



Mental health consequences of child sexual abuse

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Abstract

Survivors of child sexual abuse (CSA) can experience a variety of long-term mental health effects on their life trajectory, which brings them to the attention of mental health services. It is vital that the Mental Health Nurse remains aware of the mental health consequences of CSA and receptive towards clients' efforts to disclose a history of CSA. Moreover, fundamentally, the Mental Health Nurse should endeavor to consider his/her own personal feelings on this emotive subject.

Key words: Child sexual abuse (CSA), Mental Health Nurses, Post-traumatic stress disorder (PTSD).

Introduction

This paper explores the emotive issue of child sexual abuse (CSA) and its long-term mental health effects into adulthood. The impetus for writing this paper is a desire to remind practitioners working in Mental Health settings of the evidence that links CSA to long-term mental health effects, and to maintain a vigilant stance for the possibility of a history of CSA among mental health clients.

The World Health Organization (2004) describes child sexual abuse as a "silent emergency". Child sexual abuse often goes unnoticed and may be grossly under-reported. For instance, Watson (2007) sent out a questionnaire examining childhood experiences to a randomly selected group of 5,000 women (18-41 years). Of the 1,335 responses, CSA was reported by 45% of the sample.

Children who have experienced sexual abuse often react with behaviours that bring them to the attention of mental health services. Long-term effects include post-traumatic stress disorder; attention-deficit/hyperactivity disorder; behaviour problems including withdrawal, sexualized behaviour and 'acting-out'. Issues in relation to depression, anxiety, suicidal ideation, bipolar disorder, violence and substance abuse also follow CSA. More specifically, there is evidence to suggest that child sexual abuse victims are more likely to be victims of rape (Cheasty et al 2002) or to be involved in abusive or violent relationships as

adolescents and as adults (Cyr et al 2006). Furthermore, adults with a history of sexual abuse as children who experience high levels of anxiety can engage in self-destructive behaviour such as alcoholism or drug abuse and experience panic attacks (Goodwin et al 2005).

Effects of child sexual abuse on pre-adolescent children

Sexual abuse in the 0-12 year age group often results in the emergence of post-traumatic stress disorder (PTSD). This is illustrated in a study reported by Ackerman et al (1998) which focused on the prevalence of post-traumatic stress disorder and other psychiatric diagnoses in three groups of abused children aged 7-13 years. The sample included children with a history of sexual abuse (n=127), children with a history of physical abuse (n=43) and children with a history of both sexual and physical abuse (n=34).

The study involved the researchers utilizing a structured interview which resulted in 13 psychiatric disorders being diagnosed among the children. These other diagnoses included attention- deficit- , phobic-, conduct- and obsessive-compulsive-disorder.

Ackerman et al (1998) reported that separation anxiety, major depression and dysthymia (chronic depression but with less severity than a major depression) were the main co-morbid diagnoses with post-traumatic stress disorder, and concluded that anxiety and behaviour disorders were more frequent than mood disorders. In addition, they reported that abused boys had higher rates of behavioural disorders, but girls had higher rates of

internalizing behaviours, such as separation anxiety and phobia. This study clearly reveals that children who have been both physically and sexually abused are at a greater risk of psychiatric disturbance. Moreover, the researchers concluded that the risk appears to be increased if the abuse begins when the child is quite young, and if there has been coercion to maintain secrecy.

Post-traumatic stress disorder among children who have been sexually abused was also the focus of a randomized control trial by Cohen et al (2004). The study included 229 children who were randomized to either trauma-focused cognitive behavioural therapy (n=114) or child-centred therapy (n = 115). The main result concluded that, after 12 weeks of trauma-focused cognitive behavioural therapy, post-traumatic stress disorder symptoms improved. At least twice as many children in the child-centred therapy group had post-traumatic stress disorder after treatment, compared with the children in the trauma-focused cognitive behavioural therapy group. The trauma-focused cognitive behavioural therapy improved symptoms of depression, behavioural problems, shame, credibility and trust. For mental health nurses, the result of this study suggests that trauma-focused cognitive therapy may be successfully used by clinicians to assist children recovering from CSA.

