



The European Journal of Psychology Applied to Legal Context

<https://journals.copmadrid.org/ejpalc>



Forensic Psychological Harm in Victims of Child Sexual Abuse: A Meta-analytic Review

Blanca Cea¹, Álvaro Montes¹, Alexander Trinidad², and Ramón Arce¹

¹Universidad de Santiago de Compostela, Spain; ²University of Cologne, Germany

ARTICLE INFO

Article history:

Received 30 April 2025

Accepted 21 July 2025

Keywords:

Posttraumatic stress disorder
Forensic evaluation
Victimization
Burden of proof
Forensic expertise
Compensation to victims

ABSTRACT

Background/aim: In child sexual abuse (CSA) cases, the forensic evaluation of psychological harm is crucial for substantiating victim testimony and informing compensation awards. Posttraumatic Stress Disorder (PTSD) is the primary diagnosis for assessing forensic harm, as it establishes the causal link between the harm and the CSA event. Thus, a meta-analysis was conducted to estimate the effect of CSA victimization on PTSD development and the probability of resulting psychological harm, and to determine the incremental harm attributable to CSA victimization. **Method:** A total of 126 primary studies were selected, yielding 195 effect sizes and a cumulative sample of 29,517 victims. Random effects psychometric meta-analyses were performed, correcting effect sizes for sampling error and criterion unreliability to obtain the true effect size (δ). **Results:** An overall large true effect size ($\delta = 0.93$) was found between CSA victimization and PTSD outcomes. Given the heterogeneity of the studies, moderating variables were examined, revealing that female victims ($\delta = 0.99$), intrafamilial abuse ($\delta = 1.68$) and penetrative acts ($\delta = 1.23$) were associated with significantly higher psychological harm attributable to CSA victimization than males ($\delta = 0.68$), extrafamilial abuse ($\delta = 1.24$) and non-penetrative sexual touching ($\delta = 1.01$), respectively. The prevalence of PTSD diagnosis in CSA survivors was estimated at 33.95%. The incremental harm due to CSA victimization was estimated at 42.2% in general, with specific higher rates for intrafamilial abuse (64.3%) and for victims of penetration (54.4%). **Conclusions:** These findings provide robust evidence of the psychological harm (PTSD) resulting from CSA victimization and identify specific abuse characteristics that exacerbate such a harm. The judicial implications for the burden of proof are discussed and gold standards for civil compensation to victims are suggested as follows: a general gold standard of 42.2% for victims of CSA, and higher gold standards for victims of intrafamilial abuse (64.3%) and victims of penetration (54.4%).

Daño psicológico forense en víctimas de abuso sexual infantil: una revisión metaanalítica

RESUMEN

Antecedentes/objetivo: En casos de abuso sexual infantil (ASI), la evaluación forense del daño psicológico es crucial para sustentar el testimonio de la víctima y estimar las compensaciones. El Trastorno de Estrés Postraumático (TEPT) es el diagnóstico primario para establecer dicho daño, ya que establece el nexo causal entre la sintomatología y la victimización. Por ello, se realizaron metaanálisis con el objetivo de cuantificar el efecto de la victimización por ASI en el desarrollo del TEPT, estimar la probabilidad de daño psicológico y determinar el incremento del daño atribuible a dicha victimización. **Método:** Se seleccionaron un total de 126 estudios primarios, de los que se extrajeron 195 tamaños del efecto, con una muestra acumulada de 29,517 víctimas. Se ejecutaron metaanálisis psicométricos de efectos aleatorios, corrigiendo los tamaños del efecto por error de muestreo y fiabilidad del criterio para obtener el tamaño del efecto verdadero (δ). **Resultados:** Los resultados mostraron, para la relación entre la victimización por ASI y el daño psicológico, un tamaño del efecto verdadero promedio general de magnitud grande ($\delta = 0.93$). Dada la heterogeneidad en los estudios primarios, se examinaron los efectos de las variables moderadoras, encontrando que las mujeres y niñas víctimas ($\delta = 0.99$), de abuso intrafamiliar ($\delta = 1.68$) y de abuso con penetración ($\delta = 1.23$) presentaron un daño psicológico significativamente mayor que los hombres y niños víctimas ($\delta = 0.68$), de abuso extrafamiliar ($\delta = 1.24$) y de tocamientos sin penetración ($\delta = 1.01$), respectivamente. La prevalencia del diagnóstico de TEPT en víctimas de ASI se estimó en un 33.95 %. El incremento del daño psicológico atribuible a la victimización por ASI se estimó en un 42.2 % en general, con estimaciones mayores para las víctimas de abuso intrafamiliar (64.3 %) y para las víctimas de penetración (54.4 %). **Conclusiones:** Los resultados dan pruebas convincentes del daño psicológico (TEP) a consecuencia

Palabras clave:

Trastorno de estrés postraumático
Evaluación forense
Victimización
Carga de la Prueba
Pericial forense
Compensación a víctimas

Cite this article as: Cea, B., Montes, A., Trinidad, A., & Arce, R. (2025). Forensic psychological harm in victims of child sexual abuse: A meta-analytic review. *European Journal of Psychology Applied to Legal Context*, 7(2), 111-129. <https://doi.org/10.5093/ejpalc2025a10>

Correspondence: ramon.arce@usc.es (R. Arce).

ISSN: 1889-1861/© 2025 Colegio Oficial de la Psicología de Madrid. This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).

de la victimización del abuso sexual infantil (ASI) y detectan características que agravan dicho daño. Se comentan las implicaciones jurídicas del peso de la prueba y se proponen criterios de referencia para compensar civilmente a las víctimas: un criterio de referencia general del 42.2% para las víctimas del ASI y mayor aún para las víctimas de abuso intrafamiliar (64.3%) y de penetración (54.4%).

Child sexual abuse (CSA) represents a severe manifestation of child maltreatment and constitutes a severe violation of children's rights (Simon et al., 2020; United Nations [UN, 1989]). It is recognized as one of the most harmful forms of trauma, associated with a wide range of adverse outcomes, including physical (Downing et al., 2021; Irish et al., 2010; Pulverman et al., 2018), psychological (Fergusson et al., 2013; Gardner et al., 2019; Hashim et al., 2024), behavioral (Hailes et al., 2019; Mii et al., 2024), social (Batoool, 2017; Daignault & Hebert, 2009), and sexual problems (Labadie et al., 2018; Wang et al., 2023). According to a recent study examining literature from 1990 to 2023, the estimated worldwide prevalence of CSA was approximately 19% for females (with variations between 16.0 and 25.2%) and 15% for males (with variations between 9.5 and 23.5%) (Cagney et al., 2025), highlighting the alarming scale of this phenomenon.

CSA research is subject to methodological issues due to varying legal definitions across different regions and countries, depending on factors such as the age of sexual consent, whether an age difference between parties is specified, and the types of acts that constitute sexual abuse (Kilimnik et al., 2018; Mathews & Collin-Vézina, 2019). Given these wide variations, the World Health Organization [WHO, 1999] established a universal criterion, defining CSA as “the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared” (pp. 15-16). Thus, CSA typically involves activity between a child and an adult—or another child who holds a position of responsibility, trust, or power due to age or development—with the activity intended for sexual gratification. Consequently, CSA encompasses a range of acts, including non-contact abuse (e.g., exposure, unwanted sexual propositions), contact abuse (e.g., fondling, genital touching), and intercourse (anal, vaginal, or oral penetration) (Fergusson et al., 2013; Finkelhor, 1994).

In a judicial setting, as defined by UN (1985), a victim is characterized by the harm suffered as a consequence of a crime. This harm can vary in nature, including emotional suffering or psychological injury. Forensic psychological evaluation assesses this injury by quantifying the effects of the alleged crime on the victim's mental health (Seymour et al., 2013; Vilariño et al., 2013; Young et al., 2025), thereby documenting evidence of the CSA victimization and supporting the victim's testimony (Arce, 2017; Goodman-Delahunty & Foote, 2009; Vallano et al., 2013). This assessment becomes crucial in CSA cases, where direct corroborating evidence, such as eyewitness or physical findings is often scarce, frequently leaves the complainant's evaluation as the primary source of information (Herman, 2010; Hershkowitz et al., 2018).

Within the scope of these forensic evaluations, psychological harm assessment focuses on posttraumatic stress disorder (PTSD) or acute stress disorder (ASD; limited to the period from 3 days to 1 month following the traumatic event). These psychiatric disorders are distinct from other disorders because they require that the clinical symptoms be directly linked to the traumatic event (Criterion A) (Blanchard & Hickling, 2004; Ellekilde et al., 2021; McCloskey & Walker, 2000). According to the DSM-5-TR (American Psychiatric Association [APA, 2022]), a PTSD diagnosis entails the presence of symptoms distributed across four clusters: (1) intrusion symptoms (e.g., re-experiencing the trauma through memories, nightmares, flashbacks); (2) avoidance (efforts to evade trauma-related stimuli); (3) negative alterations in cognitions and mood (e.g., persistent negative beliefs, emotional numbing); and (4) alterations in arousal and reactivity (e.g., hypervigilance, exaggerated startle response,

irritability). Furthermore, in a judicial setting, the suspicion of malingering (the intentional simulation or exaggeration of symptoms) must be assessed in line with the presumption of innocence principle (no innocent should be sentenced) (Arce, 2017; Melton et al., 2017; Puente-López et al., 2024). Additionally, to establish a causal link, the evaluation must rule out other stressful life events experienced by the victim as the cause of their symptomatology (Young et al., 2025).

