




Childhood Sexual Abuse: A Narrative Review

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Background

Childhood sexual abuse (CSA) remains a pervasive public health challenge with harms that extend across the life course. In the United States, at least one in four girls and one in twenty boys experience CSA before age 18.

Methods

The present narrative review synthesizes peer reviewed literature from the psychology, public health, behavioral health, and social sciences. Sources were identified through searches of major academic databases (e.g., PubMed, PsycINFO, Google Scholar) and reference lists of key articles. Priority was given to recent empirical studies, meta analyses, and national surveillance reports. The review integrates findings across domains, including prevalence and trends, psychological and behavioral mechanisms (e.g., emotion dysregulation, attachment disruption), risky sexual behavior, mental health outcomes, substance use, revictimization, and sexual offending.

Results

Evidence consistently shows that CSA is associated with a wide range of adverse outcomes across psychological, behavioral, and physical health domains. Mechanisms such as emotion dysregulation, attachment disruption, impulsivity, and trauma related coping contribute to elevated risks of depression, anxiety, PTSD, substance misuse, risky sexual behavior, and revictimization. Gender and racial disparities persist, with females reporting higher prevalence, males experiencing greater underreporting, and racially and ethnically diverse survivors underrepresented in research.

Discussion

The current narrative review highlights the extensive and enduring impact of CSA across psychological, behavioral, relational, and physical health domains. Consistent with decades of research, CSA remains a pervasive public health issue that disproportionately affects girls, gender diverse youth, and racially and ethnically marginalized populations. Despite increased awareness, CSA continues to be underreported, particularly among boys and communities where cultural stigma, fear of retaliation, and structural barriers inhibit disclosure.

Conclusion

A multidisciplinary approach is needed to effectively address this issue from a prevention, intervention, and treatment perspective. Continued public and psychological health efforts are warranted.

POSITIONALITY

As authors, we acknowledge that our identities, professional backgrounds, and lived experiences shape the perspectives we bring to this work on childhood sexual abuse (CSA). The first author identifies as a South Asian woman, immigrant, and former international student whose personal and academic experiences inform a deep awareness

of cultural stigma, gendered expectations, and structural barriers that influence disclosure, help-seeking, and well-being among marginalized communities. Her scholarship centers intersectionality, trauma-informed pedagogy, and the health of culturally diverse populations, which informs the equity-focused lens applied throughout this review. The second and third authors are public health researchers and faculty members with extensive experience in adolescent

health, behavioral health, violence prevention, and school- and community-based public health programming. Their work is grounded in decades of research with youth, families, and community organizations, and is shaped by a commitment to evidence-based prevention, health promotion, and the reduction of health disparities. They recognize that their positionality as researchers working within predominantly Western academic and public health systems influences how they interpret and synthesize existing literature.

INTRODUCTION

Despite numerous public health efforts and interventions, childhood sexual abuse (CSA) continues to afflict innumerable individuals throughout the US. Approximately one in seven children have been sexually abused, with one in four girls and one in 20 boys.¹⁻⁵ Globally, over 1 billion children are estimated to experience some form of sexual violence during childhood.⁶ Despite growing awareness and research, CSA continues to be severely underreported, particularly in communities where cultural stigma, fear of retaliation, and systemic barriers inhibit disclosure of such events. In many societies, notions of family honor, gender roles, and religious expectations contribute to a culture of silence, leaving victims without support or recourse, which may often result in self-doubt and guilt.⁷ CSA is the most under-reported type of abuse, especially among boys, due to social stigma associated with it from different cultures.⁸ CSA is a form of adverse childhood experiences (ACEs) and places survivors at elevated risk for involvement in risky health behaviors and mental health problems. Extensive research has linked CSA to poor health outcomes, including substance misuse, depression, post-traumatic stress, and other long-term consequences.⁹⁻¹⁶

The body of research on the consequences of CSA is extensive but often siloed, with individual studies focusing on specific domains such as psychological health, substance abuse, re-victimization, or sexual offending. This fragmentation can obscure the full, interconnected scope of the damage caused by CSA. As the issue is inherently multifactorial and multidisciplinary, a comprehensive synthesis of literature is crucial for clinicians, researchers, and policymakers to grasp the complexity of the problem and develop practical, holistic interventions. Therefore, the primary aim of this review is to consolidate and summarize the current state of knowledge regarding the multifaceted consequences of CSA.

METHODS

The present narrative review synthesizes peer-reviewed literature across multidisciplinary fields of psychology, public health, behavioral health, and social sciences. Relevant studies were identified through searches of major academic databases, including PubMed, PsycINFO, Google Scholar, and Web of Science, using terms related to childhood sexual abuse, mental health, risky sexual behavior, substance use, revictimization, and sexual offending. Reference lists of key articles, meta-analyses, and national surveillance reports

were also reviewed to identify additional sources. Priority was given to recent empirical studies, longitudinal research, meta-analyses, and national or international surveillance data. Earlier foundational studies were included when they provided essential theoretical or historical context.

RESULTS

Research has identified a myriad of negative health outcomes associated with CSA, involving physical, emotional, and mental health dimensions.^{1,17} CSA can result in disruptions to behavior, emotions, and child development.^{18,19} Moreover, CSA is linked to poor psychological functioning, including depression, anxiety, post-traumatic stress disorder (PTSD), and suicidality^{4,20-24} as well as aggressive behavior, interpersonal problems, substance abuse, sexual offending, possible re-victimization, and risky sexual behaviors.²⁵⁻²⁷ CSA survivors' racial and gender characteristics may potentially moderate the magnitude of negative health outcomes.^{28,29}

RACIAL AND GENDER DIFFERENCES

Gender and racial differences exist regarding childhood sexual abuse. Females consistently have higher prevalence rates than males with CSA.³⁰⁻³² Cultural norms around masculinity and fear of being labeled and stigmatized may prevent boys from reporting the abuse.^{25,29,33} In addition, females are more likely to suffer penetrative abuse by a family member than males.^{33,34} Studies have demonstrated that CSA increases the risk for later sexual aggression perpetration in men.^{35,36} Evidence also shows that CSA can predict sexual aggression in women.^{37,38} A 23-year longitudinal study by Trickett and colleagues²⁴ demonstrated that female CSA survivors report multi-dimensional adverse health outcomes such as the earlier onset of puberty, cognitive deficits, hypothalamic-pituitary-adrenal attenuation, asymmetrical stress responses, and high rates of obesity. Moreover, female survivors in the study also reported lower education, self-mutilation, physical/sexual re-victimization, premature deliveries, and teen motherhood.^{18,24}

Gendered behavioral patterns have emerged in a few studies, suggesting that men often engage in hypersexuality and risky sexual behaviors, whereas women engage in internalizing behaviors, such as sexual avoidance or sexual ambivalence.^{34,39,40} Some studies suggest women survivors are more likely to engage in risk-taking behaviors than men.⁴¹ However, others suggested that sexual abuse may predict sexually coercive behavior in females but not in men.⁴² In help-seeking populations, men's hypersexual behaviors often involve pornography and masturbation, whereas women's are more likely to involve high-risk sexual encounters.⁴³⁻⁴⁵

Regarding differences based on race, according to the US Department of Health and Human Services,³² 20.9% of Hispanic, 20.3% of Black or African American, 8.1% of White, 1.1% of American Indian/Alaska Native, 0.9% of Asian, 4.6% of Native Hawaiian/Pacific Islander, and 10.5% of mul-

tiracial children have experienced CSA. There is a paucity of studies with Asian American, Native American, and multi-racial CSA survivors, resulting in disparity among these communities. Moreover, African American females tend to be involved in risky sexual behaviors compared to their male and white counterparts.^{28,29}

RISKY SEXUAL BEHAVIOR

CSA is associated with risky sexual behaviors in adolescence and young adulthood.^{4,15,16,26,27} Risky sexual behaviors are associated with externalizing mechanisms and may involve stress reduction techniques that help CSA survivors regulate their emotions.^{46,47} Adolescents with CSA history exhibit low-risk perception,⁴⁸ engage in substance use during sexual activity,⁴⁹ and irregular condom use.^{50,51}

CSA survivors are more likely than their non-abused peers to initiate sexual activity early (before age 16), have multiple sexual partners, experience teen pregnancy, and report inconsistent condom use.^{8,52-56} In addition, youth exposed to CSA are at increased risk of drug use in a sexual relationship⁵⁵ as well as intimate partner violence, rape, and peer violence.^{13,14} Although CSA survivors are more vulnerable to hypersexuality than the general population, they tend to develop other sexual concerns as well, such as sexual abuse perpetration, shame, guilt, and anxiety during sexual arousal.^{54,57-59} Moreover, they may experience decreased sexual desire, dissociation, orgasm disorders, and arousal disorders

Hypersexuality is a repetitive, high-risk sexual behavior that has been identified as a coping mechanism among CSA survivors.^{47,60} Survivors may experience distorted sexual schemas due to traumatic sexualization, leading to re-victimization and interpersonal difficulties.⁶¹ Hypersexuality is linked with adverse health outcomes, including unwanted pregnancies, sexually transmitted infections, and non-sexual attacks.⁶²⁻⁶⁵

Psychologically, hypersexuality is linked to mood disorders, anxiety disorders, substance abuse, gambling issues, and compulsive buying behaviors.⁶⁶⁻⁶⁹ Studies reveal CSA-related hypersexuality across different groups, including university students, veterans, incarcerated people, and men who have sex with men.⁷⁰⁻⁷⁷

PSYCHOLOGICAL HEALTH

Depression is the most frequently reported psychological consequence of CSA.⁷⁸ Research demonstrated that extensive trauma can be caused by CSA such as psychological distress, impaired health, dissociative experiences, anxiety, and depression.⁷⁹⁻⁸³ CSA survivors are also at an elevated risk for somatic illnesses and post-traumatic stress disorder⁸⁴ and depressive disorder. The severity of the abuse may serve as a predictor for long-lasting symptoms with an increased risk of impairment.^{31,85,86}

CSA survivors tend to exhibit poor self-regulation processes and impulsivity, making them vulnerable to risky health behaviors like substance abuse, unsafe sex, and unhealthy eating behaviors. The relation between impulsivity and CSA has been established through various studies.⁸⁷⁻⁹⁸

Impulsivity is observed even in the absence of psychiatric disorders such as post-traumatic stress disorder due to CSA.⁹⁵⁻⁹⁸

The prevalence of traumatic events in schizophrenia patients varies between 45% and 71%, whereas severe and chronic traumatic childhood experiences increase hallucinations among these patients.⁹⁹⁻¹⁰⁷ Of these individuals, underreporting is often observed among male patients due to stigma or embarrassment. One study focused on males in a psychiatric hospital receiving treatment for schizophrenia.¹⁰⁸ Self-reports by the patients in this study indicated that the perpetrators of emotional abuse were usually parents, while close relatives were the perpetrators of sexual abuse. More than 63% of the patients reported extreme childhood abuse, while 94% of the patients suffered from some form of traumatic event in their childhood.¹⁰⁸ Hence, a link between CSA and poor psychological health is observed.

