrieved on 26 November 2008.
14. Child Sexual Abuse. (2014). retrieved on 08-09-2014 from http://www.nlm.nih.gov/medlineplus/childsexualabuse.html
15. Chu, J.A., Frey, L. M., Ganzel, B.L., & Matthews, J.A. (1999). "Memories of childhood abuse: dissociation, amnesia, and corroboration". *The American Journal of Psychiatry, 156*(5), 749–55. PMID 10327909.
16. Courtois, C. A. (1988). *Healing the incest wound: adult survivors in therapy*. New York: Norton. ISBN 0-393-31356-5.
17. Cynthia, W., Anthony, J., & Urquiza, (2004). *Treatment for Abused and Neglected Children: Infancy to Age, 18 – User Manual Series*. Diane Pub Co. ISBN 0-7881-1661-4.
18. De Jong, A.R. (1985). "Vaginitis due to Gardnerella vaginalis and to Candida albicans in sexual abuse". *Child Abuse & Neglect*, 9(1), 27–9. doi:10.1016/0145-2134(85)90088-2. PMID 3872154.
19. Draijer, N., & Langeland, W. (1999). "Childhood trauma and perceived parental dysfunction in the etiology of dissociative symptoms in psychiatric inpatients". *The*

American Journal of Psychiatry, 156(3), 379–85. doi:10.1016/j.biopsych.2003.08.018. PMID 10080552.

20. Finkelhor, D. (1979). Sexually victimised children. New York: Free Press
21. Finkelhor, D; Richard, O (2004). "Prostitution of Juveniles: Patterns From NIBRS". *Juvenile Justice Bulletin* (U.S. Office of Juvenile Justice and Delinquency Prevention).
22. Freyd, J.J., Putnam, F.W., & Lyon, T.D. (2005). "Psychology. The science of child sexual abuse". *Science*, 308 (5721): 501. doi:10.1126/science.1108066. PMID 15845837.
23. Fridell, L. A. (1990). "Decision-Making Of The District Attorney: Diverting Or Prosecuting Intrafamilial Child Sexual Abuse Offenders". *Criminal Justice Policy Review*, 4 (3): 249. doi:10.1177/088740349000400304.\
24. Goldman, J. D & Padayachi, (1997). "The prevalence and nature of child sexual abuse in Queensland, Australia". *Child Abuse & Neglect* 21 (5): 489–98. doi:10.1016/S0145-2134(97)00008-2. PMID 9158908.
25. Gries, L., Goh, D., Andrews, M., Gilbert, J., Praver, F., & Stelzer, D. (2000). "Positive reaction to disclosure and recovery from child sexual abuse". *Journal of Child Sexual Abuse, 9*(1), 29–51. doi:10.1300/J070v09n01_03.
26. Groth, A. N., & Birnbaum, H. J. (1978). "Adult sexual orientation and attraction to underage persons". *Archives of Sexual Behavior* 7 (3): 175–81. doi:10.1007/BF01542377. PMID 666571.
27. Holguin, G. H., & David, J. (2003). "The 'sexually abused child': Potential mechanisms of adverse influences of such a label". *Aggression and Violent Behavior* 8 (6): 645. doi:10.1016/S1359-1789(02)00101-5.
28. Holmes, R.M., Holmes, S. T. (2002-03-12). *Profiling Violent Crimes: An Investigative Tool*. Thousand Oaks, CA: Sage Publications, Inc. ISBN 978-0-7619-2593-4.
29. Hornor, G. (2010). "Child sexual abuse: Consequences and implications". *Journal of Pediatric Health Care*, *24*(6), 358–364. doi:10.1016/j.pedhc.2009.07.003. PMID 20971410.http://williamapercy.com/wiki/images/Father-son_incest_a_review.pdf
30. Ito, Y., Teicher, M.H., Glod, C. A., & Ackerman, E. (1998). "Preliminary evidence for aberrant cortical development in abused children: a quantitative EEG study". *The Journal of Neuropsychiatry and Clinical Neuroscience*, *10*(3), 298–307. PMID 9706537.