Regarding comorbidity, PTSD frequently co-occurs with other mental health conditions, including depression or anxiety disorders (Kessler et al., 2005; MacDonald et al., 2010; Mureşanu et al., 2022; Oquendo et al., 2003). In a forensic setting, such comorbid conditions, in the absence of a primary PTSD diagnosis, are insufficient evidence of psychological harm because they fail to establish a causal link between the victimization by CSA and the reported psychological harm (Arce, 2018; Goodman-Delahunty & Foote, 2009; Melton et al., 2017). Nevertheless, the presence of these disorders alongside PTSD typically indicates a greater severity of psychological harm (Kessler et al., 2005; Konstantopoulou et al., 2024; Marshall et al., 2001). Furthermore, PTSD subsyndromes (when a victim experiences significant PTSD symptoms but Criterion A—in our case, CSA victimization—is not fulfilled) do not meet the threshold required to constitute forensic psychological harm (O'Donnell et al., 2006).

In relation to its course, the duration of PTSD can be extensive, sometimes lasting for more than 50 years (i.e., a lifespan) (APA, 2022). The disorder can manifest with a delayed onset (at least 6 months passing between the traumatic event–CSA victimization—and the onset of full PTSD symptoms; APA, 2022). It can also manifest with delayed expression, in which some symptoms appear immediately after the event but meeting the full criteria is delayed (APA, 2022). This delayed presentation is particularly relevant, as significant symptoms may not manifest during childhood but can emerge or become more pronounced in adulthood (Ellekilde et al., 2021; O'Donnell et al., 2013).

This delayed onset is particularly relevant considering that young children may not exhibit internalizing symptoms necessary for the forensic evaluation mandate of establishing a causal link between the CSA victimization and the PTSD (J. A. Cohen et al., 2010; Dyregrov & Yule, 2006; Scheeringa et al., 1995); instead, the immediate impact of trauma often manifests through behavioral dysregulation or distress reactions (McLaughlin & Peverill, 2020). Moreover, the trajectory of PTSD is not uniform, involving periods of chronic symptoms, or waxing and waning of symptoms. (Handiso et al., 2025; Miller-Graff & Howell, 2015; Putnam & Trickett, 1993).

Although the psychological impact on CSA survivors might be broadly perceived as uniform, the literature has identified potential factors that moderate the risk for developing PTSD and its severity (APA, 2022; McTavish et al., 2019). These factors, in a context of CSA victimization, include individual characteristics, such as the victim's age and gender (Assink et al., 2019; Bulik et al., 2001) or history of prior trauma (Gould et al., 2021; Suliman et al., 2009), specific characteristics of the abuse, like the type of acts (e.g., no contact, contact, intercourse) (Fergusson et al., 2013; Jonas et al., 2011), the victim-perpetrator relationship (Koçtürk & Yüksel, 2019; Molnar et al., 2001), and the duration of the abuse (Batchelder et al., 2021; Gokten & Uyulan, 2021). Post-abuse experiences can also shape the outcomes, such as the availability of social support after disclosure (Cea et al., 2022; Fletcher et al., 2021) and interaction with the judicial system (Campbell & Raja, 1999; Quas & Goodman, 2012).

Given the acknowledged heterogeneity in PTSD outcomes (Alves et al., 2024; Haag et al., 2023) and contradictory findings regarding

how specific characteristics of abuse affect psychological harm in CSA survivors (Boumpa et al., 2024; Hailes et al., 2019; McLean et al., 2014; Nagtegaal & Boonmann, 2022), this study suggests a meta-analysis to synthesize existing research. The primary objectives were to determine the effect of CSA victimization on PTSD development, the probability of resultant psychological harm, and the incremental harm attributable to CSA victimization. Additionally, to better understand the observed outcome variability, this investigation examined key moderators identified in literature, including measurement type (diagnosis and symptom severity), victim gender, abuse type, and perpetrator relationship. Such findings are crucial for advancing forensic assessment and informing evidence base for economic compensations to victims' harm with delayed onset or expression (UN, 1989).

Method

Search of Studies

The literature search aimed to identify those studies addressing the development of PTSD or ASD in victims of CSA. To achieve this, a comprehensive and sensitive multi-source search was conducted employing several meta-search strategies. First, existing systematic and meta-analytic reviews on this topic were identified, and the primary studies that they include were examined. Subsequently, systematic searches were conducted in scientific references databases (Web of Science, Scopus, Pubmed, PsycInfo, and Dialnet), in the ProQuest Dissertations & Theses databases, and in the academic search engine Google Scholar. In the initial search, terms were combined as follows: (child*) AND (sexual abuse OR sexual victimization OR sexual maltreatment) AND (post-traumatic stress disorder) OR (acute stress disorder). To these initial descriptors, those identified in the sources (e.g., adolescent sexual abuse, child molestation, child sexual violence, CSA survivors, incest, childhood sexual trauma,) were added until an exhaustive search was completed. Additionally, a "snowball" procedure was conducted by screening the bibliographies of eligible articles for further potentially suitable studies.

Study Selection Criteria

Studies were included if they met the following inclusion criteria: (1) participants reported exposure to CSA prior to the age of 18 years (WHO, 1999), the study clearly set the definition of CSA used and the criteria for classifying participants as victims (e.g., self-reported or substantiated); (2) studies provided descriptive data on the sample characteristics (e.g., gender, age, sample size); (3) studies reported an evaluation of PTSD (or ASD), either as a dichotomous variables (e.g., a psychologist/psychiatric diagnosis or meeting a specific cutoff on a scale) or as continuous variable (i.e., a measure of symptom severity using psychometric instruments); and (4) studies reported the effect sizes for the association between CSA and PTSD/ASD, or provided sufficient data from which an effect size could be derived.

Studies not meeting the specified criteria were excluded from this review. Specifically, studies were excluded if they did not report a direct and isolated effect of CSA on PTSD. This includes studies referring to general childhood abuse without a specific focus on CSA; studies comparing CSA with other forms of maltreatment (such as physical abuse or neglect) without distinctly reporting the CSA-PTSD association; and studies where the CSA-PTSD relationship was only reports within multivariate models (e.g., multiple regressions), as the effect in such models is inherently presented as moderated by or adjusted for other covariates. Furthermore, studies were excluded if they did not provide a general measure of PTSD, offering instead only subscales scores or specific symptoms. Exclusion also was applied to

studies for which the data required for calculating effect sizes were unavailable, even after contacting the authors. Additionally, studies presenting data errors, such as unexplained inconsistencies in group sizes not attributable to missing data, were removed. Finally, to ensure the independence of samples, if multiple publications reported on the same or overlapping samples, the study providing the most comprehensive information was selected.

After the screening, 126 primary studies were selected (see PRISMA flowchart in Figure 1), with a cumulative sample of 89,341 subjects, of whom 29,517 were CSA survivors, obtaining a total of 195 effect sizes (see Appendix).

Data Extraction

The data from the included studies were coded according to the following categories: a) primary study reference; b) document type (i.e., journal article, doctoral thesis, conference proceeding, book, unpublished study); c) sample characteristics (i.e., size, age, gender, country, data collection context); d) measures of PTSD or ASD (i.e., clinical diagnosis, symptom severity scores); e) measures of CSA (i.e., self-report, official records, validated questionnaire); f) reliability of the measurement instruments; and g) moderators (i.e., gender, type of abuse, relationship with the perpetrator, type of PTSD measure). The Appendix presents a summary of the characteristics of the primary studies included in the present meta-analysis.

All the studies were coded independently by two experienced and trained researchers. To ensure consistency, each rater re-coded 50% of the studies (for intra-rater reliability). Both between-rater and within-rater agreement were assessed using the true kappa (Fariña et al., 2002). This measure corrects for chance agreement and ensures only exact coding matches are considered agreements, controlling for systematic error. The assessment revealed total concordance ($\kappa = 1$); thus, the coding process was deemed reliable, indicating that other trained raters would likely achieve the same results (Wicker, 1975). In relation to moderators, a successive approach procedure was employed (Vilarinho et al., 2013) to identify and define moderators. This consisted of scanning by the two raters the selected papers searching for moderators. Identified potential moderators and categories were discussed and a consensus was reached by the raters. As a result, four moderators of relevance for a testimony were coded: 1) gender (categories: male and female), 2) type of abuse (categories: no-contact, touching and penetration), 3) victim-perpetrator relationship (categories: intrafamilial and extrafamilial perpetrator), and type of PTSD measure (categories: diagnosis and symptom severity).

Data Analysis

Random effects psychometric meta-analyses of primary studies were performed (Schmidt & Hunter, 2015). Initially, effect sizes were standardized as Cohen's d . These were either extracted directly from primary studies or transformed from other statistics (e.g., odds ratio, r , χ^2) using established formulas (J. Cohen, 1988; Rosenthal, 1994). When means and standard deviations were available for PTSD measures for each group, Cohen's d was computed (or Hedges' g in cases of unequal sample sizes or heterogeneity of variances); when data for PTSD were provided in probabilities prevalence ratio or Cohen's h was computed and converted to Cohen's d ; when other statistics (e.g., χ^2) were reported in the primary studies, Cohen's d was estimated; and when other than Cohen's d effect size for the relationship between PTSD and CSA victimization (e.g., odds ratios, correlation coefficients) were reported in primary studies, they were converted to Cohen's d . For studies reporting multiple effect sizes across distinct subsamples, a weighted composite score was derived to establish an overall effect size. In cases where a study lacked a control comparison group, the