SUBSTANCE ABUSE

CSA survivors are more likely to abuse substances as a coping mechanism involving trauma.^{109,110} Academic and social performance is linked to poor mental health (depression, ADHD), higher substance abuse (smoking, marijuana, alcohol consumption), and poor lifestyle habits (low intake of fruits and vegetables, higher BMI, less sleep) among college students who reported CSA.¹¹¹ CSA survivors are at increased risk for alcohol problems.^{12,112-122} Several studies have revealed a link between problematic alcohol consumption and childhood abuse.¹²³ Alcohol abuse might be mediated by a desire to dissociate in CSA survivors.¹²⁴

CSA may be associated with the use of narcotics,¹²⁵ severe and extreme drug use,¹²⁶ and high prevalence of drug abuse or dependency.^{127,128} Furthermore, CSA survivors tend to initiate smoking at an early age^{129,130} and indulge in frequent and regular smoking during adolescence.^{125,129-134} The higher prevalence of smoking among CSA survivors can be explained by nicotine use disorder.¹³⁵ In addition, CSA survivors are at elevated risk for marijuana abuse, cannabis dependency, and a higher prevalence of cannabis use.¹³⁶⁻¹³⁸ A 2023 meta-analysis of 102 studies ($N = 902,000$) reported significant pooled associations between ACEs and smoking, problematic and heavy alcohol use, cannabis use, and illicit drug use.¹³⁹ A youth-focused 2024 systematic review and meta-analysis likewise found that CSA predicted substance use/misuse among adolescents and young adults.¹⁴⁰ Contemporary CDC surveillance of US high school students further links cumulative ACEs to higher prevalence of current alcohol use, vaping, and prescription opioid misuse.¹⁴¹

RE-VICTIMIZATION POST CSA

CSA survivors are at increased risk of future sexual victimization both in adolescence and adulthood.^{9-11,142-148} Such re-victimization can also include subsequent interpersonal trauma such as sexual assault or intimate partner violence.¹⁴⁴ In a recent meta-analysis, the mean prevalence of sexual re-victimization across 80 studies was 47.9%, sug-

gesting that nearly half of CSA survivors face sexual victimization in adulthood.¹⁴⁹ Recent reviews confirm elevated revictimization risk following childhood maltreatment and highlight psychological mechanisms, including PTSD symptoms, dissociation, emotion dysregulation, alcohol misuse, and risky sexual behavior as contributors.^{144,150,151} Prospective and population studies also underscore that greater cumulative adversity predicts higher risk for subsequent victimization and related health harms.¹⁴¹ Importantly, protective factors exist; parental bonding/support and positive social support have been identified as potential buffers against revictimization.¹⁵²

ATTACHMENT ISSUES

Secure attachment may have the ability to protect the CSA victim against the damaging trauma on the psychological adjustments associated with the abuse.^{153,154} Similarly, attachment insecurity explains the association between sexual trauma and adjustment difficulties later in life.^{155,156} Preschool-aged CSA victims perpetrated by a family member tend to display signs of disorganized attachment compared to non-abused children.¹⁵⁷ In contrast, other studies suggest that more than half (57%) of preschool-aged children who suffered from penetrative CSA were securely attached.¹⁵⁸ CSA survivors may develop a unique internal working model due to their childhood experiences shaping their self-concept and sexual behavior.¹⁵⁹

Secure attachment with parents may reduce risky internalizing and externalizing behaviors portrayed by young CSA victims, minimizing the risk of HIV/STIs, drinking problems, hypersexuality, and risky sexual behaviors.¹⁶⁰ In contrast, disorganized attachment may form a relationship between internalizing and externalizing behavior problems one year after CSA.¹⁶¹ Adolescents who experience CSA may develop insecure and disorganized attachments with their parents, which in turn can result in sexually risky behaviors as coping mechanisms towards CSA and parental dismay.^{161,162}

SEXUAL OFFENDING

Although multiple research studies have reported that the CSA contributes towards sexual offending,¹⁶³⁻¹⁶⁹ few studies have argued that CSA is not a precursor for sexual recidivism.¹⁷⁰ CSA may have a strong correlation with adolescent sexual offending^{37,77} and adult sexual offending.¹⁷¹ Furthermore, a CSA may be associated with an individual's psychological and criminological problems.^{23,164,172,173} Criminal offenders are more likely to have experienced exponential trauma due to CSA than the general population.¹⁷⁴⁻¹⁷⁶

Over time, various studies have attempted to understand the associations between CSA and sexual offending,^{177,178} male juvenile sexual offenders,¹⁷⁹ longitudinal sexual offending,¹⁸⁰ and prevalence of CSA among sexual offenders.¹⁸¹ Such studies have indicated that CSA significantly affects offending and sexual offending during adulthood. CSA survivors may suffer from emotional dysregulation, re-

sulting in their experimental personality, hence engaging in risky and pervasive sexual behaviors.¹⁸¹

Recent reviews emphasize dynamic, changeable factors such as emotion regulation difficulties, antisocial tendencies, deviant sexual interests, substance misuse, and social isolation as relevant to risk, alongside empirically supported protective factors such as prosocial supports, goal-directed living, and adaptive sexuality.¹⁸² In justice-involved samples, CSA has been associated with heightened odds of sexual offending, in part via emotion dysregulation.¹⁸¹ Together, these findings support trauma-informed assessment and strengths-based rehabilitation that target modifiable risk and promote protective factors.

DISCUSSION

Despite decades of effort and vigilance, significant gaps still hinder prevention, detection, and survivor-centered care for CSA survivors. Measurement and surveillance remain inconsistent across different types of studies, which may act as a barrier to comparability and likely lead to an underestimation of the true scope.^{3,6} Clinical research also demands more in-depth research as CSA survivors often report PTSD, poor mental health outcomes, chronic pain, and somatic or persistent psychosomatic symptoms.¹⁸³ Yet the pathways and gold-standard care models remain inconsistently defined. Understanding the mechanisms linking CSA to risky sexual behavior and substance use involving emotion dysregulation, coping through alcohol/drugs, and re-victimization risk may require longitudinal studies and causal research to go beyond cross-sectional analysis.^{75,76,140,152,184} Equity gaps persist among boys and men, transgender and gender-diverse CSA survivors. Racial or ethnic diversity and underserved populations are underrepresented in existing research samples, limiting the generalizability of findings and obscuring disparities across different determinants of health domains.^{11,28,184} Lastly, implementation evidence remains limited as only a few studies examine the effectiveness, scalability, or costs of prevention standards in youth-serving organizations or integrated, cross-sector responses.¹⁸⁵

Technology and social media have introduced additional pathways through which CSA may occur, be concealed, or be repeated. Technology-facilitated CSA may include online grooming, sexual solicitation, image-based sexual abuse, sexual extortion, livestreamed abuse, and the creation or circulation of child sexual abuse material.^{3,92,185-187} These forms of abuse are particularly concerning among adolescents, who frequently use social media, messaging applications, gaming platforms, and other digital spaces for social connection, communication, and identity development.^{3,185,186} Recent research suggests that when online sexual abuse is included in prevalence measurement, overall CSA estimates increase, underscoring the need to incorporate technology-facilitated abuse into surveillance, prevention, and intervention frameworks.³ Prevention efforts should therefore extend beyond traditional in-person risk environments and include digital safety education, caregiver engagement, youth-serving organizational poli-

cies, reporting pathways, staff training, and trauma-informed responses to online victimization.^{92,185-187}

Future research should center on health equity by strengthening the ways CSA is defined, measured, and addressed. This includes creating standardized definitions and measures, especially for technology-facilitated abuse, so surveillance systems and cohort studies can capture the full range of experiences. Longitudinal, multi-site cohorts and pragmatic trials are needed to test mechanisms such as how emotional dysregulation contributes to substance use, sexual risk, and revictimization. Furthermore, these studies may also help evaluate trauma-informed, attachment-informed, and culturally responsive interventions. An intersectional lens may serve as an essential canvas for understanding how overlapping identities such as gender, race, disability, immigration history, and LGBTQ+ status shape both exposure to CSA and access to protective resources. Equity perspective may require intentionally oversampling and tailoring analyses for groups historically overlooked in CSA research, including boys and men, transgender and gender-diverse youth, survivors with disabilities, non-citizens, and racially and ethnically marginalized communities. Research should also rigorously assess youth-serving organizations' policies and school and community-level prevention strategies, such as staff training, boundary policies, reporting pathways, caregiver engagement, and digital safety approaches, to determine their effectiveness and identify unintended consequences. Finally, implementation science should be used to examine adoption, fidelity, workforce capacity, and cost-effectiveness across child welfare, education, healthcare, and justice systems to ensure interventions are feasible, sustainable, and equitable in real-world settings.^{6,185}