Another consequence of childhood sexual abuse is attention-deficit/hyperactivity disorder (ADHD). For instance, a longitudinal study reported by Briscoe-Smith and Hinshaw (2006) examined the linkages between childhood sexual abuse and attention-deficit/hyperactivity disorder (ADHD) in 228 girls. This study aimed to explore whether a

carefully diagnosed sample of pre-adolescent girls with ADHD (60% of the sample) showed higher rates of documented abuse than a matched comparison sample (40% of the sample), and reported that girls with ADHD were at increased risk of having abuse histories.

Quas et al (2003) examined the co-morbid and combined influence of child abuse characteristics on children's self-blame and internalizing behaviour problems, including self-blame, withdrawal, fear and avoidance. The researchers hypothesized that the use of force would increase self-blame among boys but not girls, and that girls would display more internalizing behaviour. Furthermore, avoidant coping strategies and negative perceptions of the abused were hypothesized to be positively related to self-blame attributions and internalizing symptomatology. The study included 218 child sexual abuse victims with ages ranging 4-17 years. The results from this study reveal that being closely related to the perpetrator and, experiencing long-lasting abuse involving the child to engage in more serious sexual acts, related to increased self-blame. Abuse severity and abuse avoidance emerged as significant predictors of self-blame. Children aged 10 or younger when the abuse ended (while being younger when the abuse began) were associated with higher self-blame attributions, and the avoidance factor was a significant predictor. Among children aged 10 or older when the abuse ended, abuse severity significantly predicted self-blame in the entire sample. This study provides further evidence to suggest that predicting self-blame and internalizing behaviour are influenced by the relationship to the perpetrator, the child's age and the severity of the abuse.

Victimization of children who have experienced sexual abused is also reported by Chromy

(2007), in a study based on a retrospective data review of clinical records. The sample comprised 125 children aged 4-12 years. An initial assessment took place prior to therapeutic intervention. Data were obtained from each child regarding type of sexual abuse experienced, age of the perpetrator, age at the onset of abuse and the frequency of it. The sexual behaviours varied in terms of their severity and nature, such as least severe, including sexual acts, and most severe, including abusive acts. Of the sample, it was reported that 52.8% exhibited sexual behaviour problems, while 47.2% did not. The result concluded that children with sexualized behavior problems were significantly younger. The children abused more frequently exhibited more sexualized behaviour problems than those who did not. This study reflects the potential implications in the early identification of children at risk of developing sexualized behavior problems, and those children exhibiting sexualized behaviours tended to have been abused at a younger age.

Effects of sexual abuse on the adolescent

The effects of child sexual abuse carries through to adolescence, and in some cases, it may take the individual this length of time to understand the impact it has on them. The personal impact on the adolescent is revealed by Martin et al (2004) in a survey of sexual abuse among 2,485 students with a response rate of 85%. The results showed that reported sexual abuse was more prevalent among girls. Moreover, 86.2% of the respondents reported high distress levels following abuse. 73% of abused adolescents compared to 25% non-abused adolescents were more likely to have "thoughts about killing themselves". 45% of abused adolescents compared to 9% of non-abused adolescents

reported to claiming to trying to kill themselves. The findings of this study suggest that the experience of sexual abuse is strongly associated with suicidal ideation and suicidal behaviour comprising of plans, threats, deliberate self-injury and suicide attempt. Feelings of hopelessness are therefore evident among many adolescents with a history of CSA.