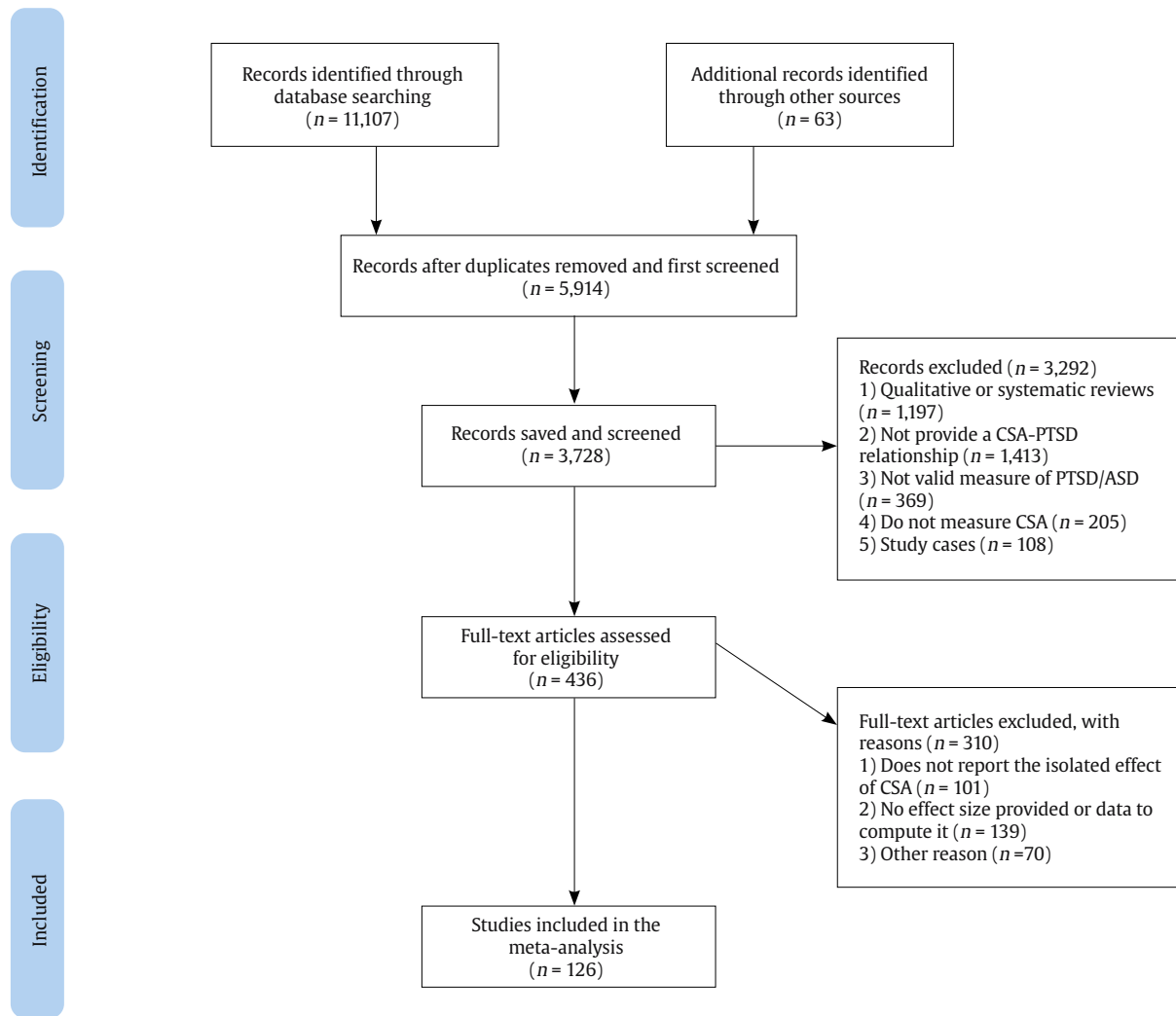


Figure 1. PRISMA Flow Diagram for Study Selection

normative sample from the creation and validation study of the psychometric PTSD instrument was employed as the control group.

Following this, effect sizes were adjusted for sampling error and, where applicable, for criterion unreliability. Consequently, the following key statistics were calculated: the effect size weighted for sampling error (d_w), the standard deviation of d (SD_d), the standard deviation of d predicted by artifactual errors (SD_{pre}), the residual standard deviation after removal of variance due to artifactual errors (SD_{res}), the mean true effect size, representing d also corrected for criterion unreliability (δ), along with its standard deviation ($SD\delta$), the percentage of variance explained by artifactual errors (%Var); the 95% confidence interval for d (95% CI $_d$), and the 80% confidence interval for δ (80% CI $_\delta$). Statistical significance was determined using the 95% CI $_d$, if this interval excluded zero, the average effect size was considered significant. Generalizability was assessed using the 80% CI $_\delta$, a lower limit above zero suggested the finding would likely extend to a substantial proportion (e.g., 90%) of potential studies. Additionally, & VAR was examined, with values below 75% (Hunter et al., 1982) indicating heterogeneity and the potential presence of moderators.

The magnitude of the mean true effect size (δ) was interpreted qualitatively using Cohen's (1988) established categories: "small" ($d = 0.20$), "moderate" ($d = 0.50$), and "large" ($d = 0.80$); occasionally augmented with "more than large" category for $d > 1.20$ (Arce et al., 2015). To assess the quantitative implications for forensic practice,

the Probability of Superiority (PS_{ES}) was calculated (Monteiro et al., 2018; Montes et al., 2022). PS_{ES} is an estimation of the probability that the score of a person from the CSA victim group will exceed the score of a person from the control group (e.g., $d = 1.20$ corresponds to $PS_{ES} = .8023$, indicating the effect size is larger than 80.23% of all possible effect sizes; $d = 0.80$ to $PS_{ES} = .7157$; $d = 0.50$ to $PS_{ES} = .6368$; and $d = 0.20$ to $PS_{ES} = .5557$). Finally, a variation of the BESD (Corrás et al., 2017) was used to estimate the severity of the psychological harm.

Criterion Unreliability

Effect sizes were corrected for both sampling error and the unreliability of the PTSD criterion measure. Reliability estimates for the PTSD measure were sourced directly from the primary studies whenever available; otherwise, they were obtained from instrument validation studies.

Results

Analysis of Atypical Values

An exploratory analysis of the distribution of primary data revealed one effect size ($d = 6.86$; Gwandure, 2007) classified

as an extreme value ($\pm 3 * \text{IQR}$) and another effect size ($d = 4.84$; Costa et al., 2016) classified as an outlier ($\pm 1.5 * \text{IQR}$). Given their exceptionally high magnitudes, the observed values of these effects indicated they were unlikely to represent merely inconvenient or spurious findings. Consequently, both effect sizes were removed from the meta-analysis.

Overall Effect

The meta-analytic results for the overall effect of CSA on PTSD (see Table 1) exhibited a significant, $Z = 16.49$, $p < .001$, positive (confirming a positive relationship between child sexual abuse victimization and suffering PTSD), generalizable (the minimum expected effect, lower bond, was $\delta = 0.19$) across studies and of a large magnitude ($\delta > 0.80$) mean true effect size ($\delta = 0.93$; an effect size above 74.5% of all possible effects, $PS_{ES} = .745$). In terms of quantifying such injury, the individuals with a history of CSA (CSA victims) reported 42.2% ($r = .422$) higher severity on PTSD measures (incremental harm due to victimization) than of those without such a history (CSA non-victims).

Nevertheless, the effect sizes derived from the primary studies were heterogeneous: all artifacts accounted for 1.94% of δ observed variance, which is below the 75% threshold criterion, indicating that the variability in the overall effect is influenced by moderators (i.e., the remaining variance is systematic). The content analysis of the primary studies identified four potential moderators for further examination: victim gender (female and male), type of PTSD measure (diagnosis and symptom severity), relationship between the perpetrator and the victim (intrafamilial and extrafamilial perpetrator), and the type of abuse (no-contact, touching and penetration).

Study of the Psychological Harm Measurement Type Moderator

Two categories of outcome measures for PTSD were observed in the primary studies: PTSD diagnosis (a clinical categorical measure) and the severity of the harm (a quantitative psychometric measure). The diagnosis category included studies where the PTSD diagnosis was made by a clinician, psychologist or psychiatrist, or when a validated scale was applied specifying a cutoff point above which a clinically significant PTSD diagnosis was established. On the other hand, the severity of injury was measured by applying psychometric instruments designed to evaluate PTSD symptoms.

Firstly, examining the results for PTSD diagnosis (see Table 2), the analysis displayed a significant, $Z = 11.27$, $p < .001$, positive (higher

diagnosis of PTSD in CSA victims than in CSA non-victims), and of large magnitude ($\delta > 0.80$) mean true effect size ($\delta = 0.96$; an effect size above 75.2%, $PS_{ES} = .752$). This effect was found to be generalizable across studies (lower bond of the credibility interval = 0.22), but with heterogeneous distribution of the population effect sizes (the artifactual components of variance in δ accounted for 1.96% of the total variance), suggesting that the overall effect is mediated by moderators. Addressing the impact of psychological harm, when the observed mean effect size was converted to a probability, it indicated that CSA victims have a 21.3% increased probability ($p = .213$) of meeting a PTSD diagnosis over non-victims.

Additionally, regarding the overall prevalence, data from a subset of studies ($k = 73$, cumulative $N = 12,993$) that directly reported the probability of PTSD diagnoses among individuals with a history of CSA were used. A weighted prevalence calculated from this subset yielded an estimated PTSD prevalence of 33.95% in CSA survivors.

Likewise, the results for the PTSD symptom severity (psychometric measure) (see Table 2) illustrated a significant, $Z = 11.55$, $p < .001$, positive (high severity in CSA victims) and of a large magnitude ($\delta > 0.80$) mean true effect size of $\delta = 0.89$ (effect size above 73.6% of all possible effects, $PS_{ES} = .736$). Quantitatively, victims of child sexual abuse endorsed a greater 40.7% ($r = .407$) score in PTSD symptom severity (incremental harm linked to victimization) than non-victims. This effect also appears to be generalizable (credibility interval lower bond = 0.18), but influenced by moderators (2.97% of variance attributable to artifacts).

Comparing these two measurement approaches for psychological harm, the analysis revealed that the observed effect was significantly higher when measured via PTSD diagnosis ($\delta = 0.96$) than when measured in terms of symptom severity ($\delta = 0.89$), $q(N = 1,480) = .096$, $Z = 2.61$, $p = .009$.