31. Julia, W. (2007). "Child Sexual Abuse". National Center for Post Traumatic Stress Disorder, US Department of Veterans Affairs.Kogan, S. (2005). "The Role of Disclosing Child Sexual Abuse on Adolescent Adjustment and Revictimization". *Journal of Child Sexual Abuse*, *14*(2), 25–47. doi:10.1300/J070v14n02_02. PMID 15914409.
32. Levesque, R.J.R. (1999). *Sexual Abuse of Children: A Human Rights Perspective*. Indiana University Press. pp. 1,5–6,176–180. ISBN 0-253-33471-3.
33. Levitan, R.D., Rector, N.A., Sheldon, T., Goering, P. (2003). "Childhood adversities associated with major depression and or anxiety disorders in a community sample of Ontario: issues of co-morbidity and specificity". *Depression and Anxiety*, 17(1), 34–42. doi:10.1002/da.10077. PMID 12577276.

34. Maia, S., & Perry, B. (2006). *The boy who was raised as a dog: and other stories from a child psychiatrist's notebook: what traumatized children can teach us about loss, love and healing*. New York: Basic Books. ISBN 0-465-05652-0
35. Martin, J., Anderson, J., Romans, S., Mullen, P., & O'Shea, M. (1993). "Asking about child sexual abuse: methodological implications of a two stage survey". *Child Abuse & Neglect*, 17 (3): 383–92. doi:10.1016/0145-2134(93)90061-9. PMID 8330225.
36. Messman-Moore, T. L., & Long, P. J. (2000). "Child Sexual Abuse and Revictimization in the Form of Adult Sexual Abuse, Adult Physical Abuse, and Adult Psychological Maltreatment". *Journal of Interpersonal Violence*, 15(5), 489. doi:10.1177/088626000015005003.
37. Meyer, I. D., & Dorais, M. (2002). *Don't tell: the sexual abuse of boys*. Montreal: McGill-Queen's University Press. p. 24. ISBN 0-7735-2261-1.
38. Navalta, C. P., Polcari, A., Webster, D. M., Boghossian, A., & Teicher, M.H.(2006). "Effects of childhood sexual abuse on neuropsychological and cognitive function in college women". *The Journal of Neuropsychiatry and Clinical Neurosciences, 18* (1): 45–53. doi:10.1176/appi.neuropsych.18.1.45. PMID 16525070.
39. Nelson, E.C., Heath, A.C., & Madden, P.A. (2002). "Association between self-reported childhood sexual abuse and adverse psychosocial outcomes: results from a twin study". *Archives of General Psychiatry*, 59 (2): 139–45. doi:10.1001/archpsyc.59.2.139. PMID 11825135.
40. Noll, J. G. (2003). "Revictimization and self-harm in females who experienced childhood sexual abuse: Results from a prospective study". *Journal of Interpersonal Violence* 18 (12): 1452–1471. doi:10.1177/0886260503258035. PMID 14678616.
41. Palmer, S., Brown, R., Rae-Grant. N., Loughlin, & J. M. (1999). "Responding to children's disclosure of familial abuse: what survivors tell us". *Child Welfare, 2*(78), 259–282.
42. Parliament passes bill to protect children from sexual abuse". NDTV. May 22, 2012.
43. Prochaska, J & Norcross, J. (1999). *Systems of psychotherapy: a transtheoretical analysis*. Pacific Grove, CA: Brooks/Cole Publishing Company.
44. Roberts, R., o'Connor, T., Dunn, J., & Golding, J. (2004). "The effects of child sexual abuse in later family life; mental health, parenting and adjustment of offspring". *Child Abuse & Neglect*, 28 (5): 525. doi:10.1016/j.chiabu.2003.07.006.
45. Roesler, T.A. (1994). "Reactions to disclosure of childhood sexual abuse: the effect on adult symptoms". *Journal of Nervous and Mental Disease, 182*(11): 618–624. doi:10.1097/00005053-199411000-00004. PMID 7964669.