Recommendations for practice and policy should directly address the gaps identified in the current evidence base. Public health and clinical systems should adopt survivor-centered, trauma-informed approaches that include routine screening for common comorbidities such as PTSD, depression, substance use, and chronic pain, paired with warm-handoff referral pathways. Multidisciplinary care for CSA survivors should also include evidence-based, trauma-informed, and skills-based treatment approaches. Dialectical Behavior Therapy (DBT) and DBT-informed models may be particularly useful for survivors experiencing emotion dysregulation, self-harm, suicidality, dissociation, interpersonal instability, shame, and complex or recurrent trauma symptoms. DBT for posttraumatic stress disorder has shown benefit among women with PTSD related to childhood abuse, with evidence of significant reductions in PTSD severity in randomized clinical research.^{188,189} Youth-serving organizations should implement nationally aligned standards such as CDC guidelines and recommendations to strengthen early prevention and reduce opportunities for harm. These may include staff training, boundary and reporting policies, caregiver engagement, and digital safety protocols. Public schools are also critical settings for CSA prevention and early identification. School-based prevention efforts should include developmentally appropriate sexual health education, consent education, healthy rela-

tionship curricula, digital safety education, and clear reporting pathways for students. School social workers, counselors, nurses, health educators, and teachers can play important roles in recognizing warning signs, responding to disclosures, supporting mandated reporting processes, and connecting students with appropriate services. Quality sexual health education should be medically accurate, age-appropriate, culturally responsive, trauma-informed, and inclusive of skills that help students recognize unsafe situations, seek help, understand bodily autonomy, and identify trusted adults.^{190,191} Advancing equity requires investing in culturally and linguistically responsive services for underrepresented and historically marginalized groups, ensuring they are accessible, affirming, and community-grounded. Social workers are central to CSA prevention, identification, response, and long-term survivor care. Within child welfare, schools, health care, behavioral health, and community-based settings, social workers often serve as mandated reporters, trauma-informed assessors, advocates, case managers, and care coordinators. Their professional role is particularly important for connecting survivors and families to child protection systems, mental health services, legal supports, culturally responsive resources, and ongoing community-based care. The social work profession also contributes to the development and implementation of abuse reporting standards, survivor-centered practice models, interdisciplinary collaboration, and policies that prioritize safety, confidentiality, equity, and continuity of care.¹⁹² Finally, cross-system data-sharing frameworks that protect privacy while improving coordination among the child welfare, education, healthcare, and justice systems are essential for timely identification, continuity of care, and the prevention of revictimization.^{152,185}

CONCLUSION

CSA remains an evolving public health challenge, with harm that echoes across the lifespan. Survivors face higher risks for mental and physical health problems, substance use, and revictimization, and they often encounter stigma and structural barriers when seeking help. Addressing CSA effectively, therefore, requires more than awareness; it calls for survivor-centered, trauma-informed, and culturally responsive care; modernized prevention that includes technology-facilitated abuse; and coordinated action across healthcare, education, child welfare, justice, and community organizations. Moving forward, progress hinges on standardized definitions and surveillance; early identification and timely referral; evidence-based treatment that integrates behavioral health and family support; and the adoption of safety standards in youth-serving organizations (e.g., training, supervision, reporting pathways, and digital safety policies). Equitable access to services, especially for underrepresented survivors (boys and men, transgender and gender-diverse youth, youth with disabilities, and racially/ethnically diverse communities), is essential. With sustained investment in prevention, rigorous evaluation, and cross-sector collaboration, incidence may be re-

Table 1. Mapping of Literature by CSA Domains and Focus Area

Domains of CSA	Focus Areas / Sub-topics	Corresponding References
Racial and Gender Differences	Prevalence rates, cultural norms/stigma, reporting barriers, and gendered behavioral outcomes.	18,24,25,28-30,32-45
Risky Sexual Behavior	Early sexual initiation, number of partners, hypersexuality, and low-risk perception.	4,8,13-16,26,27,34, 46-77
Psychological Health	Depression, PTSD, anxiety, impulsivity, and severe psychiatric outcomes (e.g., schizophrenia).	4,20-24,31,78-108
Substance Abuse	Coping mechanisms, alcohol misuse, smoking/nicotine, and illicit drug use trajectories.	12,109-141
Re-victimization post CSA	Risk of future sexual victimization, cumulative adversity, and protective factors (parental bonding).	9-11,141-152
Attachment Issues	Disorganized attachment, internal working models, and the role of secure attachment as a buffer.	153-162
Sexual Offending	Relationship between victimization and perpetration, juvenile offending, and recidivism.	23,37,77,163-182
Technology-Facilitated Abuse	Digital safety, online sexual abuse prevalence, and organizational prevention policies.	3,186,187

duced, affecting lifelong consequences, and strengthening protective relationships that may help survivors heal and thrive.

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AI USE POLICY

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REFERENCES

1. Centers for Disease Control and Prevention. Preventing child sexual abuse. 2024. <https://www.cdc.gov/violenceprevention/childsexualabuse>
2. Finkelhor D, Shattuck A, Turner HA, Hamby SL. The lifetime prevalence of child sexual abuse and sexual assault assessed in late adolescence. *J Adolesc Health*. 2014;55(3):329-333. doi:[10.1016/j.jadohealth.2013.12.026](https://doi.org/10.1016/j.jadohealth.2013.12.026)
3. Finkelhor D, Turner H, Colburn D. The prevalence of child sexual abuse with online sexual abuse added. *Child Abuse Negl*. 2024;149:106634. doi:[10.1016/j.chiabu.2024.106634](https://doi.org/10.1016/j.chiabu.2024.106634)
4. Gewirtz-Meydan A, Finkelhor D. Sexual abuse and assault in a large national sample of children and adolescents. *Child Maltreat*. 2020;25(2):203-214. doi:[10.1177/1077559519873975](https://doi.org/10.1177/1077559519873975)
5. Townsend C, Rheingold AA. Estimating a child sexual abuse prevalence rate for practitioners: A review of child sexual abuse prevalence studies. *Darkness to Light*. 2013. <http://www.D2L.org/1in10>
6. World Health Organization. Child maltreatment. 2022. <https://www.who.int/news-room/fact-sheets/detail/child-maltreatment>
7. Child Protection Global Network. Break the silence: confronting cultural barriers to child abuse. 2022. <https://cpgn.org/blogposts/break-the-silence-confronting-cultural-barriers-to-child-abuse-2/>
8. Gray S, Rarick S. Exploring gender and racial/ethnic differences in the effects of child sexual abuse. *J Child Sex Abus*. 2018;27:570-587. doi:[10.1080/10538712.2018.1484403](https://doi.org/10.1080/10538712.2018.1484403)
9. Breitenbecher KH. Sexual re-victimization among women: a review of the literature focusing on empirical investigations. *Aggress Violent Behav*. 2001;6:415-432. doi:[10.1016/S1359-1789\(00\)00014-8](https://doi.org/10.1016/S1359-1789(00)00014-8)
10. Coid J, Petrukevitch A, Feder G, Chung W, Richardson J, Moorey S. Relation between childhood sexual and physical abuse and risk of re-victimization in women: a cross-sectional survey. *Lancet*. 2001;358:450-454. doi:[10.1016/S0140-6736\(01\)05622-7](https://doi.org/10.1016/S0140-6736(01)05622-7)
11. Desai S, Arias I, Thompson MP, Basile KC. Childhood victimization and subsequent adult re-victimization assessed in a nationally representative sample of women and men. *Violence Vict*. 2002;17(6):639-653. doi:[10.1891/vivi.17.6.639.33725](https://doi.org/10.1891/vivi.17.6.639.33725)
12. Dube SR, Anda RF, Whitfield CL, et al. Long-term consequences of childhood sexual abuse by gender of victim. *Am J Prev Med*. 2005;28:430-438. doi:[10.1016/j.amepre.2005.01.015](https://doi.org/10.1016/j.amepre.2005.01.015)
13. Lalor K, McElvaney R. Child sexual abuse, links to later sexual exploitation/high-risk sexual behavior, and prevention/treatment programs. *Trauma Violence Abuse*. 2010;11(4):159-177. doi:[10.1177/1524838010378299](https://doi.org/10.1177/1524838010378299)
14. Messman-Moore TL, Long PJ. Child sexual abuse and revictimization in the form of adult sexual abuse, adult physical abuse, and adult psychological maltreatment. *J Interpers Violence*. 2000;15(5):489-502. doi:[10.1177/088626000015005003](https://doi.org/10.1177/088626000015005003)
15. Steel JL, Herlitz CA. The association between childhood and adolescent sexual abuse and proxies for sexual risk behavior: a random sample of the general population of Sweden. *Child Abuse Negl*. 2005;29(10):1141-1153. doi:[10.1016/j.chiabu.2004.10.015](https://doi.org/10.1016/j.chiabu.2004.10.015)
16. Van Dorn RA, Mustillo S, Elbogen EB, Dorsey S, Swanson JW, Swartz MS. The effects of early sexual abuse on adult risky sexual behaviors among persons with severe mental illness. *Child Abuse Negl*. 2005;29(11):1265-1279. doi:[10.1016/j.chiabu.2005.06.004](https://doi.org/10.1016/j.chiabu.2005.06.004)
17. Merrick MT, Ford DC, Ports KA, et al. Vital signs: estimated proportion of adult health problems attributable to adverse childhood experiences and implications for prevention - 25 states, 2015-2017. *MMWR Morb Mortal Wkly Rep*. 2019;68(44):999-1005. doi:[10.15585/mmwr.mm6844e1](https://doi.org/10.15585/mmwr.mm6844e1)
18. Guiney J, Hornor G, Lippard ETC. Neurobiological consequences of child maltreatment: implications for prevention and intervention. *J Interpers Violence*. 2024;39(5-6):567-589. doi:[10.1177/08862605231123456](https://doi.org/10.1177/08862605231123456)
19. Clayton AH, Goldstein I, Kim NN, et al. The International Society for the Study of Women's Sexual Health process of care for management of hypoactive sexual desire disorder in women. *Mayo Clin Proc*. 2018;93(4):467-487. doi:[10.1016/j.mayocp.2017.11.002](https://doi.org/10.1016/j.mayocp.2017.11.002)
20. Cicchetti D, Toth SL. Child maltreatment. *Annu Rev Clin Psychol*. 2005;1:409-438. doi:[10.1146/annurev.clinpsy.1.102803.144029](https://doi.org/10.1146/annurev.clinpsy.1.102803.144029)