This hopelessness is also revealed by Swanston et al (1999) who investigated the relationship between child sexual abuse and impaired coping and hopelessness among abused young people. The sexually abused adolescents (n=28) were compared to the non-abused adolescents (n=32) over 5 years, with the researchers employing semi-structured interviews and the Beck depression inventory. The findings of this study reveal that sexually abused young people were less hopeful compared to non-abused. In addition, personal hopefulness scores were significantly lower among abused young people. Sexual abuse therefore influences an individual's personal hopefulness. Similarly, it is also reported in a study of delinquent, diverted and high-risk adolescent girls (n=159) that those who had experienced sexual abuse reported higher levels of depression (Ruffolo et al 2004).

Depression, discussed earlier in pre-adolescent children, also occurs in adolescence, along with substance abuse and violence among those who have been sexually abused. This is illustrated in a study by Chen et al (2004) who examined child sexual abuse experiences and associations with demographic factors, self-reported health and risky behaviours among senior high school adolescents (n=3,032) in China. The adolescents completed an

anonymous questionnaire, in which issues such as experience of sexual intercourse, child sexual abuse experiences, depression, self-esteem and risk behaviours were analyzed. 13.6% of respondents reported some form of child sexual abuse and a further 8% reported penetrative acts. The results from this study showed that depression was significantly higher among both males and females who reported child sexual abuse. In relation to males, a significantly higher proportion of abused reported using tobacco, than did non-abused. Alcohol use was higher in both male and female reporting sexual abuse compared to non-abused. Among males, child sexual abuse was clearly associated with violent behaviours and experiences, these included carrying weapons and fighting. A small proportion of sexually abused girls reported violent behaviours.

The thread of violence among sexually abused adolescents is also revealed in a study reported by Cyr et al (2006). In this study, the researchers focused on the prevalence and predictors of violence among adolescent female victims of child sexual abuse. This has significant implications for mental health nurses as it highlights how some adolescents vent their feelings through anger and aggression and accept relationships with such elements. Respondents to this study included 126 females aged between 13-17 years. The results revealed that 36.5% of girls were sexually abused on two or more distinct occasions. The vast majority of the girls reported to perpetrating (84.1%) or receiving psychological violence (81.7%) in the past year. It was notable that 90% of the adolescents reported to perpetrating violence as well as receiving it. In addition, more than 45.2% reported being the victim of physical abuse in the past twelve months. The result of this study can be

compared to those of DiLillo et al (2001) who report higher rates of physical victimization for women who had been sexually abused, with more than 80% of girls in this study reported perpetrating or receiving psychological violence.

Long term effects of child abuse into adulthood

The ripple effects of child sexual abuse can be difficult to pinpoint, even though abuse may affect every area of an individual's life. These effects might not necessarily be permanent but can be overwhelming. A longitudinal study carried out by Molnar et al (2001) examined the relationship between CSA and subsequent onset of psychiatric disorders. Data for the study was collected between the years 1990 and 1992 by the National Comorbidity Survey (NCS). This was the first nationally representative general population survey of the United States, yielding DSM-III-R diagnosis. The sample consisted of 8,098 participants with a very high response rate of 82.4%. Respondents were shown a list of 12 traumas and asked about each during an interview. Estimated child rape and molestation was higher for females (13.5%) than for males (2.5%) in this study, with most perpetrators being known to the respondents. Among the sexually abused respondents, the prevalence of lifetime psychiatric disorders was higher among those who reported CSA when compared to those who did not report CSA. For example, the percentage of women with lifetime alcoholic dependence, and a history of child sexual abuse was 15.6%, but only 7.6% prevalence of psychiatric disorders was found among those not reporting CSA. Among men it was 37.7% compared with 19.2%. Among women, significant associations were found between CSA and 14 of the 17 subsequent lifetime mood,

anxiety and substance disorders. In men, 5 subsequent disorders were associated with CSA. The results of this study supports previous findings of a strong correlation between CSA and psycho-pathology among men and women.