Study of the Effect of the Gender Moderator

The meta-analytic results for female victims (see Table 3) displayed a significant, $Z = 10.26$, $p < .001$, positive (female CSA victims scored higher in PTSD than CSA non-victims), generalizable across studies (minimum expected effect, lower bound was 0.23), and of a large magnitude ($\delta > 0.80$) mean true effect size ($\delta = 0.99$, above 75.8% of all effects, $PS_{ES} = .758$). As for severity of psychological harm, female victims reportedly experienced 44.4% ($r = .444$) more PTSD (incremental harm due to victimization) than non-victims.

As for male victims (see Table 3), the analysis revealed a significant, $Z = 6.37$, $p < .001$, positive (male CSA victims scored higher in PTSD

Table 1. Meta-analyses of the Overall Effect of CSA Victimization and Forensic Psychological Harm (PTSD)

k	N_T	N_E	d_w	SD_d	SD_{pre}	SD_{res}	δ	SD_δ	% Var	80% CI_δ
Overall effect										
129	89,341	29,517	0.91	0.57	0.08	0.57	0.93	0.58	1.94	[0.19, 1.68]

Note. k = number of effect sizes; N_T = total sample size; N_E = CSA group sample size d = sample size weighted mean effect size; SD_d = standard deviation of d ; SD_{pre} = standard deviation predicted for sampling error alone; SD_{res} = standard deviation of d after removing sampling error variance; δ = mean true effect size; SD_δ = the standard deviation of δ ; % var = percent of observed variance accounted by artifactual errors; 80% CI_δ = 80% credibility interval for δ .

Table 2. Meta-analyses of CSA Victimization and Forensic Psychological Harm (PTSD) Type of PTSD Measure Moderator

k	N_T	N_E	d_w	SD_d	SD_{pre}	SD_{res}	δ	SD_δ	% Var	80% CI_δ
Measure of the effect: Diagnosis of PTSD										
84	57,400	22,457	0.96	0.58	0.08	0.57	0.96	0.58	1.96	[0.22, 1.70]
Measure of the effect: Symptom Severity of PTSD										
43	31,941	6,871	0.84	0.53	0.77	0.52	0.89	0.56	2.97	[0.18, 1.61]

Note. k = number of effect sizes; N_T = total sample size; N_E = CSA group sample size d = sample size weighted mean effect size; SD_d = standard deviation of d ; SD_{pre} = standard deviation predicted for sampling error alone; SD_{res} = standard deviation of d after removing sampling error variance; δ = mean true effect size; SD_δ = the standard deviation of δ ; % var = percent of observed variance accounted by artifactual errors; 80% CI_δ = 80% credibility interval for δ .

Table 3. Meta-analyses of CSA Victimization and Forensic Psychological Harm (PTSD) for the Gender Moderator

<i>k</i>	N_T	N_E	d_w	SD_d	SD_{pre}	SD_{res}	δ	SD_δ	% Var	80% CI_δ
Victim gender: Female										
47	22,771	9,204	0.95	0.58	0.10	0.57	0.99	0.59	2.78	[0.23, 1.75]
Victim gender: Male										
20	7,469	2,141	0.65	0.42	0.11	0.40	0.68	0.42	6.59	[0.14, 1.22]

Note. k = number of effect sizes; N_T = total sample size; N_E = CSA group sample size d = sample size weighted mean effect size; SD_d = standard deviation of d ; SD_{pre} = standard deviation predicted for sampling error alone; SD_{res} = standard deviation of d after removing sampling error variance; δ = mean true effect size; SD_δ = the standard deviation of δ ; % var = percent of observed variance accounted by artifactual errors; 80% CI_δ = 80% credibility interval for δ .

Table 4. Meta-analyses of CSA Victimization and Forensic Psychological Harm (PTSD) for the Perpetrator Relationship Moderator

<i>k</i>	N_T	N_E	d_w	SD_d	SD_{pre}	SD_{res}	δ	SD_δ	% Var	80% CI_δ
Perpetrator relationship: Intrafamilial										
9	1,185	457	1.62	0.42	0.20	0.37	1.68	0.37	24.40	[1.21, 2.15]
Perpetrator relationship: Extrafamilial										
8	1,395	667	1.20	0.62	0.17	0.60	1.24	0.61	7.38	[0.46, 2.02]

Note. k = number of effect sizes; N_T = total sample size; N_E = CSA group sample size d = sample size weighted mean effect size; SD_d = standard deviation of d ; SD_{pre} = standard deviation predicted for sampling error alone; SD_{res} = standard deviation of d after removing sampling error variance; δ = mean true effect size; SD_δ = the standard deviation of δ ; % var = percent of observed variance accounted by artifactual errors; 80% CI_δ = 80% credibility interval for δ .

than CSA non-victims), generalizable across studies (minimum expected effect, lower bound was 0.14), mean true effect size ($\delta = 0.68$). However, the magnitude of the effect was moderate ($0.50 < \delta < 0.80$), above 68.4% of all effects, $PS_{ES} = .684$. Regarding incremental harm, male victims of child sexual abuse reported 32.2% ($r = .322$) greater severity in PTSD symptoms than non-victims.

Nevertheless, for both female and male groups, the data from the primary studies exhibited significant heterogeneity. Artifactual components of variance in the observed effect sizes accounted for 2.78% of the total variance for the female-specific data and 6.59% for the male-specific data (under the 75% rule), suggesting that moderators influenced the observed true mean effects.

A comparison of the effect sizes for females ($\delta = 0.99$) and males ($\delta = 0.68$) showed that psychological harm was significantly higher in females, $q(N = 11247) = 0.143$, $Z = 10.72$, $p < .001$. These gender differences were also reflected in prevalence rates (derived as weighted prevalences from subsets of studies), with a PTSD diagnosis of 39.81% in female victims ($k = 24$, $N = 3,547$), compared to 24.23% among male victims ($k = 12$, $N = 1,118$).

Study of the Effect of the Victim-perpetrator Relationship Moderator

Victims in primary studies were classified as having been abused by intrafamilial or extrafamilial perpetrators.

The results of the meta-analysis of psychological harm experiences by victims of intrafamilial sexual abuse (see Table 4) showed a significant, $Z = 8.23$, $p < .001$, positive (CSA victims of intrafamilial perpetrators scored higher in PTSD than CSA non-victims), and more

than large magnitude ($\delta > 1.20$) mean true effect size ($\delta = 1.68$; above 88.3% of all effects, $PS_{ES} = .883$). This effect was generalizable (lower bound of the credibility interval = 1.21), but heterogeneous, % Var = 24.40, suggesting that the overall effect is mediated by moderators.

For victims of extrafamilial sexual abuse, the results (see Table 4) displayed a significant, $Z = 7.65$, $p < .001$, positive (CSA victims of extrafamilial perpetrators scored higher in PTSD than CSA non-victims), and of a more than large magnitude ($\delta > 1.20$) mean true effect size ($\delta = 1.24$; above 81.1% of all effects, $PS_{ES} = .811$). Moreover, these results were generalizable (the minimum expected effect, lower bound = 0.46), but influenced by moderators (% Var = 7.38).

Comparatively, psychological harm resulting from intrafamilial abuse was significantly greater, $q(N = 1281) = 0.177$, $Z = 4.47$, $p < .001$, with victims abused by intrafamilial perpetrators experiencing 64.3% ($r = .643$) more psychological harm (incremental harm due to victimization) than non-victims, whereas victims of extrafamilial abuse reported 52.7% ($r = .527$) more psychological harm than non-victims.

Effect of the Type of Abuse

Information regarding the type of sexual abuse described in the primary studies was coded into three categories: no-contact abuse (sexual exposure without direct contact, like public masturbation or unwanted sexual propositions); touching (episodes involving physical contact such as sexual fondling or genital touching); and penetration (any form of sexual abuse involving vaginal, oral, or anal intercourse).

For the no-contact abuse moderator (see Table 5), the primary studies ($k = 3$) exhibited a non-random distribution, with a total

Table 5. Meta-analyses of CSA Victimization and Forensic Psychological Harm (PTSD) for Type of Abuse Moderator

<i>k</i>	N_T	N_E	d_w	SD_d	SD_{pre}	SD_{res}	δ	SD_δ	% Var	80% CI_δ
Type of abuse: no contact										
3	857	48	0.71	0.15	-----	-----	0.76	-----	-----	-----
Type of abuse: touching										
8	1,554	678	0.96	0.78	0.15	0.76	1.01	0.77	4.12	[0.03, 1.99]
Type of abuse: penetration										
8	1,414	538	1.17	0.65	0.16	0.63	1.23	0.64	6.69	[0.41, 2.05]

Note. k = number of effect sizes; N_T = total sample size; N_E = CSA group sample size d = sample size weighted mean effect size; SD_d = standard deviation of d ; SD_{pre} = standard deviation predicted for sampling error alone; SD_{res} = standard deviation of d after removing sampling error variance; δ = mean true effect size; SD_δ = the standard deviation of δ ; % var = percent of observed variance accounted by artifactual errors; 80% CI_δ = 80% credibility interval for δ .

sample size of 857, distributed in individual study samples of 3, 17, and 837 participants (the largest study comprising 97.7% of the total). Therefore, although the observed mean true effect size ($\delta = 0.76$) was positive and significant, $Z = 6.18$, $p < .001$, it is not considered generalizable to other studies, requiring more research to ascertain the generalizable effect of no-contact abuse on PTSD outcomes.

In turn, the meta-analytic results for the touching abuse moderator (see Table 5) showed a significant, positive (higher scores in PTSD in touching abuse victims than in non-victims), $Z = 6.59$, $p < .001$, generalizable across studies (the lower bond of the credibility interval was 0.03) and of large magnitude ($\delta > 0.80$). Nevertheless, the effect sizes from the primary studies were heterogeneous (% Var = 4.12%), suggesting the influence of moderators.