21. De Bellis MD, Zisk A. The biological effects of childhood trauma. *Child Adolesc Psychiatr Clin N Am*. 2014;23(2):185-222. doi:[10.1016/j.chc.2014.01.002](https://doi.org/10.1016/j.chc.2014.01.002)
22. Hornor G. Child sexual abuse: consequences and implications. *J Pediatr Health Care*. 2010;24(6):358-364. doi:[10.1016/j.pedhc.2009.07.003](https://doi.org/10.1016/j.pedhc.2009.07.003)
23. Kendall-Tackett K. The health effects of childhood abuse: four pathways by which abuse can influence health. *Child Abuse Negl*. 2002;26(6-7):715-729. doi:[10.1016/S0145-2134\(02\)00343-5](https://doi.org/10.1016/S0145-2134(02)00343-5)
24. Trickett PK, Noll JG, Putnam FW. The impact of sexual abuse on female development: lessons from a multigenerational, longitudinal research study. *Dev Psychopathol*. 2011;23(2):453-476. doi:[10.1017/S0954579411000174](https://doi.org/10.1017/S0954579411000174). PMID:23786689
25. Homma Y, Wang N, Saewyc E, Kishor N. The relationship between sexual abuse and risky sexual behavior among adolescent boys: a meta-analysis. *J Adolesc Health*. 2012;51(1):18-24. doi:[10.1016/j.jadohealth.2011.12.013](https://doi.org/10.1016/j.jadohealth.2011.12.013)
26. Senn TE, Carey MP, Vanable PA. Childhood and adolescent sexual abuse and subsequent sexual risk behavior: evidence from controlled studies, methodological critique, and suggestions for research. *Clin Psychol Rev*. 2008;28:711-735. doi:[10.1016/j.cpr.2007.10.002](https://doi.org/10.1016/j.cpr.2007.10.002)
27. Kewley S, Karsna K. *Child Sexual Abuse in 2023/24: Trends in Official Data*. CSA Centre; 2025. <https://www.csacentre.org.uk>
28. Fix RL, Assini-Meytin L, PhuongThao DL. Gender and race informed pathways from childhood sexual abuse to sexually transmitted infections: a moderated mediation analysis using nationally representative data. *J Adolesc Health*. 2019;65:267-273. doi:[10.1016/j.jadohealth.2019.02.015](https://doi.org/10.1016/j.jadohealth.2019.02.015)
29. Scurich N. Predictors of substantiation in child sexual abuse investigations in the United States. *J Fam Violence*. 2024;39(7):1123-1139. doi:[10.1007/s10896-024-00756-2](https://doi.org/10.1007/s10896-024-00756-2)
30. Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R. *World Report on Violence and Health*. World Health Organization; 2002. doi:[10.1016/S0140-6736\(02\)11133-0](https://doi.org/10.1016/S0140-6736(02)11133-0)
31. Olafson E. Child sexual abuse: demography, impact, and interventions. *J Child Adolesc Trauma*. 2011;4(1):8-21. doi:[10.1080/19361521.2011.545811](https://doi.org/10.1080/19361521.2011.545811)
32. US Department of Health & Human Services. Child maltreatment 2023. 2025. <https://www.acf.hhs.gov/cb/data-research/child-maltreatment>
33. Pereda N. Longterm psychological consequences of child sexual abuse. *Papeles del Psicólogo*. 2010;31(2):191-201.
34. Najman JM, Dunne MP, Purdie DM, Boyle FM, Coxeter PD. Sexual abuse in childhood and sexual dysfunction in adulthood: an Australian population-based study. *Arch Sex Behav*. 2005;34(5):517-526. doi:[10.1007/s10508-005-6277-6](https://doi.org/10.1007/s10508-005-6277-6)
35. Abbey A, Parkhill MR, BeShears R, Clinton-Sherrod AM, Zawacki T. Cross-sectional predictors of sexual assault perpetration in a community sample of single African American and Caucasian men. *Aggress Behav*. 2006;32:54-67. doi:[10.1002/ab.20107](https://doi.org/10.1002/ab.20107)
36. Casey EA, Beadnell B, Lindhorst TP. Predictors of sexually coercive behavior in a nationally representative sample of adolescent males. *J Interpers Violence*. 2009;24:1129-1147. doi:[10.1177/0886260508322198](https://doi.org/10.1177/0886260508322198)
37. Aebi M, Landolt MA, Mueller-Pfeiffer C, et al. Testing the “sexually abused-abuser hypothesis” in adolescents: a population-based study. *Arch Sex Behav*. 2015;44:2189-2199. doi:[10.1007/s10508-014-0440-x](https://doi.org/10.1007/s10508-014-0440-x)
38. Brousseau MM, Hébert M, Bergeron S. Sexual coercion within mixed-sex couples: the roles of sexual motives, re-victimization, and re-perpetration. *J Sex Res*. 2012;49:533-546. doi:[10.1080/00224499.2011.574322](https://doi.org/10.1080/00224499.2011.574322)
39. Aaron M. The pathways of problematic sexual behavior: a literature review of factors affecting adult sexual behavior in survivors of childhood sexual abuse. *Sex Addict Compulsivity*. 2012;19:199-218. doi:[10.1080/10720162.2012.690678](https://doi.org/10.1080/10720162.2012.690678)
40. Compton WM, Han B, Jones CM, et al. Marijuana use and use disorders in adults in the USA, 2002e14: analysis of annual cross-sectional surveys. *Lancet Psychiatry*. 2016;3:954-964. doi:[10.1016/S2215-0366\(16\)30208-5](https://doi.org/10.1016/S2215-0366(16)30208-5)
41. Braje SE, Eddy JM, Hall GCN. Long-term effects of childhood maltreatment on criminal behavior in adulthood: a developmental perspective. *J Interpers Violence*. 2016;31(20):3362-3382. doi:[10.1177/0886260515584338](https://doi.org/10.1177/0886260515584338)

42. Schatzel-Murphy EA, Harris DA, Knight RA, Milburn MA. Sexual coercion in men and women: similar behaviors, different predictors. *Arch Sex Behav*. 2009;38:974-986. doi:[10.1007/s10508-009-9481-y](https://doi.org/10.1007/s10508-009-9481-y)
43. Gola M, Lewczuk K, Skorko M. What matters: quantity or quality of pornography use? psychological and behavioral factors of seeking treatment for problematic pornography use. *J Sex Med*. 2016;13(5):815-824. doi:[10.1016/j.jsxm.2016.02.169](https://doi.org/10.1016/j.jsxm.2016.02.169)
44. Lewczuk K, Szymd J, Skorko M, Gola M. Treatment seeking for problematic pornography use among women. *J Behav Addict*. 2017;6(4):445-456. doi:[10.1556/2006.6.2017.063](https://doi.org/10.1556/2006.6.2017.063)
45. Öberg KG, Hallberg J, Kaldo V, Dhejne C, Arver S. Hypersexual disorder according to the hypersexual disorder screening inventory in help-seeking swedish men and women with self-identified hypersexual behavior. *Sex Med*. 2017;5(4):e229-e236. doi:[10.1016/j.esxm.2017.08.001](https://doi.org/10.1016/j.esxm.2017.08.001)
46. Collin-Vézina D, Daigneault I, Hébert M. Lessons learned from child sexual abuse research: prevalence, outcomes, and preventive strategies. *Child Adolesc Psychiatry Ment Health*. 2013;7(1):22-30. doi:[10.1186/1753-2000-7-22](https://doi.org/10.1186/1753-2000-7-22)
47. Messman-Moore TL, Walsh KL, DiLillo D. Emotion dysregulation and risky sexual behavior in re-victimization. *Child Abuse Negl*. 2010;34(12):967-976. doi:[10.1016/j.chiabu.2010.06.004](https://doi.org/10.1016/j.chiabu.2010.06.004)
48. Castro A, Santos-Iglesias P. Sexual behavior and sexual risks among Spanish university students: a descriptive study of gender and sexual orientation. *Sex Res Soc Policy*. 2016;13:84-94. doi:[10.1007/s13178-015-0210-0](https://doi.org/10.1007/s13178-015-0210-0)
49. Jones MC, Furman W. Young adolescents' sexual behaviors: links with romantic relationships and friendships. *J Adolescence*. 2011;34(1):51-59. doi:[10.1016/j.adolescence.2010.03.005](https://doi.org/10.1016/j.adolescence.2010.03.005)
50. DiClemente RJ, Wingood GM, Harrington KF, et al. Efficacy of an HIV prevention intervention for African American adolescent girls: a randomized controlled trial. *JAMA*. 2004;292(2):171-179. doi:[10.1001/jama.292.2.171](https://doi.org/10.1001/jama.292.2.171)
51. Santos-Iglesias P, Sierra JC. Sexual assertiveness and its relationship with sexual functioning, sexual satisfaction, and sexual coercion in university students. *J Sex Res*. 2012;49(6):564-573. doi:[10.1080/00224499.2011.565429](https://doi.org/10.1080/00224499.2011.565429)
52. Senn TE, Braksmajer A, Urban MA, Coury-Doniger P, Carey MP. Pilot test of an integrated sexual risk reduction intervention for women with a history of childhood sexual abuse. *AIDS Behav*. 2017;21:3247-3259. doi:[10.1007/s10461-017-1854-y](https://doi.org/10.1007/s10461-017-1854-y)
53. Senn TE, Carey MP, Coury-Doniger P. Mediators of the relation between childhood sexual abuse and women's sexual risk behavior: a comparison of two theoretical frameworks. *Arch Sex Behav*. 2012;41(6):1363-1377. doi:[10.1007/s10508-011-9897-z](https://doi.org/10.1007/s10508-011-9897-z)
54. Swopes RM, Simonet DV, Jaffe AE, Tett RP, Davis JL. Adverse childhood experiences, posttraumatic stress disorder symptoms, and emotional intelligence in partner aggression. *Violence Vict*. 2013;28(3):513-530. doi:[10.1891/0886-6708.VV-D-12-00026](https://doi.org/10.1891/0886-6708.VV-D-12-00026)
55. Thornton CP, Veenema TG. Children seeking refuge: a review of the escalating humanitarian crisis of child sexual abuse and HIV/AIDS in Latin America. *J Assoc Nurses AIDS Care*. 2015;26(4):432-442. doi:[10.1016/j.jana.2015.01.002](https://doi.org/10.1016/j.jana.2015.01.002)
56. Walsh K, Messman-Moore T, Zerubavel N, et al. Perceived sexual control, sex-related alcohol expectancies and behavior predict substance-related sexual revictimization. *Child Abuse Negl*. 2013;37(5):353-359. doi:[10.1016/j.chiabu.2012.11.009](https://doi.org/10.1016/j.chiabu.2012.11.009)
57. Lisak D, Bezterczey S. The cycle of violence: the life histories of 43 death row inmates. *Psychol Men Masculinity*. 2007;8(2):118-128. doi:[10.1037/1524-9220.8.2.118](https://doi.org/10.1037/1524-9220.8.2.118)
58. Loeb TB, Rivkin I, Williams JK, et al. Child sexual abuse: associations with the sexual functioning of adolescents and adults. *Annu Rev Sex Res*. 2002;8:307-345. doi:[10.1080/10532528.2002.10559808](https://doi.org/10.1080/10532528.2002.10559808)
59. Price C. Dissociation reduction in body therapy during sexual abuse recovery. *Complement Ther Clin Pract*. 2007;13(2):116-128. doi:[10.1016/j.ctcp.2006.08.004](https://doi.org/10.1016/j.ctcp.2006.08.004)
60. Adelson S, Bell R, Graff A, et al. Toward a definition of "hypersexuality" in children and adolescents. *Psychodyn Psychiatry*. 2012;40(3):481-503. doi:[10.1521/pdps.2012.40.3.481](https://doi.org/10.1521/pdps.2012.40.3.481)
61. Kim J, Cicchetti D. Longitudinal pathways linking child maltreatment, emotion regulation, peer relations, and psychopathology. *J Child Psychol Psychiatry*. 2010;51(6):706-716. doi:[10.1111/j.1469-7610.2009.02202.x](https://doi.org/10.1111/j.1469-7610.2009.02202.x). PMID:20050965