Female childhood sexual abuse can also result in adulthood re-victimization and the emergence of symptoms such as maladaptive coping, a degree of self-blame, and post-traumatic stress disorder. This was revealed in a survey by Phillipas and Ullman (2006) of 577 females (response rate of 92%) examining the psychological sequelae of CSA and the factors that contributed to re-victimization in the form of adult sexual assault. The researchers hypothesized that child sexual abuse survivors would be expected to have a greater likelihood of being sexually victimized in adulthood compared to the non-abused group. The sample included those with no sexual victimization, child sexual abuse only (CSA), Adult Sexual Assault (ASA) only, and both CSA and ASA. Post-Traumatic Stress Disorder Symptomatology was explored, along with attributions of blame (self and others). Respondents were also surveyed for their coping styles, i.e. whether they withdrew from people, acted out sexually, went to a therapist or forgot about the experience as a way of coping. Phillipas and Ullman (2006) report that greater CSA severity was associated with more self-blame, maladaptive coping strategies and PTSD symptoms. Moreover, as hypothesized, re-victimized participants had significantly more PTSD symptoms. Significantly more self-blame was also experienced by participants at the time of the abuse in the re-victimized group. The re-victimized group reported higher current self-blame than the CSA-only group. The findings from this study support a definite link between childhood sexual abuse and re-victimization in adulthood, with ASA

being almost four times more likely for those individuals who experienced CSA. Similarly, Hetzel and Mc Canne (2005) report that those who report sexual abuse only, as opposed to physical abuse, report significantly higher numbers of PTSD symptoms.

The relationship between childhood physical and/or sexual abuse and unipolar and bipolar depression is also evident. Hyun et al (2000) hypothesized that abuse histories would be more frequent among bipolar depressives than unipolar depressives, and that women with bipolar disorder would be more likely to have abuse histories than men. The researchers also hypothesized that individuals with abuse histories would be more likely to have an earlier onset, and history of co-morbid disorders compared to study participants with no history of abuse. Among the total of 333 bipolar and unipolar participants studied, 41 patients related a history of childhood sexual abuse, 19 gave a history of physical abuse and 34 gave a history of both physical and sexual abuse. Compared to male subjects, there was an elevated rate of sexual abuse in female subjects during investigation of gender by abuse history, while females had an increased rate of both physical and sexual abuse. In this study, the bipolar sample demonstrated a significantly increased incidence of child sexual abuse as compared to unipolar depressives. The study findings suggest that a history of child sexual abuse and physical abuse is more frequent among bipolar patients compared to unipolar patients, although physical abuse prevalence did not differ between psychiatric groups.

The association between CSA and substance abuse and dependence is also reported (Jarvis et al 1998, Berry and Sellman 2001). Jarvis et al (1998) included a sample of 180 women

receiving either drug or alcohol treatment, or child sexual abuse counseling. The results concluded that 66% of the women reported some form of memory loss in relation to child sexual abuse at some point in their life. The theories of self-medication and impaired self-esteem are supported in this study, and the data reveals that substance abuse facilitated temporary dissociation from painful feelings and emotions. Similarly, Berry and Sellman (2001) report findings from their survey of 80 women (aged 18-73 years) admitted to a community alcohol and drug service. 80% responded to a questionnaire asking the women about their experience of CSA. Of those, 66% had experienced CSA involving physical contact, including attempted anal, oral or vaginal intercourse.

Discussion

The role of CSA in the development of mental health problems in adolescence and adulthood is evident. However, there are 'protective' factors that can promote resilience among children who have sexually abused. These factors include education, having plans for the future, family support, peer influence, and religion (Edmond et al 2006). In a study of 99 sexually abused adolescent girls in the foster care system, Edmond et al (2006) report that nearly half were functioning well psychologically. These girls were significantly more certain of their educational plans and optimistic about their future and had more positive peer influences when compared to the symptomatic girls in the study. Furthermore, in a longitudinal study of African-American women, Banyard et al (2002) reports that 40 survivors (29% of the sample) had high resilience scores and 25 women (18% of the sample) had excellent resilience

scores. The high resilient women were less likely to have experienced incest or severe child physical abuse. Furthermore, they were more likely to have been in a stable family environment with fewer moves or foster care placements and less parental drug abuse. In addition, the receipt of support from someone special in their lives was an important protective factor evident in the women with more resilience (Banyard et al 2002).