Meanwhile, for abuse involving penetration (see Table 5), the results illustrated a significant, $Z = 7.46$, $p < .001$, positive (higher scores in PTSD in penetration abuse victims than in non-victims), and more than large magnitude ($\delta > 1.20$) mean true effect size ($\delta = 1.23$, above 80.8% of all effects, $PS_{ES} = .808$). It was also generalizable across studies (the minimum expected effect, lower bound was 0.41). However, the distribution of the effects also showed evidence for moderators (% Var = 6.69%) i.e., the effects for different studies might be quite different.

The comparison of effect sizes indicates that psychological harm (PTSD) derived from penetrative abuse was significantly higher in victims of abuse involving penetration ($\delta = 1.23$) than in those who endured non-penetrative sexual touching ($\delta = 1.01$), $q(N = 1480) = 0.032$, $Z = 4.58$, $p < .001$. Quantitatively and in terms of the incremental harm due to victimization, victims of touching abuse reportedly suffered 45.1% more psychological harm ($r = .451$) than non-victims, and victims of penetration experienced 54.4% ($r = .544$) psychological harm in relation to non-victims.

Discussion

Overall, the results demonstrated a robust (a large magnitude overall effect size) and positive relationship between CSA victims and PTSD outcomes. However, heterogeneity in the distribution of the studies was observed in the overall analysis suggesting that effects for different studies might be quite different (moderators of the effect). In any case, this pattern of results, positive relationship between CSA victimization and psychological harm (PTSD), was observed for the four moderators of the relationship between forensic psychological harm (PTSD) and CSA victimization identified in primary studies: the victim's gender (males and females), the type of abuse (no-contact, touching and penetration), the victim-perpetrator relationship, and the type of PTSD measure (diagnosis and symptom severity).

Thus, the meta-analyses' results showed a significantly larger effect size for the PTSD-CSA relationship when psychological harm was measured in diagnoses compared to severity scales. Although this may seem counterintuitive, despite stricter diagnostic criteria, it may be due to the greater use of samples from clinical settings in diagnostic studies (Taubman-Ben-Ari et al., 2001), unlike population samples used for severity scores. In the context of forensic evaluation, symptom scores are not optimal indicators for determining psychological injury, as they do not require fulfillment of all diagnostic criteria and do not assess the causation of harm (Arce, 2018; Goodman-Delahunty & Foote, 2009; Melton et al., 2017). Therefore, in forensic settings, a multi-method approach is essential, combining diagnostic interviews (symptom knowledge task) with psychometric instruments (symptom recognition task) (Arce, 2018; Vale et al., 2024; Young et al., 2025), ensuring greater sensitivity and specificity, while meeting stringent forensic standards (Arce et al., 2009; Pereda & Arch, 2012).

Regarding victim gender, both females and males face a significant risk of developing psychological harm following CSA.

Although consistent with prior research (Mitra et al., 2021; Olf, 2017; Walker et al., 2004), the impact is significantly greater among females, being the estimated PTSD diagnosis prevalence of 39.81% for females compared to 24.23% for males. This association might be explained by an interaction of biological factors (e.g., neurochemical and hormonal influences and genetic predisposition) (Christiansen & Berke, 2020; Garza & Jovanovic, 2017), stronger psychological trauma responses in women (e.g., more intrusive symptoms, hyperarousal, distress and self-blame) (Nomamiukor et al., 2024; Olf, 2017), and sociocultural influences (Ullman & Filipas, 2005), along with the evidence that abuse among women often appears to be more severe (Putnam, 2003; Soylu et al., 2016). However, research has led to an underrepresentation of male CSA survivors, potentially overstating its impact on females (Urquiza & Keating, 1990; Walker et al., 2004).

Finally, meta-analyses identified specific abuse characteristics that amplify psychological harm following CSA. With respect to the victim-offender relationship, both categories studied, intrafamilial and extrafamilial, involve a more than large effect in psychological harm ($\delta = 1.68$ and 1.24 for intra- and extra-familial, respectively). Comparatively, intrafamilial abuse entails a significantly greater risk of psychological harm than extrafamilial. This may be attributable to the profound betrayal of trust by a caregiver within a dependent power dynamic (Filipas & Ullman, 2006) and to the nature of the abuse itself, since intrafamilial victimization typically has an earlier onset, longer duration, and involves more severe forms of abuse (Ferragut et al., 2021; Kiser et al., 2014). Additionally, intrafamilial abuse has an indirect effect on family disestablishment, which is strongly related to psychological distress. Similarly, abuse involving greater physical contact was associated with increased psychological harm (Downing et al., 2021). Specifically, abuse involving penetration was associated with an incremental harm of approximately 54%, compared with 45% for non-penetrative (touching), suggesting that different typologies should warrant distinct legal classifications of severity (Amado et al., 2015).

As for the estimation of compensation to victims (UN, 1985), the results quantified the incremental harm (loss attributable to CSA victimization) at 42.2%, proposing this value as a general gold standard. This compensation should be paid by the perpetrator (or the states when compensation is not available; UN, 1985). Specific higher gold standards may be considered for intrafamilial abuse, 64.3%, and for victims of penetration, 54.4%.

In summary, this research confirmed a large effect between CSA and PTSD, with significantly greater forensic psychological harm (PTSD) observed in female victims (in comparison to males), victims of intrafamilial abuse (in comparison to extrafamilial abuse), and in cases of penetrative abuse (in comparison to non-penetrative abuse). These findings advocate that the criminal responsibility of offenders should not be solely punitive but should also include civil economic compensation for psychological injuries and moral harm caused to victims (Aoláin et al., 2015; Barret et al., 2014; Cea et al., 2022; UN, 1985). To ensure a just and effective reparation, compensation must be commensurate with the magnitude of the harm suffered (UN, 1989). This implies that legal responses must consider factors that exacerbate the severity of abuse, such as an intrafamilial relationship or acts involving penetration (Coburn et al., 2017; Pozzulo et al., 2010), when determining punitive measures and economic compensation (Greene et al., 1999; Vallano, 2013). As for the burden of proof, psychological harm (PTSD), when a causal link between the reported psychological harm and the investigated event of CSA may be established (Arce, 2018), may constitute the keystone of the burden of proof in around 40% of cases. Furthermore, this implies that the absence of psychological harm does not mean that CSA did not exist (however, as for civil implications, the absence of psychological harm may imply no compensation to the victim), nor does it exclude the possibility that psychological harm may manifest in the future (Utzon-Frank et al., 2014). For the remaining cases (\pm

60%), the evaluation of the witness statement will be the keystone of the burden of proof (Arce, 2017).

In this context, it is essential to systematically conduct forensic evaluations to assess psychological harm in CSA cases (Arce, 2017; Kane & Dvoskin, 2011; Montes et al., 2022; Seymour et al., 2013), reinforcing the victim's testimony and providing it with objective evidence (Carrasco-Azogue et al., 2024). Indeed, research has demonstrated that the assessment of psychological injury affects jurors' and judges' judgment making, leading to higher rates of guilty verdicts, higher damage awards, and more severe sentences (Diamond & Salerno, 2013; Novo & Seijo, 2010; Vallano et al., 2013; Vredeveltdt et al., 2024). Furthermore, when evaluating young children (i.e., under 12 years), assessment methodologies must be adapted to their cognitive capabilities (Arce & Fariña, 2012; Bull, 1995; Melton et al., 2017) to avoid distorting the results or causing undue distress.

Limitations of the Study

Despite its findings, this meta-analysis has several limitations that should be considered when interpreting the results. First, the ascertainment of CSA exposure in some primary studies was based on self-report measures, which lack reliability indicators and do not entirely control for the risk of false positives. Second, several methodological issues in PTSD assessment warrant caution. Concerning the evaluation context, many primary studies were conducted in clinical rather than forensic settings, which may involve less stringent criteria (i.e., the causal link between CSA and PTSD was not always rigorously established, nor was malingering systematically ruled out). Further limitations relate to the types of PTSD measures used: some were based on psychiatric diagnoses for which reliability indicators were absent, while other studies employed psychometric instruments measuring symptom severity, which is often insufficient to assess psychological injury in legal contexts. Third, a methodological issue in some studies was the lack of a control group. Consequently, normative population data were sometimes used as a contrast, which could lead to potential distortions in the calculated effect sizes (Briere, 1992). Fourth, although the results of the meta-analysis were highly generalizable ($Ns > 400$ and a large k ; Schmidt & Hunter, 2015), they exhibited variability, implying the potential influence of moderating factors that could not be comprehensively examined. The main reason for this was that primary studies often did not report differential effects related to specific characteristics of CSA potentially involved in PTSD outcomes (i.e., age of onset, duration of abuse, relationship with the perpetrator, types of abuse, polyvictimization); or because the number of these studies was insufficient for certain potential moderator analyses ($k \leq 3$). Future research should therefore aim to identify additional moderators with impact in the probability of psychological harm in CSA cases.

Conflict of Interest

The authors of this article declare no conflict of interest.