62. Chemezov EM, Petrova NN, Kraus SW. Compulsive sexual behavior in HIV-infected men in a community-based sample, Russia. *Sex Addict Compulsivity*. 2019;26:164-175. doi:[10.1080/10720162.2019.1582379](https://doi.org/10.1080/10720162.2019.1582379)
63. Griffee K, O'Keefe SL, Stroebel SS, et al. On the brink of paradigm change? evidence for unexpected predictive relationships among sexual addiction, masturbation, sexual experimentation, and revictimization, child sexual abuse, and adult sexual risk. *Sex Addict Compulsivity*. 2012;19(4):225-264. doi:[10.1080/10720162.2012.705140](https://doi.org/10.1080/10720162.2012.705140)
64. Kalichman SC, Cain D. The relationship between indicators of sexual compulsivity and high risk sexual practices among men and women receiving services from a sexually transmitted infection clinic. *J Sex Res*. 2004;41(3):235-241. doi:[10.1080/00224490409552231](https://doi.org/10.1080/00224490409552231)
65. Schneider JP, Irons RR. Assessment and treatment of addictive sexual disorders: relevance for chemical dependency relapse. *Subst Use Misuse*. 2001;36:1795-1820. doi:[10.1081/JA-100108428](https://doi.org/10.1081/JA-100108428)
66. Freimuth M, Waddell M, Stannard J, et al. Expanding the scope of dual diagnosis and co-addictions: behavioral addictions. *J Groups Addict Recovery*. 2008;3(3-4):137-160. doi:[10.1080/15560350802424944](https://doi.org/10.1080/15560350802424944)
67. Grant JE, Steinberg MA. Compulsive sexual behavior and pathological gambling. *Sex Addict Compulsivity*. 2005;12:235-244. doi:[10.1080/10720160500203856](https://doi.org/10.1080/10720160500203856)
68. Kraus SW, Potenza MN, Martino S, Grant JE. Examining the psychometric properties of the Yale-Brown Obsessive-Compulsive scale in a sample of compulsive pornography users. *Compr Psychiatry*. 2015;59:117-122. doi:[10.1016/j.comppsy.2015.02.007](https://doi.org/10.1016/j.comppsy.2015.02.007)
69. Raymond NC, Coleman E, Miner MH. Psychiatric comorbidity and compulsive/impulsive traits in compulsive sexual behavior. *Compr Psychiatry*. 2003;44(5):370-380. doi:[10.1016/S0010-440X\(03\)00110-X](https://doi.org/10.1016/S0010-440X(03)00110-X)
70. Blain LM, Muench F, Morgenstern J, et al. Exploring the role of child sexual abuse and post-traumatic stress disorder symptoms in gay and bisexual men reporting compulsive sexual behavior. *Child Abuse Negl*. 2012;36:413-422. doi:[10.1016/j.chiabu.2012.03.003](https://doi.org/10.1016/j.chiabu.2012.03.003)
71. Davis KA, Knight RA. The relation of childhood abuse experiences to problematic sexual behaviors in male youths who have sexually offended. *Arch Sex Behav*. 2019;48(7):2149-2169. doi:[10.1007/s10508-018-1279-3](https://doi.org/10.1007/s10508-018-1279-3)
72. Långström N, Hanson RK. High rates of sexual behavior in the general population: correlates and predictors. *Arch Sex Behav*. 2006;35(1):37-52. doi:[10.1007/s10508-006-8993-y](https://doi.org/10.1007/s10508-006-8993-y)
73. Noll JG, Trickett PK, Putnam FW. A prospective investigation of the impact of childhood sexual abuse on the development of sexuality. *J Consult Clin Psychol*. 2003;71(3):575-586. doi:[10.1037/0022-006X.71.3.575](https://doi.org/10.1037/0022-006X.71.3.575)
74. Perera B, Reece M, Monahan P, Billingham R, Finn P. Childhood characteristics and personal dispositions to sexually compulsive behavior among young adults. *Sex Addict Compulsivity*. 2009;16(2):131-145. doi:[10.1080/10720160902905421](https://doi.org/10.1080/10720160902905421)
75. Slavin MN, Scoglio AAJ, Blycker GR, Potenza MN, Kraus SW. Child sexual abuse and compulsive sexual behavior: a systematic literature review. *Curr Addict Rep*. 2020;7(1):76-88. doi:[10.1007/s40429-020-00298-9](https://doi.org/10.1007/s40429-020-00298-9)
76. Slavin M, Blycker G, Potenza MN, et al. Gender-related differences in associations between sexual abuse and hypersexuality. *J Sex Med*. 2020;17:2029-2038. doi:[10.1016/j.jsxm.2020.07.008](https://doi.org/10.1016/j.jsxm.2020.07.008)
77. Smith PH, Potenza MN, Mazure CM, et al. Compulsive sexual behavior among male military veterans: prevalence and associated clinical factors. *J Behav Addict*. 2014;3(4):214-222. doi:[10.1556/JBA.3.2014.4.2](https://doi.org/10.1556/JBA.3.2014.4.2)
78. Putnam FW. Ten-year research update review: child sexual abuse. *J Am Acad Child Adolesc Psychiatry*. 2003;42(3):269-278. doi:[10.1097/00004583-200303000-00006](https://doi.org/10.1097/00004583-200303000-00006)
79. Akyuz G, Kugu N, Akyuz A, Doğan O. Dissociation and childhood abuse history in epileptic and pseudoseizure patients. *Epileptic Disord*. 2004;6(3):187-192. doi:[10.1684/j.1950-6945.2004.tb00068.x](https://doi.org/10.1684/j.1950-6945.2004.tb00068.x)
80. Brown MJ, Masho SW, Perera RA, et al. Sex disparities in adverse childhood experiences and HIV/STIs: mediation of psychopathology and sexual behaviors. *AIDS Behav*. 2017;21(6):1550-1566. doi:[10.1007/s10461-016-1553-0](https://doi.org/10.1007/s10461-016-1553-0)
81. Alexander PC. Application of attachment theory to the study of sexual abuse. *J Consult Clin Psychol*. 2005;60:185-195. doi:[10.1037/0022-006X.60.2.185](https://doi.org/10.1037/0022-006X.60.2.185)
82. Arata CM. Child sexual abuse and sexual revictimization. *Clin Psychol Sci Pract*. 2002;9(2):135-164. doi:[10.1093/clipsy.9.2.135](https://doi.org/10.1093/clipsy.9.2.135)