Not surprisingly, survivors of CSA are often very reluctant to disclose spontaneously their history of abuse to mental health professionals and often remain silent to protect themselves from stigma (Holmes and Slap 1998). The potential for mental health nurses in leading the therapeutic care of survivors is apparent. It is argued that nurses play a central role in case finding sexual abuse and through empathic listening, can promote patients to disclose a history of abuse (Valente 2005). At the very least, mental health nurses should be alert for the possibility that the client with any of the mental health issues discussed in this paper may have been sexually abused as a child.

It is vital that the Mental Health Nurse is equipped with the appropriate skills to assist clients in disclosing CSA. One useful nursing intervention is literary analysis. This is reported to be used with adolescents by Harrison (2005) as an intervention which uses imaginative literature to help ease the difficulty of full disclosure of abuse. This type of approach compares two novels, in which descriptions and details of abuse are disclosed through wording, images, themes and so on. The adolescent reads the novels and then is

asked questions about human experiences. This approach has similarities with a form of ethnography known as autoethnography, where creative writing explicates a personal experience, such as bereavement (Furman, 2004). The relevance of literary analysis to mental health nurses is that it takes apart the literary work and puts it back together in order to establish meaning or reveal the truth, and offers a valuable contribution to the exploration of the suffering associated with child sexual abuse (Harrison 2005). The therapeutic potential of supporting adolescents to write their feelings is also evident. Furthermore, Harrison (2005) argues that writing should be encouraged and supported by nurses, because it “may help to break the conspiracy of silence surrounding child sexual abuse, and contribute significantly to understanding of the experiences of these suffering children” (p. 133).

Mental health nurses should also be aware of appropriate therapies for CSA survivors. McGregor et al (2006) report on a survey of women (n=191) and interviews with a sub sample (n=20) with histories of CSA, which asked for descriptions of what was helpful and unhelpful to them in therapy. Women in the study identified the importance of establishing a therapeutic relationship with their therapist, and their frustration with therapists who were passive or who exaggerated their objectivity. They also stressed that it was preferable that therapists were knowledgeable, able to listen to accounts of CSA and were able to normalize the effects of CSA.

Cognitive processing therapy, based on cognitive processing therapy (CPT-SA) is an effective treatment approach for child sexual abuse survivors (House 2006). This approach

to cognitive processing therapy for sexual abuse (CPT-SA) differs from standard cognitive processing therapy (CPT) in many ways. Firstly, it combines individual therapy (9 sessions) and group therapy (17 sessions). It also promotes exposure to traumatic memory by the use of written homework assignments, processed in individual therapy sessions, in order to avoid secondary trauma of group members. In addition, CPT-SA focuses on helping clients identify beliefs and behaviours that have continued unchallenged since the occurrence of the abuse in order to develop a new range of thoughts and behaviors. Finally, CPT-SA also includes assertiveness training and discussion on sexual dysfunction and sexual identity (House 2002).

Another approach, labeled “contextual therapy” (Gold 2001, p. 61) is guided by awareness of the effects not only of CSA but also by acknowledgment of the impact of the family and social context within which CSA occurs. Gold (2001) sensitively argues that such a contextual perspective “helps to remind us that CSA survivors’ abusive experiences are not the sole defining moments in their lives” but need to be understood within the interpersonal environment in which CSA occurred (Gold 2001, p. 67).

Finally, Edmond and Rubin (2004) present findings supporting the short-term effectiveness of Eye Movement Desensitization and Reprocessing (EMDR) in reducing trauma symptoms among adult female survivors of CSA. EMDR is based on the view that within the context of the treatment approach, eye movements, as well as some other choice of bilateral stimulation (for instance, finger snaps near the ears) can enable the traumatized

individual to rationally process their distress and conquer PTSD (Shapiro 2001).