References

- References marked with an asterisk indicate studies included in the meta-analysis.
- *Ackerman, P. T., Newton, J. E., McPherson, W. B., Jones, J. G., & Dykman, R. A. (1998). Prevalence of post-traumatic stress disorder and other psychiatric diagnoses in three groups of abused children (sexual, physical, and both). *Child Abuse & Neglect*, 22(8), 759-774. [https://doi.org/10.1016/s0145-2134\(98\)00062-3](https://doi.org/10.1016/s0145-2134(98)00062-3)
- *Adam, B. S., Everett, B. L., & O'Neal, E. (1992). PTSD in physically and sexually abused psychiatrically hospitalized children. *Child Psychiatry and Human Development*, 23(1), 3-8. <https://doi.org/10.1007/bf00706695>
- *Alix, S., Cossette, L., Hébert, M., Cyr, M., & Frappier, J. Y. (2017). Posttraumatic stress disorder and suicidal ideation among sexually abused adolescent girls: The mediating role of shame. *Journal of Child Sexual Abuse*, 26(2), 158-174. <https://doi.org/10.1080/10538712.2017.1280577>
- Alves, A. C., Leitão, M., Sani, A. I., & Moreira, D. (2024). Impact of sexual abuse on post-traumatic stress disorder in children and adolescents: A systematic review. *Social Sciences*, 13(4), Article189. <https://doi.org/10.3390/socsci13040189>
- Amado, B. G., Arce, R., & Herraiz, A. (2015). Psychological injury in victims of child sexual abuse: A meta-analytic review. *Psychosocial Intervention*, 24(1), 49-62. <https://doi.org/10.1016/j.psi.2015.03.002>
- American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). American Psychiatric Association Publishing. <https://doi.org/10.1176/appi.books.9780890425787>
- Andrews, B., Brewin, C. R., Philpott, R., & Stewart, L. (2007). Delayed-onset posttraumatic stress disorder: A systematic review of the evidence. *American Journal of Psychiatry*, 164(9), 1319-1326. <https://doi.org/10.1176/appi.ajp.2007.06091491>
- Aoláin, F. N., O'Rourke, C., & Swaine, A. (2015). Transforming reparations for conflict-related sexual violence: Principles and practice. *Harvard Human Rights Journal*, 16(03), 97-146.
- *Arata, C. M. (2000). From child victim to adult victim: A model for predicting sexual revictimization. *Child Maltreatment*, 5(1), 28-38. <https://doi.org/10.1177/1077559500005001004>
- Arce, R. (2017). El análisis de contenido de las declaraciones de testigos: la evaluación de la validez científica y judicial de la hipótesis y la prueba forense [Content analysis of the witness statements: Evaluation of the scientific and judicial validity of the hypothesis and the forensic proof]. *Acción Psicológica*, 14(2), 171-190. <https://doi.org/10.5944/ap.14.2.21347>
- Arce, R. (2018). Evaluación del daño psicológico: psicometría, entrevista y técnica forense. In E. Carbonell, D. Pineda, & M. Novo (Eds.), *Psicología jurídica: ciencia y profesión. Colección Psicología y Ley*, 15 (pp. 235-244). Sociedad Española de Psicología Jurídica y Forense.
- Arce, R., & Fariña, F. (2012). La entrevista psicológica forense a niños, adultos y discapacitados. In S. Delgado, F. Bandrés, & A. Tejerina (Eds.), *Tratado de medicina legal y ciencias forenses: Vol. V. Pediatría legal y forense. Violencia. Víctimas* (pp. 795-817). Bosch.
- Arce, R., Fariña, F., Carballal, A., & Novo, M. (2009). Creación y validación de un protocolo de evaluación forense de las secuelas psicológicas de la violencia de género [Creation and validation of a forensic protocol to assess psychological harm in battered women]. *Psicothema*, 21(2), 241-247. <http://www.psicothema.com/pdf/3621.pdf>
- Arce, R., Fariña, F., Seijo, D., & Novo, M. (2015). Assessing impression management with the MMPI-2 in child custody litigation. *Assessment*, 22(6), 769-777. <https://doi.org/10.1177/1073191114558111>
- *Asberg, K., & Renk, K. (2014). Perceived stress, external locus of control, and social support as predictors of psychological adjustment among female inmates with or without a history of sexual abuse. *International Journal of Offender Therapy and Comparative Criminology*, 58(1), 59-84. <https://doi.org/10.1177/0306624X12461477>
- Assink, M., Van der Put, C. E., Meeuwse, M. W., de Jong, N. M., Oort, F. J., Stams, G. J. J., & Hoeve, M. (2019). Risk factors for child sexual abuse victimization: A meta-analytic review. *Psychological Bulletin*, 145(5), 459-489. <https://doi.org/10.1037/bul0000188>
- *Auslander, W., Tlapek, S. M., Threlfall, J., Edmond, T., & Dunn, J. (2018). Mental health pathways linking childhood maltreatment to interpersonal revictimization during adolescence for girls in the child welfare system. *Journal of Interpersonal Violence*, 33(7), 1169-1191. <https://doi.org/10.1177/0886260515614561>
- *Aydin, B., Akbas, S., Turla, A., Dundar, C., Yuce, M., & Karabekiroglu, K. (2015). Child sexual abuse in Turkey: An analysis of 1002 cases. *Journal of Forensic Sciences*, 60(1), 61-65. <https://doi.org/10.1111/1556-4029.12566>
- *Bahali, K., Akcan, R., Tahiroglu, A. Y., & Avci, A. (2010). Child sexual abuse: Seven years in practice. *Journal of Forensic Sciences*, 55(3), 633-636. <https://doi.org/10.1111/j.1556-4029.2010.01357.x>
- *Baker, C. K., Norris, F. H., Jones, E. C., & Murphy, A. D. (2009). Childhood trauma and adulthood physical health in Mexico. *Journal of Behavioral Medicine*, 32(3), 255-269. <https://doi.org/10.1007/s10865-009-9199-2>
- *Ballard, E. D., Van Eck, K., Musci, R. J., Hart, S. R., Storck, C. L., Breslau, N., & Wilcox, H. C. (2015). Latent classes of childhood trauma exposure predict the development of behavioral health outcomes in adolescence and young adulthood. *Psychological Medicine*, 45(15), 3305-3316. <https://doi.org/10.1017/S003329171500069X>
- Batchelder, A. W., Safren, S. A., Coleman, J. N., Boroughs, M. S., Thiim, A., Ironson, G. H., Shipherd, J. C., & O'Leirigh, C. (2021). Indirect effects from childhood sexual abuse severity to PTSD: The role of avoidance coping. *Journal of Interpersonal Violence*, 36(9-10), NP5476-NP5495. <https://doi.org/10.1177/0886260518801030>
- Batool, S., & Abtahi, A. (2017). Psychosocial impact of childhood sexual abuse: Perspective of victims. *Journal of Arts and Social Sciences*, 4(2), 36-48. <https://jass.pk/assets/allabs/8th04.pdf>
- *Bernard-Bonnin, A. C., Hébert, M., Daignault, I. V., & Allard-Dansereau, C. (2008). Disclosure of sexual abuse, and personal and familial factors as predictors of post-traumatic stress disorder symptoms in school-aged girls. *Paediatrics & Child Health*, 13(6), 479-486. <https://doi.org/10.1093/pch/13.6.479>
- Blanchard, E. B., & Hickling, E. J. (2004). What are the psychosocial effects of MVAs on survivors? In E. B. Blanchard & E. J. Hickling (Eds.), *After*