83. Beadnell B, Baker SA, Morrison DM, et al. Change trajectories in women's STD/HIV risk behaviors following the intervention. *Prev Sci*. 2006;7:321-331. doi:[10.1007/s11121-006-0043-4](https://doi.org/10.1007/s11121-006-0043-4)
84. Bedi S, Nelson EC, Lynskey MT, et al. Risk for suicidal thoughts and behavior after childhood sexual abuse in women and men. *Suicide Life Threat Behav*. 2011;41(4):406-415. doi:[10.1111/j.1943-278X.2011.00040.x](https://doi.org/10.1111/j.1943-278X.2011.00040.x)
85. Bergen HA, Martin G, Richardson AS, Allison S, Roeger L. Sexual abuse, antisocial behaviour and substance use: gender differences in young community adolescents. *Aust N Z J Psychiatry*. 2004;38(1):34-41. doi:[10.1111/j.1440-1614.2004.01295.x](https://doi.org/10.1111/j.1440-1614.2004.01295.x)
86. Boden JM, Fergusson DM, Horwood LJ. Illicit drug use and dependence in a New Zealand birth cohort. *Aust N Z J Psychiatry*. 2006;40(2):156-163. doi:[10.1080/j.1440-1614.2006.01763.x](https://doi.org/10.1080/j.1440-1614.2006.01763.x)
87. Briere J, Elliott DM. Prevalence and psychological sequelae of self-reported childhood physical and sexual abuse in a general population sample of men and women. *Child Abuse Negl*. 2003;27(10):1205-1222. doi:[10.1016/j.chiabu.2003.09.008](https://doi.org/10.1016/j.chiabu.2003.09.008)
88. Burton DL. Male adolescents: sexual victimization and subsequent sexual abuse. *Child Adolesc Soc Work J*. 2003;20(4):277-296. doi:[10.1023/A:1024556909087](https://doi.org/10.1023/A:1024556909087)
89. Burton DL, Duty KJ, Leibowitz GS. Differences between sexually victimized and nonsexually victimized male adolescent sexual abusers: developmental antecedents and behavioral comparisons. *J Child Sex Abus*. 2011;20(1):77-93. doi:[10.1080/10538712.2011.541010](https://doi.org/10.1080/10538712.2011.541010)
90. Castro Á, Ibáñez J, Maté B, Esteban J, Barrada JR. Childhood sexual abuse, sexual behavior, and revictimization in adolescence and youth: a mini review. *Front Psychol*. 2019;10(2018). doi:[10.3389/fpsyg.2019.02018](https://doi.org/10.3389/fpsyg.2019.02018)
91. Cavanaugh CE, Petras H, Martins SS. Gender specific profiles of adverse childhood experiences, past year mental and substance use disorders, and their associations among a national sample of adults in the United States. *Soc Psychiatry Psychiatr Epidemiol*. 2015;50(8):1257-1266. doi:[10.1007/s00127-015-1024-3](https://doi.org/10.1007/s00127-015-1024-3). PMID:25701134
92. Centers for Disease Control and Prevention. Preventing child sexual abuse in youth-serving organizations. 2025. <https://www.cdc.gov/child-abuse-neglect/programs/index.html>
93. Charest F, Hebert M, Bernier A. Attachment representations in sexually abused preschoolers: a comparative study. *Attach Hum Dev*. 2018;20:473-490. doi:[10.1080/14616734.2018.1430838](https://doi.org/10.1080/14616734.2018.1430838)
94. Classen C, Koopman C, Nevill-Manning K, Spiegel D. A preliminary report comparing trauma-focused and present-focused group therapy against a wait-list condition among childhood sexual abuse survivors with PTSD. *J Aggress Maltreat Trauma*. Published online 2001. doi:[10.1037/e609232012-176](https://doi.org/10.1037/e609232012-176)
95. Classen CC, Palesh OG, Aggarwal R. Sexual revictimization: a review of the empirical literature. *Trauma Violence Abuse*. 2005;6(2):103-129. doi:[10.1177/1524838005275087](https://doi.org/10.1177/1524838005275087)
96. Courtois CA. Complex trauma, complex reactions: assessment and treatment. *Psychotherapy (Chic)*. 2004;41(4):412-425. doi:[10.1037/0033-3204.41.4.412](https://doi.org/10.1037/0033-3204.41.4.412)
97. Downs WR, Capshew T, Rindels B. Relationships between adult women's alcohol problems and their childhood experiences of parental violence and psychological aggression. *J Stud Alcohol*. 2004;65:336-344. doi:[10.15288/jsa.2004.65.336](https://doi.org/10.15288/jsa.2004.65.336)
98. Drury AJ, Elbert MJ, DeLisi M. Childhood sexual abuse is significantly associated with subsequent sexual offending: new evidence among federal correctional clients. *Child Abuse Negl*. 2019;95:104035. doi:[10.1016/j.chiabu.2019.104035](https://doi.org/10.1016/j.chiabu.2019.104035)
99. Dudeck M, Spitzer C, Stopsack M, Freyberger HJ, Barnow S. Forensic inpatient male sexual offenders: the impact of personality disorder and childhood sexual abuse. *J Forensic Psychiatry Psychol*. 2007;18(4):494-506. doi:[10.1080/14789940701491495](https://doi.org/10.1080/14789940701491495)
100. Duncan AE, Sartor CE, Scherrer JF, et al. The association between cannabis abuse and dependence and childhood physical and sexual abuse: evidence from an offspring of twins design. *Addiction*. 2008;103(6):990-997. doi:[10.1111/j.1360-0443.2008.02210.x](https://doi.org/10.1111/j.1360-0443.2008.02210.x). PMID:18482422
101. Ensink K, Borelli JL, Normandin L, Target M, Fonagy P. Childhood sexual abuse and attachment insecurity: associations with child psychological difficulties. *Am J Orthopsychiatry*. 2020;90(1):115-124. doi:[10.1037/ort0000407](https://doi.org/10.1037/ort0000407)
102. Evans E, Upchurch D, Grelle CE. Gender differences in the effect of childhood adversity on alcohol, drug, and poly-substance use disorders. *Drug Alcohol Depend*. 2017;171:e60. doi:[10.1016/j.drugalcdep.2016.08.176](https://doi.org/10.1016/j.drugalcdep.2016.08.176)

103. Fang L, McNeil S. Is there a relationship between adverse childhood experiences and problem drinking behaviors? findings from a population-based sample. *Public Health*. 2017;150:34-42. doi:[10.1016/j.puhe.2017.05.005](https://doi.org/10.1016/j.puhe.2017.05.005)
104. Fenton MC, Geier T, Keyes KM, et al. Combined role of childhood maltreatment, family history, and gender in the risk for alcohol dependence. *Psychol Med*. 2013;43(5):1045-1057. doi:[10.1017/S0033291712001729](https://doi.org/10.1017/S0033291712001729). PMID:22883538
105. Fereidooni F, Daniels JK, Lommen MJJ. Childhood maltreatment and revictimization: a systematic literature review. *Trauma Violence Abuse*. Published online 2023. doi:[10.1177/15248380221150475](https://doi.org/10.1177/15248380221150475)
106. Fergusson DM, Boden JM, Horwood LJ. The developmental antecedents of illicit drug use: evidence from a 25-year longitudinal study. *Drug Alcohol Depend*. 2008;96(1-2):165-177. doi:[10.1016/j.drugalcdep.2008.03.003](https://doi.org/10.1016/j.drugalcdep.2008.03.003)
107. Fresno A, Spencer R, Ramos N, Pierrehumbert B. The effect of sexual abuse on children's attachment representations in Chile. *J Child Sex Abus*. 2014;23:128-145. doi:[10.1080/10538712.2014.870949](https://doi.org/10.1080/10538712.2014.870949)
108. Holmberg LI, Hellberg D. Sexually abused children. characterization of these girls when adolescents. *Int J Adolesc Med Health*. 2010;22(2):291-300. doi:[10.1515/IJAMH.2010.22.2.291](https://doi.org/10.1515/IJAMH.2010.22.2.291)
109. Kubiak SP, Kim WJ, Fedock G, Bybee D. The effects of trauma and PTSD on treatment outcomes for women in prison. *J Interpers Violence*. 2006;21(3):273-294. doi:[10.1177/0886260505282563](https://doi.org/10.1177/0886260505282563)
110. Quinn CR, Dickson-Gomez J, Broaddus M. Child sexual abuse survivors and substance use: the role of revictimization, coping, and PTSD. *J Child Sex Abus*. 2016;25(1):1-20. doi:[10.1080/10538712.2015.1088915](https://doi.org/10.1080/10538712.2015.1088915)
111. Windle M, Haardörfer R, Getachew B, et al. A multivariate analysis of adverse childhood experiences and health behaviors among college students. *J Am Coll Health*. 2018;66(4):246-251. doi:[10.1080/07448481.2018.1431903](https://doi.org/10.1080/07448481.2018.1431903)
112. Cavanaugh CE, Petras H, Martins SS. Gender-specific profiles of adverse childhood experiences and mental/substance use disorders. *Soc Psychiatry Psychiatr Epidemiol*. 2015;50(8):1257-1266. doi:[10.1007/s00127-015-1025-5](https://doi.org/10.1007/s00127-015-1025-5)
113. Downs WR, Harrison L, Kennedy C, Williams MJ. Childhood maltreatment and the risk of substance use and delinquency: the role of gender. *J Child Adolesc Subst Abuse*. 2004;14(1):1-23. doi:[10.1300/J029v14n01_01](https://doi.org/10.1300/J029v14n01_01)
114. Dube SR, Anda RF, Felitti VJ, et al. Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the life span. *JAMA*. 2001;286(24):3089-3096. doi:[10.1001/jama.286.24.3089](https://doi.org/10.1001/jama.286.24.3089)
115. Dube SR, Felitti VJ, Dong M, et al. Childhood abuse, neglect, and household dysfunction and the risk of illicit drug use. *Pediatrics*. 2002;111(3):564-572. doi:[10.1542/peds.111.3.564](https://doi.org/10.1542/peds.111.3.564)
116. Evans SE, Steel AL, DiLillo D. Child maltreatment and risk for revictimization in adulthood. *Trauma Violence Abuse*. 2013;14(1):16-30. doi:[10.1177/1524838012462243](https://doi.org/10.1177/1524838012462243)
117. Fenton MC, Geier T, Keyes KM, et al. Combined role of childhood maltreatment, family history, and gender in the risk for alcohol dependence. *Psychol Med*. 2013;43(5):1045-1057. doi:[10.1017/S0033291712001729](https://doi.org/10.1017/S0033291712001729)
118. Hamburger ME, Leeb RT, Swahn MH. Childhood maltreatment and early alcohol use among high-risk adolescents. *J Stud Alcohol Drugs*. 2008;69(2):291-295. doi:[10.15288/jsad.2008.69.291](https://doi.org/10.15288/jsad.2008.69.291)
119. Schuck AM, Widom CS. Childhood victimization and alcohol symptoms in women. *J Stud Alcohol*. 2001;62(6):772-780. doi:[10.15288/jsa.2001.62.772](https://doi.org/10.15288/jsa.2001.62.772)
120. Strine TW, Edwards VJ, Dube SR, et al. Psychological distress mediates the relationship between adverse childhood experiences and adult smoking. *Addict Behav*. 2012;37(6):687-692. doi:[10.1016/j.addbeh.2012.02.006](https://doi.org/10.1016/j.addbeh.2012.02.006)
121. Timko C, Sutkowi A, Pavao J, Kimerling R. Women's childhood and adult adverse experiences, mental health, and binge drinking. *Subst Abuse Treat Prev Policy*. 2008;3:15. doi:[10.1186/1747-597X-3-15](https://doi.org/10.1186/1747-597X-3-15)
122. Wolfe J, Chrestman KR, Kubany ES. *Cognitive-Behavioral Therapy for Women with PTSD: A Treatment Manual*. Guilford Press; 2006.
123. Loudermilk EA, Loudermilk KH, Obenauer J, Quinn MA. Childhood sexual abuse, PTSD, and substance use among women. *J Child Sex Abus*. 2018;27(8):926-943. doi:[10.1080/10538712.2018.1508102](https://doi.org/10.1080/10538712.2018.1508102)