Conclusion

It is argued that nurses working with those who have been sexually abused as children have a moral obligation to develop appropriate skills necessary to the care of these clients (Gillespie 1993). However, it is acknowledged that many mental health professionals may not be comfortable addressing the topic of CSA with their clients. Moreover, if the nurse is also a survivor of CSA, the impact of this on the client/nurse relationship cannot be ignored (Warne and McAndrew 2005).

At the very least, awareness by mental health nurses of their feelings on this emotive topic is a starting point on which to build upon. Promoting such awareness can be achieved by supporting nurses in reflecting on their own personal views of CSA in order to explore difficult thoughts and feelings (Leech and Trotter 2006).

REFERENCES:

Ackerman PT, Newton EO, Mc Pherson WB, Jones, JG, Dykman RA (1998) Prevalence of post-traumatic stress disorder and other psychiatric diagnoses in three groups of abused children. *Child Abuse and Neglect* **28**(8): 759-774.

Banyard VL, Williams LM, Siegel JA, West CM (2002) Childhood sexual abuse in the lives of Black Women: risk and resilience in a longitudinal study. *Women & Therapy* **25**(3/4): 45-58

Berry R, Sellman JD (2001) Childhood adversity in alcohol-and drug dependent women presenting to out-patient treatment. *Drug and Alcohol Review* **20**(4): 361-367.

Briscoe-Smith AM, Hinshaw SP (2006) Linkages between child abuse and attention-deficit/hyperactivity disorder in girls: Behavioural and social correlates. *Child Abuse and Neglect* **30** (11):1239-1255.

Cheasty M, Clare AW, Collins C (2002) Child sexual abuse: a predictor of persistent depression in adult rape and sexual assault victims. *Journal of Mental Health* **11**(1): 79-84.

Chen J, Dunne MP, Han P (2004) Child Sexual Abuse in China: A Study of Adolescents in four provinces. *Child Abuse and Neglect* **28**(11): 1171-1186.

Chromy S (2007) Sexually Abused Children who exhibit sexual behaviour problems: Victimization characteristics. *Brief Treatment and Crisis Intervention* **7**(1):25-33.

Cohen JA, Deblinger E, Mannarino AP, Steer RA (2004) A Multisite, Randomized controlled Trial for children with sexual abuse-related PTSD symptoms. *Adolescent Psychiatry* **43**(4):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**(8):1000-1017.

DiLillo D, Giuffre D, Tremblay GC, Peterson L (2001) A closer look at the nature of intimate partner violence reported by women with a history of Child Sexual Abuse. *Journal*

of Interpersonal Violence **16**(2):116-132.

Edmond T, Rubin A (2004) Assessing the long-term effects of EMDR: results from an 18-month follow-up study with adult female survivors of CSA. *Journal of Child Sexual Abuse* **13**(1): 69-86

Edmond T, Auslander W, Elze D, Bowland S (2006) Signs of resilience in sexually abused adolescent girls in the foster care system. *Journal of Sexual Abuse* **15**(1): 1-28

Filipas HH, Ullman SE (2006) Child Sexual Abuse, Coping Responses, Self-Blame, Post-traumatic Stress Disorder and Adult Sexual re-victimization. *Journal of Interpersonal violence*. **21**(5): 652-672.

Furman R (2004) Using Poetry and Narrative as Qualitative data: exploring a father's cancer through poetry. *Families, systems and Health* **22**(2):162-170

Gillespie J (1993) Child sexual abuse 2: techniques for helping adult survivors. *British Journal of Nursing*. **7**(1): 313-315

Gold S (2001) Conceptualizing child sexual abuse in interpersonal context: recovery of people, not memories. *Journal of Child Sexual Abuse* **10**(1): 51-71

Goodwin RD, Ferguson DM, Horwood LJ (2005) Childhood abuse and familial violence and the risk of panic attacks and panic disorder in young adulthood. *Psychological Medicine* **35**(6): 881-890.