46. Romans SE, Martin JL, Anderson JC, O'Shea ML, Mullen PE (January 1995). "Factors that mediate between child sexual abuse and adult psychological outcome". *Psychological Medicine* 25 (1): 127–42. doi:10.1017/S0033291700028154. PMID 7792348.

47. Schechter, D.S., Brunelli, S.A., Cunningham, N., Brown, J., & Baca, P. (2002). "Mother-daughter relationships and child sexual abuse: A pilot study of 35 dyads". *Bulletin of the Menninger Clinic, 66*(1): 39–60. doi:10.1521/bumc.66.1.39.23374. PMID 11999103.
48. Shaw, J. A., Lewis, J.E., Loeb, A., Rosado, J., & Rodriguez, R. A. (2000). "Child on child sexual abuse: psychological perspectives". *Child Abuse & Neglect, 24* (12): 1591–600. doi:10.1016/S0145-2134(00)00212-X.
49. Steine, I. M., & Krystal (2012). "Insomnia, nightmare frequency, and nightmare distress in victims of sexual abuse: The role of perceived social support and abuse characteristics". *Journal of Interpersonal Violence,27*(9), 51827–1843. doi:10.1177/0886260511430385.
50. Summit, R. C. (1983). "The child sexual abuse accommodation syndrome". *Child Abuse & Neglect,7*(22), 177–93. doi:10.1016/0145-2134(83)90070-4. PMID 6605796
51. Teicher, M.H. (2002). "Scars that won't heal: the neurobiology of child abuse". *Scientific American, 286*(3), 68–75. doi:10.1038/scientificamerican0302-68. PMID 11857902.
52. Teicher, M.H., Glod, C.A., Surrey, J., & Swett, C. (1993). "Early childhood abuse and limbic system ratings in adult psychiatric outpatients". *The Journal of Neuropsychiatry and Clinical Neurosciences, 5*(3), 301–6. PMID 8369640.
53. *The United Nations Children's Fund (UNICEF) May 2006*
54. Tough law on sexual offences against children comes into force". *The Hindu*. 15 November 2012. Retrieved 23 March 2013.
55. Turner, J.S. (1996). *Encyclopedia of relationships across the lifespan*. Westport, Conn: Greenwood Press. p. 92. ISBN 0-313-29576-X.
56. Tyler, K.A. (2002). "Social and emotional outcomes of childhood sexual abuse: A review of recent research". *Aggression and Violent Behavior* 7 (6): 567–589. doi:10.1016/S1359-1789(01)00047-7.
57. Ullman, S.E. (2003). "Social reactions to child abuse disclosure: A critical review". *Journal of Child Sexual Abuse,12,*(1), 89–121. doi:10.1300/J070v12n01_05. PMID 16221661.
58. *United Nations Convention on the Rights of the Child (1989).*
59. Walsh, K., & DiLillo, D. (2011). "Child sexual abuse and adolescent sexual assault and revictimization". In Paludi, Michael A. *The psychology of teen violence and victimization* 1. Santa Barbara, CA: Praeger. pp. 203–16. ISBN 0-313-39375-3
60. Watkins, B., & Bentovim, A. (1992). "The sexual abuse of male children and adolescents: a review of current research". *Journal of Clinical Psychology & Psychiatry,* 33. (10) 197–248. doi:10.1111/j.1469-7610.1992.tb00862.x. PMID 1737828.
61. Widom, C.S., DuMont, K., & Czaja, S. J. (2007). "A prospective investigation of major depressive disorder and comorbidity in abused and neglected children grown up". *Archives of General Psychiatry,*64(1), 49–56. doi:10.1001/archpsyc.64.1.49. PMID 17199054.
62. Zickler, P. (2002). "Childhood Sex Abuse Increases Risk for Drug Dependence in Adult Women". *NIDA Notes* (National Institute of Drug Abuse) 17(1): 5. doi:10.1151/v17i1CSAIRDDAW.