- the crash: Psychological assessment and treatment of survivors of motor vehicle accidents (2nd ed., pp. 57-97). American Psychological Association.
- *Boney-McCoy, S., & Finkelhor, D. (1996). Is youth victimization related to trauma symptoms and depression after controlling for prior symptoms and family relationships? A longitudinal, prospective study. *Journal of Consulting and Clinical Psychology*, 64(6), 1406-1416. <https://doi.org/10.1037/0022-006X.64.6.1406>
- *Bourghs, M. S., Valentine, S. E., Ironson, G. H., Shipherd, J. C., Safren, S. A., Taylor, S. W., Dale, S. K., Baker, J. S., Wilner, J. G., & O'Leirigh, C. (2015). Complexity of childhood sexual abuse: Predictors of current post-traumatic stress disorder, mood disorders, substance use, and sexual risk behavior among adult men who have sex with men. *Archives of Sexual Behavior*, 44(7), 1891-1902. <https://doi.org/10.1007/s10508-014-0463-3>
- Boumpa, V., Papatoukaki, A., Kourti, A., Mintzia, S., Panagouli, E., Bacopoulou, F., Psaltopoulou, T., Spiliopoulou, C., Tosolia, M., Sergentanis, T. N., & Tsitsika, A. (2024). Sexual abuse and post-traumatic stress disorder in childhood, adolescence and young adulthood: A systematic review and meta-analysis. *European Child & Adolescent Psychiatry*, 33(6), 1653-1673. <https://doi.org/10.1007/s00787-022-02015-5>
- *Brabant, M. E., Hébert, M., & Chagnon, F. (2014). Predicting suicidal ideations in sexually abused female adolescents: A 12-month prospective study. *Journal of Child Sexual Abuse*, 23(4), 387-397. <https://doi.org/10.1080/10538712.2014.896842>
- *Brand, E. F., King, C. A., Olson, E., Ghaziuddin, N., & Naylor, M. (1996). Depressed adolescents with a history of sexual abuse: Diagnostic comorbidity and suicidality. *Journal of the American Academy of Child & Adolescent Psychiatry*, 35(1), 34-41. <https://doi.org/10.1097/00004583-199601000-00010>
- *Briere, J., & Elliott, D. M. (2003). Prevalence and psychological sequelae of self-reported childhood physical and sexual abuse in a general population sample of men and women. *Child Abuse & Neglect*, 27(10), 1205-1222. <https://doi.org/10.1016/j.chiabu.2003.09.008>
- Bulik, C. M., Prescott, C. A., & Kendler, K. S. (2001). Features of childhood sexual abuse and the development of psychiatric and substance use disorders. *British Journal of Psychiatry*, 179(5), 444-449. <https://doi.org/10.1192/bjp.179.5.444>
- Bull, R. (1995). Interviewing children in legal contexts. In R. Bull & D. Carson (Eds.), *Handbook of psychology in legal contexts* (pp. 355-375). John Wiley & Sons.
- Cagney, J., Spencer, C., Flor, L., Herbert, M., Khalil, M., O'Connell, E., Mullany, E., Bustreo, F., Chandan, J. S., Metheny, N., Knaul, F., & Gakidou, E. (2025). Prevalence of sexual violence against children and age at first exposure: A global analysis by location, age, and sex (1990-2023). *Lancet*, 405(10492), 817-836. [https://doi.org/10.1016/S0140-6736\(25\)00311-3](https://doi.org/10.1016/S0140-6736(25)00311-3)
- Campbell, R., & Raja, S. (1999). Secondary victimization of rape victims: Insights from mental health professionals who treat survivors of violence. *Violence and Victims*, 14(3), 261-275. <https://doi.org/10.1891/0886-6708.14.3.261>
- *Canton-Cortes, D., Canton, J., & Cortés, M. R. (2012). The interactive effect of blame attribution with characteristics of child sexual abuse on posttraumatic stress disorder. *Journal of Nervous and Mental Disease*, 200(4), 329-335. <https://doi.org/10.1097/NMD.0b013e31824cc078>
- *Caravaca Sánchez, F., Ignatyev, Y., & Mundt, A. P. (2019). Associations between childhood abuse, mental health problems, and suicide risk among male prison populations in Spain. *Criminal Behaviour and Mental Health*, 29(1), 18-30. <https://doi.org/10.1002/cbm.2099>
- *Carey, P. D., Walker, J. L., Rossouw, W., Seedat, S., & Stein, D. J. (2008). Risk indicators and psychopathology in traumatised children and adolescents with a history of sexual abuse. *European Child & Adolescent Psychiatry*, 17(2), 93-98. <https://doi.org/10.1007/s10508-014-0463-3>
- Carrasco-Azogue, K. C., Cruz-Yasaca, G. A., Pullupaxi-Garzón, T. C., & Páez-Maldonado, A. S. (2024). Psychological expert evidence on the credibility of testimony of rape victims. *Verdad y Derecho*, 3(2), 195-203. <https://doi.org/10.62574/3zxpbv12>
- Cea, B., Montes, Á., & Arce, R. (2022). Apoyo social percibido en víctimas de abuso sexual infantil: Una revisión meta-analítica. In L. Rodríguez, D. Seijo, & F. Fariña (Eds.), *Ciencia psicológica al servicio de la justicia y la ley* (pp. 221-236). Sociedad Española de Psicología Jurídica y Forense.
- *Celbis, O., Altun, I., Ayaz, N., Bork, T., & Karatoprak, S. (2020). Evaluation of incest cases: 4-year retrospective study. *Journal of Child Sexual Abuse*, 29(1), 79-89. <https://doi.org/10.1080/10538712.2019.1634664>
- *Chaplo, S. D., Kerig, P. K., Modrowski, C. A., & Bennett, D. C. (2017). Gender differences in the associations among sexual abuse, posttraumatic stress symptoms, and delinquent behaviors in a sample of detained adolescents. *Journal of Child & Adolescent Trauma*, 10(1), 29-39. <https://doi.org/10.1007/s40653-016-0122-z>
- *Choi, N. G., DiNitto, D. M., Marti, C. N., & Choi, B. Y. (2017). Association of adverse childhood experiences with lifetime mental and substance use disorders among men and women aged 50+ years. *International Psychogeriatrics*, 29(3), 359-372. <https://doi.org/10.1017/S104161021600179X>
- Christiansen, D. M., & Berke, E. T. (2020). Gender-and sex-based contributors to sex differences in PTSD. *Current Psychiatry Reports*, 22(4), Article 19. <https://doi.org/10.1007/s11920-020-1140-y>
- Coburn, P. I., Chong, K., & Connolly, D. A. (2017). The effect of case severity on sentence length in cases of child sexual assault in Canada. *Journal of Child Sexual Abuse*, 26(3), 319-333. <https://doi.org/10.1080/10538712.2017.1283651>
- Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Academic Press.
- Cohen, J. A., Bukstein, O., Walter, H., Benson, S. R., Chrisman, A., Farchione, T. R., Hamilton, J., Keable, H., Kinlan, J., Schoettl, U., Siegel, M., Stock, S., Medicus, J., & AACAP Work Group on Quality Issues (2010). Practice parameter for the assessment and treatment of children and adolescents with posttraumatic stress disorder. *Journal of the American Academy of Child and Adolescent Psychiatry*, 49(4), 414-430. <https://doi.org/10.1016/j.jaac.2009.12.020>
- *Collin-Vézina, D., & Hébert, M. (2005). Comparing dissociation and PTSD in sexually abused school-aged girls. *Journal of Nervous and Mental Disease*, 193(1), 47-52. <https://doi.org/10.1097/01.nmd.0000149218.76592.26>
- *Conway, F., Talreja, P., McCarthy, J., & Conway, F. (2013). Thought and language disorder among sexually abused children in a psychiatric hospital. *Psychological Reports*, 112(2), 340-352. <https://doi.org/10.2466/16.02.PR0.112.2.340-352>
- Corrás, T., Seijo, D., Fariña, F., Novo, M., Arce, R., & Cabanach, R. G. (2017). What and how much do children lose in academic settings owing to parental separation? *Frontiers in Psychology*, 8, 1545. <https://doi.org/10.3389/fpsyg.2017.01545>
- *Costa, E. C., Guimarães, S., Ferreira, D., & Pereira, M. G. (2019). Resource loss moderates the association between child abuse and current PTSD symptoms among women in primary-care settings. *Journal of Interpersonal Violence*, 34(17), 3614-3636. <https://doi.org/10.1177/0886260516670883>
- *Crouch, J. L., Smith, D. W., Ezzell, C. E., & Saunders, B. E. (1999). Measuring reactions to sexual trauma among children: Comparing the Children's Impact of Traumatic Events Scale and the Trauma Symptom Checklist for Children. *Child Maltreatment*, 4(3), 255-263. <https://doi.org/10.1177/1077559599004003006>
- *Cutajar, M. C., Mullen, P. E., Ogloff, J. R., Thomas, S. D., Wells, D. L., & Spataro, J. (2010). Psychopathology in a large cohort of sexually abused children followed up to 43 years. *Child Abuse & Neglect*, 34(11), 813-822. <https://doi.org/10.1016/j.chiabu.2010.04.004>
- Daignault, I. V., & Hébert, M. (2009). Profiles of school adaptation: Social, behavioral and academic functioning in sexually abused girls. *Child Abuse & Neglect*, 33(2), 102-115. <https://doi.org/10.1016/j.chiabu.2008.06.001>
- *Daigneault, I., Hébert, M., & Tourigny, M. (2006). Attributions and coping in sexually abused adolescents referred for group treatment. *Journal of Child Sexual Abuse*, 15(3), 35-59. https://doi.org/10.1300/J070v15n03_03
- *De Rose, P., Salvaguardia, F., Bergonzini, P., Cirillo, F., Demaria, F., Casini, M. P., Menghini, D., & Vicari, S. (2016). Current psychopathological symptoms in children and adolescents who suffered different forms of maltreatment. *Scientific World Journal*, 2016(1), 8654169. <https://doi.org/10.1155/2016/8654169>
- *Deblinger, E., Mcleer, S. V., Atkins, M. S., Ralphe, D., & Foa, E. (1989). Post-traumatic stress in sexually abused, physically abused, and nonabused children. *Child Abuse & Neglect*, 13(3), 403-408. [https://doi.org/10.1016/0145-2134\(89\)90080-X](https://doi.org/10.1016/0145-2134(89)90080-X)
- Diamond, S. S., & Salerno, J. M. (2013). Empirical analysis of juries in tort cases. In J. H. Arlen (Ed.), *Research handbook on the economics of torts* (pp. 414-436). Edward Elgar Publishing.
- *Dias, A., Sales, L., Mooren, T., Mota-Cardoso, R., & Kleber, R. (2017). Child maltreatment, revictimization and Post-Traumatic Stress Disorder among adults in a community sample. *International Journal of Clinical and Health Psychology*, 17(2), 97-106. <https://doi.org/10.1016/j.ijchp.2017.03.003>
- *Dodson, T. S., & Beck, J. G. (2019). Do negative attitudes about using social support matter in the association of post-traumatic cognitions and perceived social support? Comparison of female survivors of intimate partner violence with and without a history of child abuse. *Journal of Interpersonal Violence*, 36(21-22), NP11674-NP11694. <https://doi.org/10.1177/0886260519888529>
- Downing, N. R., Akinlotan, M., & Thornhill, C. W. (2021). The impact of childhood sexual abuse and adverse childhood experiences on adult health related quality of life. *Child Abuse & Neglect*, 120, Article 105181. <https://doi.org/10.1016/j.chiabu.2021.105181>
- *Dykman, R. A., McPherson, B., Ackerman, P. T., Newton, J. E., Mooney, D. M., Wherry, J., & Chaffin, M. (1997). Internalizing and externalizing characteristics of sexually and/or physically abused children. *Integrative Physiological and Behavioral Science*, 32(1), 62-83. <https://doi.org/10.1007/BF02688614>
- Dyregrov, A., & Yule, W. (2006). A Review of PTSD in Children. *Child & Adolescent Mental Health*, 11(4), 174-184. <https://doi.org/10.1111/j.1475-3588.2005.00384.x>
- *Elklit, A., Christiansen, D. M., Palic, S., Karsberg, S., & Eriksen, S. B. (2014). Impact of traumatic events on posttraumatic stress disorder among Danish survivors of sexual abuse in childhood. *Journal of Child Sexual Abuse*, 23(8), 918-934. <https://doi.org/10.1080/10538712.2014.964440>