Harrison E (2005) Disclosing the details of Child Sexual Abuse: Can imaginative Literature Help ease the suffering. *Journal of child and adolescent psychiatric nursing*. **18**(3):127-139.

Hetzl MD, McCanne TR (2005) The Roles of Peritraumatic dissociation, Child Physical Abuse, and Child Sexual Abuse in the development of Post-Traumatic Stress Disorder and Adult Victimization. *Child Abuse and Neglect*. **29**(8):915-930.

Holmes WC, Slap GB (1998) Sexual abuse of boys. *JAMA* **280**(21):1855-1862

House AS (2006) Increasing the usability of cognitive processing therapy for survivors of child sexual abuse. *Journal of Child Sexual Abuse* **15**(1): 87-103

Hyun M, Friedman HM, Dunner DL (2000) Relationship of Childhood Physical and sexual abuse to adult bipolar disorder. *Bipolar disorders* **2**: 131-135.

Jarvis TJ, Copeland J, Layton W (1998) Exploring the nature of the relationship between Child Sexual Abuse and substance use among women. *Addiction* **93**(6):865-875.

Leech N, Trotter J (2006) Alone and together: some thoughts on reflective learning for work with adult survivors of child sexual abuse. *Journal of Social Work Practice* **20**(2): 175-187

Martin G, Bergen HA, Richardson AS, Roeger L, Allison, S (2004) Sexual Abuse and Suicidality: Gender differences in a large Community Sample of Adolescents. *Child Abuse and Neglect* **28**(5): 491-503

McGregor K, Thomas DR, Read J (2006) Therapy for child sexual abuse: women talk about helpful and unhelpful therapy experiences. *Journal of Child Sexual Abuse* **15**(4): 35-59

Molnar BE, Buka SL, Kessler RC (2001) Child Sexual Abuse and Subsequent Psychopathology: Results from the National Comorbidity Survey. *American Journal of Public Health* **91**(5):753-760.

Quas JA, Goodman GS, Jones DP (2003) Predictors and attributions of Self-Blame and Internalizing Behaviour Problems in Sexually Abused children. *Journal of Child and Adolescent Psychiatry* **44**(5): 723-736.

Ruffolo MC, Sarri R, Goodkind S (2004) Study of delinquent, diverted, and high-risk adolescent girls: Implications for mental health intervention. *Social Work Research* **28**(4): 237-245.

Shapiro F (2001) *Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures*. (2nd Edition) Guilford Press, New York

Swanston HY, Nunn KP, Oates RK, Tebutt JS, O'Toole BI (1999) Hoping and Coping in

young people who have been sexually abused. *European Child and Adolescent Psychiatry* **8**(2): 134-142.

Valente SM (2005) Sexual abuse of boys. *Journal of Child and Adolescent Psychiatric Nursing* **18**(1):10-16

Warne T, McAndrew S (2005) The shackles of abuse: unprepared to work at the edges of reason. *Journal of Psychiatric & Mental Health Nursing* **12**(6): 679-686

Watson B (2007) *Sexual abuse of girls and adult couple relationships: Risk and protective factors*. Unpublished PhD dissertation, School of Psychology, Griffith University, Australia.

World Health Organization (2004) <http://www.who.int/en>.

Key Phrases

Child sexual abuse (CSA) results in long-term mental health effects.

Among pre-adolescent children, CSA can result in post-traumatic stress disorder, attention- deficit, phobic, conduct and obsession-compulsive disorder.

Adolescents who have been sexually abused may express a sense of hopelessness and report suicide ideation and suicidal behavior. In addition, substance abuse and violence are consequences of CSA which can emerge in adolescence.

The long-term mental health effects of CSA reveal a variety of psycho-pathologies.

Mental health nurses need to be aware of their personal feelings on the emotive topic of CSA.