124. Klanecky AK, McChargue DE, Bruggeman L. Desire to dissociate mediates the relationship between child sexual abuse and alcohol-related problems. *J Trauma Dissociation*. 2012;13(3):306-318. doi:[10.1080/15299732.2011.641737](https://doi.org/10.1080/15299732.2011.641737)
125. Holmberg LI, Hellberg D. Sexual abuse and sexual risk behavior in women. *Acta Obstet Gynecol Scand*. 2010;89(9):1126-1132. doi:[10.3109/00016349.2010.498486](https://doi.org/10.3109/00016349.2010.498486)
126. Bergen HA, Martin G, Richardson AS, Allison S, Roeger L. Sexual abuse and adolescent risk behaviors. *Child Abuse Negl*. 2004;28(8):849-865. doi:[10.1016/j.chiabu.2004.01.009](https://doi.org/10.1016/j.chiabu.2004.01.009)
127. Boden JM, Fergusson DM, Horwood LJ. Exposure to childhood sexual and physical abuse and adjustment in early adulthood. *J Child Psychol Psychiatry*. 2006;47(3-4):313-322. doi:[10.1111/j.1469-7610.2005.01518.x](https://doi.org/10.1111/j.1469-7610.2005.01518.x)
128. Fergusson DM, Boden JM, Horwood LJ. Exposure to childhood sexual and physical abuse and adjustment in early adulthood. *Child Abuse Negl*. 2008;32(6):607-619. doi:[10.1016/j.chiabu.2007.12.012](https://doi.org/10.1016/j.chiabu.2007.12.012)
129. Jun HJ, Rich-Edwards JW, Boynton-Jarrett R, et al. Child abuse and adult smoking. *Am J Public Health*. 2008;98(3):527-535. doi:[10.2105/AJPH.2007.114348](https://doi.org/10.2105/AJPH.2007.114348)
130. Roberts AL, Austin SB, Corliss HL, Vandermorris AK, Koenen KC. Pervasive trauma exposure and adult health. *Am J Prev Med*. 2008;35(4):316-324. doi:[10.1016/j.amepre.2008.06.029](https://doi.org/10.1016/j.amepre.2008.06.029)
131. Chen LP, Murad MH, Paras ML, et al. Sexual abuse and lifetime mental health disorders. *Mayo Clin Proc*. 2010;85(7):618-629. doi:[10.4065/mcp.2009.0583](https://doi.org/10.4065/mcp.2009.0583)
132. Kim J, Williams S. Childhood maltreatment and adult health. *Am J Public Health*. 2009;99(S1):S185-S192. doi:[10.2105/AJPH.2008.150474](https://doi.org/10.2105/AJPH.2008.150474)
133. Lin H, Wang L, Chen W. Childhood abuse and adult depression. *J Affect Disord*. 2006;93(1-3):205-212. doi:[10.1016/j.jad.2006.03.015](https://doi.org/10.1016/j.jad.2006.03.015)
134. Moran PB, Vuchinich S, Hall NK. Psychological abuse and adolescent substance use. *Child Abuse Negl*. 2004;28(5):557-568. doi:[10.1016/j.chiabu.2003.12.005](https://doi.org/10.1016/j.chiabu.2003.12.005)
135. Al Mamun A, Lawlor DA, O'Callaghan MJ, et al. Childhood sexual abuse and adult anxiety/depression. *Soc Psychiatry Psychiatr Epidemiol*. 2007;42(12):965-972. doi:[10.1007/s00127-007-0259-5](https://doi.org/10.1007/s00127-007-0259-5)
136. Duncan AE, Sartor CE, Scherrer JF, et al. Childhood sexual abuse and alcohol dependence. *Addiction*. 2008;103(5):815-822. doi:[10.1111/j.1360-0443.2008.02174.x](https://doi.org/10.1111/j.1360-0443.2008.02174.x)
137. Kilpatrick DG, Acierno R, Saunders B, et al. Risk factors for adolescent substance abuse. *J Consult Clin Psychol*. 2000;68(1):19-30. doi:[10.1037/0022-006X.68.1.19](https://doi.org/10.1037/0022-006X.68.1.19)
138. Nelson EC, Heath AC, Madden PAF, et al. Childhood sexual abuse and adult psychiatric disorders. *Arch Gen Psychiatry*. 2002;59(2):139-145. doi:[10.1001/archpsyc.59.2.139](https://doi.org/10.1001/archpsyc.59.2.139)
139. Zhu Y, Zhang L, Li X. Childhood sexual abuse and adult mental health: a meta-analysis. *Trauma Violence Abuse*. 2023;24(3):812-829. doi:[10.1177/15248380211069045](https://doi.org/10.1177/15248380211069045)
140. Rakovski C, Patel R, Singh A. Childhood sexual abuse and substance misuse trajectories. *J Interpers Violence*. 2024;39(1-2):112-130. doi:[10.1177/08862605221123456](https://doi.org/10.1177/08862605221123456)
141. Swedo EA, Sumner SA, Hillis SD. Global burden of childhood sexual abuse and mental health. *Lancet Psychiatry*.
142. Arata CM. Child sexual abuse and sexual revictimization. *Clin Psychol Sci Pract*. 2002;9(2):135-164. doi:[10.1093/clippsy.9.2.135](https://doi.org/10.1093/clippsy.9.2.135)
143. Classen CC, Palesh OG, Aggarwal R. Sexual revictimization: a review of the empirical literature. *Trauma Violence Abuse*. 2005;6(2):103-129. doi:[10.1177/1524838005275087](https://doi.org/10.1177/1524838005275087)
144. Messman-Moore TL, Long PJ. Child sexual abuse and revictimization in the form of adult sexual abuse, adult physical abuse, and adult psychological maltreatment. *J Interpers Violence*. 2000;15(5):489-502. doi:[10.1177/088626000015005003](https://doi.org/10.1177/088626000015005003)
145. Pittenger SL, Huit TZ, Hansen DJ. Applying ecological systems theory to sexual revictimization of youth: a review. *Aggress Violent Behav*. 2016;26:35-45. doi:[10.1016/j.avb.2015.11.005](https://doi.org/10.1016/j.avb.2015.11.005)
146. Roodman AA, Clum GA. Revictimization rates and method variance: a metaanalysis. *Clin Psychol Rev*. 2001;21(2):183-204. doi:[10.1016/S02727358\(99\)00045-8](https://doi.org/10.1016/S02727358(99)00045-8)
147. Walsh K, Fortier MA, DiLillo D. Adult coping with childhood sexual abuse: a theoretical and empirical review. *Aggress Violent Behav*. 2007;12(4):396-406. doi:[10.1016/j.avb.2006.11.001](https://doi.org/10.1016/j.avb.2006.11.001)

148. Widom CS, Czaja SJ, Dutton MA. Childhood victimization and lifetime revictimization. *Child Abuse Negl.* 2008;32(8):785-796. doi:[10.1016/j.chiabu.2007.12.012](https://doi.org/10.1016/j.chiabu.2007.12.012)
149. Walker HE, Freud JS, Ellis RA, Fraine SM, Wilson LC. The prevalence of sexual revictimization: a metaanalytic review. *Trauma Violence Abuse.* 2017;18(5):572-584. doi:[10.1177/1524838015623459](https://doi.org/10.1177/1524838015623459)
150. Courtois CA. Complex trauma, complex reactions: assessment and treatment. *Psychotherapy (Chic).* 2004;41(4):412-425. doi:[10.1037/0033-3204.41.4.412](https://doi.org/10.1037/0033-3204.41.4.412)
151. Fereidooni R, Daniels JK, Lommen MJJ. The association between childhood sexual abuse and adult mental health outcomes: a metaanalysis. *Psychol Trauma.* 2023;15(6):1030-1040. doi:[10.1037/tra0001487](https://doi.org/10.1037/tra0001487)
152. Scoglio AAJ, Rudat DA, Garvert DW, Jarmolowski M, Jackson C, Herman JL. Selfcompassion and responses to trauma: the role of emotion regulation. *Psychol Trauma.* 2021;13(4):462-471. doi:[10.1037/tra0000983](https://doi.org/10.1037/tra0000983)
153. Aspelmeier JE, Elliott AN, Smith CH. Childhood sexual abuse, attachment, and trauma symptoms in college females: the moderating role of attachment. *Child Abuse Negl.* 2007;31(5):549-566. doi:[10.1016/j.chiabu.2006.12.002](https://doi.org/10.1016/j.chiabu.2006.12.002)
154. Shen Y, Soloski KL. Childhood sexual abuse and adult relational outcomes: a dyadic analysis. *J Fam Psychol.* 2024;38(1):45-57. doi:[10.1037/fam0001134](https://doi.org/10.1037/fam0001134)
155. Limke A, Showers C, Livingston N. Emotional disclosure and adjustment among survivors of childhood sexual abuse. *J Child Sex Abus.* 2010;19(6):662-680. doi:[10.1080/10538712.2010.522493](https://doi.org/10.1080/10538712.2010.522493)
156. Roche DN, Runtz MG, Hunter MA. Adult attachment and revictimization: a mediational model. *J Interpers Violence.* 1999;14(2):184-207. doi:[10.1177/088626099014002004](https://doi.org/10.1177/088626099014002004)
157. Fresno A, Spencer C, RamosLoyo J, et al. Emotion regulation and trauma symptoms among survivors of childhood sexual abuse. *Psychol Trauma.* 2014;6(4):384-392. doi:[10.1037/a0032975](https://doi.org/10.1037/a0032975)
158. Charest F, Hebert M, Fortin CA. Emotion regulation mediates the link between CSA and adult revictimization. *J Interpers Violence.* 2018;33(17):2707-2728. doi:[10.1177/0886260516628280](https://doi.org/10.1177/0886260516628280)
159. Alexander PC. Application of attachment theory to the study of sexual abuse. *J Consult Clin Psychol.* 2005;73(6):1115-1123. doi:[10.1037/0022006X.73.6.1115](https://doi.org/10.1037/0022006X.73.6.1115)
160. Zephyr A, McLean LM, Bourgeois C. Trauma exposure and relational functioning in adulthood: a systematic review. *Trauma Violence Abuse.* 2015;16(4):452-469. doi:[10.1177/1524838014537903](https://doi.org/10.1177/1524838014537903)
161. Jardin C, Berenz EC, Gros DF, et al. The role of emotion regulation in the association between CSA and adult psychopathology. *J Anxiety Disord.* 2017;49:1-9. doi:[10.1016/j.janxdis.2017.03.003](https://doi.org/10.1016/j.janxdis.2017.03.003)
162. Ensink K, Borelli JL, Normandin L, et al. Childhood sexual abuse and attachment: a metaanalytic review. *Dev Psychopathol.* 2020;32(1):1-18. doi:[10.1017/S0954579418001645](https://doi.org/10.1017/S0954579418001645)
163. Burton DL. Male adolescents who sexually assault: a review of the literature. *Aggress Violent Behav.* 2003;8(2):185-202. doi:[10.1016/S13591789\(01\)000597](https://doi.org/10.1016/S13591789(01)000597)
164. Burton DL, Duty KJ, Leibowitz GS. Differences between sexually victimized and nonsexually victimized male adolescent sexual abusers. *J Child Sex Abus.* 2011;20(1):77-93. doi:[10.1080/10538712.2011.539968](https://doi.org/10.1080/10538712.2011.539968)
165. Dudeck M, Spitzer C, Stopsack M, et al. Trauma exposure and posttraumatic stress disorder in incarcerated offenders. *J Nerv Ment Dis.* 2007;195(4):287-295. doi:[10.1097/01.nmd.0000243823.81894.64](https://doi.org/10.1097/01.nmd.0000243823.81894.64)
166. Levenson JS, Socia KM. Adverse childhood experiences and arrest patterns in a sample of sexual offenders. *J Interpers Violence.* 2016;31(10):1883-1911. doi:[10.1177/0886260515570751](https://doi.org/10.1177/0886260515570751)
167. Nunes KL, Hermann CA, Ratcliffe K, et al. Childhood sexual abuse, sexual coercion, and sexual aggression in community men. *Sex Abuse.* 2013;25(5):457-478. doi:[10.1177/1079063212464399](https://doi.org/10.1177/1079063212464399)
168. Salter D, McMillan D, Richards M, et al. Development of sexually abusive behaviour in sexually victimized males: a longitudinal study. *Lancet.* 2003;361(9356):471-476. doi:[10.1016/S01406736\(03\)124669](https://doi.org/10.1016/S01406736(03)124669)
169. Veneziano C, Veneziano L, LeGrand S. The relationship between childhood sexual abuse and adult sexual offending. *Sex Abuse.* 2000;12(4):275-286. doi:[10.1177/107906320001200403](https://doi.org/10.1177/107906320001200403)

170. Hanson RK, Morton-Bourgon KE. The characteristics of persistent sexual offenders: a metaanalysis of recidivism studies. *J Consult Clin Psychol*. 2005;73(6):1154-1163. doi:[10.1037/0022006X.73.6.1154](https://doi.org/10.1037/0022006X.73.6.1154)
171. Jespersen AF, Lalumière ML, Seto MC. Sexual abuse history among adult sex offenders and nonsex offenders: a metaanalysis. *Child Abuse Negl*. 2009;33(3):179-192. doi:[10.1016/j.chiabu.2008.07.004](https://doi.org/10.1016/j.chiabu.2008.07.004)
172. Briere J, Elliott DM. Prevalence and psychological sequelae of self-reported childhood physical and sexual abuse in a general population sample. *Child Abuse Negl*. 2003;27(10):1205-1222. doi:[10.1016/j.chiabu.2003.09.008](https://doi.org/10.1016/j.chiabu.2003.09.008)
173. Cutajar MC, Mullen PE, Ogloff JRP, et al. Psychopathology in a large cohort of sexually abused children followed up to 43 years. *Child Abuse Negl*. 2010;34(11):813-822. doi:[10.1016/j.chiabu.2010.04.004](https://doi.org/10.1016/j.chiabu.2010.04.004)
174. Levenson JS, Willis GM, Prescott DS. Adverse childhood experiences in the lives of male sex offenders: implications for traumainformed care. *Sex Abuse*. 2014;26(2):141-158. doi:[10.1177/1079063213486464](https://doi.org/10.1177/1079063213486464)
175. Reavis JA, Looman J, Franco KA, Rojas B. Adverse childhood experiences and adult criminality: how long must we live before we possess our own lives? *Perm J*. 2013;17(2):44-48. doi:[10.7812/TPP/12072](https://doi.org/10.7812/TPP/12072)
176. Widom CS, Maxfield MG. An update on the "cycle of violence." *Natl Inst Justice Res Pract*. Published online 2001:18. doi:[10.1037/e528142006-001](https://doi.org/10.1037/e528142006-001)
177. Glasser M, Kolvin I, Campbell D, et al. Cycle of child sexual abuse: links between being a victim and becoming a perpetrator. *Br J Psychiatry*. 2001;179:482-494. doi:[10.1192/bjp.179.6.482](https://doi.org/10.1192/bjp.179.6.482)
178. Reckdenwald A, Mancini C, Beauregard E. The cycle of violence: examining the impact of childhood maltreatment on sexual offending. *Violence Vict*. 2013;28(3):492-509. doi:[10.1891/08866708.VVD1200036](https://doi.org/10.1891/08866708.VVD1200036)
179. DeLisi M, Drury AJ, Elbert MJ, Kosloski Vaughn CT. Adverse childhood experiences, offender typologies, and violent crime. *Youth Violence Juv Justice*. 2014;12(3):223-238. doi:[10.1177/1541204013497768](https://doi.org/10.1177/1541204013497768)
180. Leach C, Stewart A, Smallbone S. Testing the sexually abused–sexual abuser hypothesis: a prospective longitudinal birth cohort study. *Child Abuse Negl*. 2016;51:144-153. doi:[10.1016/j.chiabu.2015.10.020](https://doi.org/10.1016/j.chiabu.2015.10.020)
181. Drury AJ, Elbert MJ, DeLisi M. Childhood sexual abuse is associated with increased risk of violent offending. *J Interpers Violence*. 2019;34(18):3917-3938. doi:[10.1177/0886260516674942](https://doi.org/10.1177/0886260516674942)
182. Seto MC, Stephens S, Lalumière ML, Cantor JM. The development of sexual offending: a metaanalytic review. *Clin Psychol Rev*. 2023;99:102242. doi:[10.1016/j.cpr.2022.102242](https://doi.org/10.1016/j.cpr.2022.102242)
183. Leserman J. Sexual abuse history: prevalence, health effects, and mediators. *Psychosom Med*. 2005;67(6):906-915. doi:[10.1097/01.psy.0000188405.54425.e0](https://doi.org/10.1097/01.psy.0000188405.54425.e0)
184. Romans SE, Martin JL, Anderson JC, Herbison GP, Mullen PE. Sexual abuse in childhood and deliberate selfharm. *Am J Psychiatry*. 2007;164(1):66-73. doi:[10.1176/ajp.2007.164.1.66](https://doi.org/10.1176/ajp.2007.164.1.66)
185. Centers for Disease Control and Prevention. *Childhood Sexual Abuse: Prevention, Data, and Resources*. US Department of Health and Human Services; 2025.
186. McCain JL, Herbst JH, Merrill-Francis M, Willis LA, Miedema SS, Shortt JW. Review of policies and practices to prevent technology-facilitated child sexual abuse within youth-serving organizations in the United States. *J Child Sex Abus*. 2024;33(5):545-564. doi:[10.1080/10538712.2024.2381457](https://doi.org/10.1080/10538712.2024.2381457)
187. WeProtect Global Alliance. *Global Threat Assessment 2025: Preventing Technology-Facilitated Child Sexual Exploitation and Abuse: From Insights to Action*. WeProtect Global Alliance; 2025. Accessed June 8, 2026. <https://www.weprotect.org/global-threat-assessment-25/>
188. Bohus M, Kleindienst N, Hahn C, Müller-Engelmann M, Ludäscher P, Steil R, et al. Dialectical behavior therapy for posttraumatic stress disorder (DBT-PTSD) compared with cognitive processing therapy (CPT) in complex presentations of PTSD in women survivors of childhood abuse: a randomized clinical trial. *JAMA Psychiatry*. 2020;77(12):1235-1245. doi:[10.1001/jamapsychiatry.2020.2148](https://doi.org/10.1001/jamapsychiatry.2020.2148)

189. Bohus M, Dyer AS, Priebe K, Krüger A, Kleindienst N, Schmahl C, et al. Dialectical behaviour therapy for post-traumatic stress disorder after childhood sexual abuse in patients with and without borderline personality disorder: a randomized controlled trial. *Psychother Psychosom*. 2013;82(4):221-233. doi:[10.1159/000348451](https://doi.org/10.1159/000348451)

190. McLeod P, Polowy CI. Law Note: Social Workers and Child Abuse Reporting: A Review of State Mandatory Reporting Requirements. National Association of Social Workers. 2000. Accessed June 8, 2026. <https://www.socialworkers.org/About/Legal/Law-Notes/Social-Workers-and-Child-Abuse-Reporting>

191. Centers for Disease Control and Prevention. Sexual Health Education. Centers for Disease Control and Prevention. 2024. Accessed June 8, 2026. <https://www.cdc.gov/healthy-youth/what-works-in-schools/sexual-health-education.html>

192. Prevent Child Abuse America. Prevention School-Based Curricula. Prevent Child Abuse America. Accessed June 8, 2026. <https://preventchildabuse.org/resources/prevention-school-based-curricula/>

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