- Ellekilde, J. P., Jensen, J. H., Smid, G. E., Flachs, E. M., Elklit, A., Mors, O., & Videbech, P. (2021). Time course of symptoms in posttraumatic stress disorder with delayed expression: A systematic review. *Acta Psychiatrica Scandinavica*, 145(2), 116-131. <https://doi.org/10.1111/acps.13372>
- *Ellenbogen, S., Collin-Vezina, D., Sinha, V., Chabot, M., & Wells, S. J. (2018). Contrasting mental health correlates of physical and sexual abuse-related shame. *Journal of Child & Adolescent Mental Health*, 30(2), 87-97. <https://doi.org/10.1080/1028415X.2018.1432935>
- *Epstein, J. N., Saunders, B. E., & Kilpatrick, D. G. (1997). Predicting PTSD in women with a history of childhood rape. *Journal of Traumatic Stress*, 10(4), 573-588. <https://doi.org/10.1002/jts.2490100405>
- Fariña, F., Arce, R., & Novo, M. (2002). Heurístico de anclaje en las decisiones judiciales [Anchorage in judicial decision making]. *Psicothema*, 14(1), 39-46. <http://www.psicothema.com/pdf/684.pdf>
- *Farley, M., & Patsalides, B. M. (2001). Physical symptoms, posttraumatic stress disorder, and healthcare utilization of women with and without childhood physical and sexual abuse. *Psychological Reports*, 89(3), 595-606. <https://doi.org/10.2466/pr0.2001.89.3.595>
- *Feerick, M. M., & Snow, K. L. (2005). The relationships between childhood sexual abuse, social anxiety, and symptoms of posttraumatic stress disorder in women. *Journal of Family Violence*, 20(6), 409-419. <https://doi.org/10.1007/s10896-005-7802-z>
- *Fergusson, D. M., McLeod, G. F., & Horwood, L. J. (2013). Childhood sexual abuse and adult developmental outcomes: Findings from a 30-year longitudinal study in New Zealand. *Child Abuse & Neglect*, 37(9), 664-674. <https://doi.org/10.1016/j.chiabu.2013.03.013>
- Ferragut, M., Ortiz-Tallo, M., & Blanca, M. J. (2021). Victims and perpetrators of child sexual abuse: Abusive contact and penetration experiences. *International Journal of Environmental Research and Public Health*, 18(18), Article 9593. <https://doi.org/10.3390/ijerph18189593>
- Filipas, H. H., & Ullman, S. E. (2006). Child sexual abuse, coping responses, self-blame, posttraumatic stress disorder, and adult sexual revictimization. *Journal of Interpersonal Violence*, 21(5), 652-672. <https://doi.org/10.1177/0886260506286879>
- Finkelhor, D. (1994). Current information on the scope and nature of child sexual abuse. *The Future of Children*, 4(2), 31-53. <https://doi.org/10.2307/1602522>
- *Fis, N. P., Arman, A., Kalaca, S., & Berkem, M. (2010). Psychiatric evaluation of sexual abuse cases: A clinical representative sample from Turkey. *Children and Youth Services Review*, 32(10), 1285-1290. <https://doi.org/10.1016/j.chiayouth.2010.04.020>
- *Fitzpatrick, M., Carr, A., Dooley, B., Flanagan-Howard, R., Flanagan, E., Tierney, K., White, M., Daly, M., Shevlin, M., & Egan, J. (2010). Profiles of adult survivors of severe sexual, physical and emotional institutional abuse in Ireland. *Child Abuse Review*, 19(6), 387-404. <https://doi.org/10.1002/car.1083>
- Fletcher, S., Elklit, A., Shevlin, M., & Armour, C. (2021). Predictors of PTSD treatment response trajectories in a sample of childhood sexual abuse survivors: The roles of social support, coping, and PTSD symptom clusters. *Journal of Interpersonal Violence*, 36(3-4), 1283-1307. <https://doi.org/10.1177/0886260517741212>
- *Fondacaro, K. M., Holt, J. C., & Powell, T. A. (1999). Psychological impact of childhood sexual abuse on male inmates: The importance of perception. *Child Abuse & Neglect*, 23(4), 361-369. [https://doi.org/10.1016/S0145-2134\(99\)00004-6](https://doi.org/10.1016/S0145-2134(99)00004-6)
- *Ford, J. D., Elhai, J. D., Connor, D. F., & Frueh, B. C. (2010). Poly-victimization and risk of posttraumatic, depressive, and substance use disorders and involvement in delinquency in a national sample of adolescents. *Journal of Adolescent Health*, 46(6), 545-552. <https://doi.org/10.1016/j.jadohealth.2009.11.212>
- *Frounfelker, R., Klodnick, V. V., Mueser, K. T., & Todd, S. (2013). Trauma and posttraumatic stress disorder among transition-age youth with serious mental health conditions. *Journal of Traumatic Stress*, 26(3), 409-412. <https://doi.org/10.1002/jts.21812>
- Gardner, M. J., Thomas, H. J., & Erskine, H. E. (2019). The association between five forms of child maltreatment and depressive and anxiety disorders: A systematic review and meta-analysis. *Child Abuse & Neglect*, 96, Article 104082. <https://doi.org/10.1016/j.chiabu.2019.104082>
- Garza, K., & Jovanovic, T. (2017). Impact of gender on child and adolescent PTSD. *Current Psychiatry Reports*, 19(11), 1-6. <https://doi.org/10.1007/s11920-017-0830-6>
- *Gauthier-Duchesne, A., Hébert, M., & Daspe, M. È. (2017). Gender as a predictor of posttraumatic stress symptoms and externalizing behavior problems in sexually abused children. *Child Abuse & Neglect*, 64, 79-88. <https://doi.org/10.1016/j.chiabu.2016.12.008>
- *Giaconia, R. M., Reinherz, H. Z., Silverman, A. B., Pakiz, B., Frost, A. K., & Cohen, E. (1995). Traumas and posttraumatic stress disorder in a community population of older adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*, 34(10), 1369-1380. <https://doi.org/10.1097/00004583-199510000-00023>
- *Glod, C. A., & Teicher, M. H. (1996). Relationship between early abuse, posttraumatic stress disorder, and activity levels in prepubertal children. *Journal of the American Academy of Child & Adolescent Psychiatry*, 35(10), 1384-1393. <https://doi.org/10.1097/00004583-199610000-00026>
- *Gokten, E. S., & Duman, N. S. (2016). Factors influencing the development of psychiatric disorders in the victims of sexual abuse: A study on Turkish children. *Children and Youth Services Review*, 69(C), 49-55. <https://doi.org/10.1016/j.chiayouth.2016.07.022>
- Gokten, E. S., & Uyulan, C. (2021). Prediction of the development of depression and post-traumatic stress disorder in sexually abused children using a random forest classifier. *Journal of Affective Disorders*, 279, 256-265. <https://doi.org/10.1016/j.jad.2020.10.006>
- Goodman-Delahunty, J., & Foote, W. E. (2009). Forensic evaluations advance scientific theory: Assessing causation of harm. *Pragmatic Case Studies in Psychotherapy*, 5(3), 38-52. <https://doi.org/10.14713/pcsp.v5i3.975>
- *Gospodarevskaya, E. (2013). Post-traumatic stress disorder and quality of life in sexually abused Australian children. *Journal of Child Sexual Abuse*, 22(3), 277-296. <https://doi.org/10.1080/10538712.2013.743953>
- Gould, F., Jones, M. T., Harvey, P. D., Reidy, L. J., Hodgins, G., Michopoulos, V., Maples-Keller, J., Rothbaum, B. O., Rothbaum, A., Ressler, K. J., & Nemeroff, C. B. (2021). The relationship between substance use, prior trauma history, and risk of developing post-traumatic stress disorder in the immediate aftermath of civilian trauma. *Journal of Psychiatric Research*, 144, 345-352. <https://doi.org/10.1016/j.jpsychires.2021.10.025>
- *Grassi-Oliveira, R., & Stein, L. M. (2008). Childhood maltreatment associated with PTSD and emotional distress in low-income adults: The burden of neglect. *Child Abuse & Neglect*, 32(12), 1089-1094. <https://doi.org/10.1016/j.chiabu.2008.05.008>
- Greene, E., Johns, M., & Bowman, J. (1999). The effects of injury severity on jury negligence decisions. *Law and Human Behavior*, 23(6), 675-693. <https://doi.org/10.1023/A:1022341522714>
- *Gudjonsson, G., Vagni, M., Maiorano, T., Giostra, V., & Pajardi, D. (2021). Trauma symptoms of sexual abuse reduce resilience in children to give 'no' replies to misleading questions. *Personality and Individual Differences*, 168, Article 110378. <https://doi.org/10.1016/j.paid.2020.110378>
- *Guerra, C., Farkas, C., & Moncada, L. (2018). Depression, anxiety and PTSD in sexually abused adolescents: Association with self-efficacy, coping and family support. *Child Abuse & Neglect*, 76, 310-320. <https://doi.org/10.1016/j.chiabu.2017.11.013>
- *Gwandure, C. (2007). Sexual assault in childhood: Risk HIV and AIDS behaviours in adulthood. *AIDS Care*, 19(10), 1313-1315. <https://doi.org/10.1080/09540120701426508>
- Haag, A. C., Bonanno, G. A., Chen, S., Herd, T., Strong-Jones, S., & Noll, J. G. (2023). Understanding posttraumatic stress trajectories in adolescent females: A strength-based machine learning approach examining risk and protective factors including online behaviors. *Development and Psychopathology*, 35(4), 1794-1807. <https://doi.org/10.1017/S0954579422000475>
- Hailes, H. P., Yu, R., Danese, A., & Fazel, S. (2019). Long-term outcomes of childhood sexual abuse: An umbrella review. *Lancet Psychiatry*, 6(10), 830-839. [https://doi.org/10.1016/S2215-0366\(19\)30286-X](https://doi.org/10.1016/S2215-0366(19)30286-X)
- Handiso, D., Belsti, Y., Boyle, J. A., Paul, E., Shawyer, F., & Enticott, J. C. (2025). A systematic review and meta-analysis of longitudinal studies on posttraumatic stress disorders in refugees and asylum seekers. *International Journal of Mental Health and Addiction*, 23, 1347-1369. <https://doi.org/10.1007/s11469-023-01172-1>
- *Harding, H. G., Burns, E. E., & Jackson, J. L. (2012). Identification of child sexual abuse survivor subgroups based on early maladaptive schemas: Implications for understanding differences in posttraumatic stress disorder symptom severity. *Cognitive Therapy and Research*, 36(5), 560-575. <https://doi.org/10.1007/s10608-011-9385-8>
- Hashim, M., Iqbal, N., Halligan, S., Alimoradi, Z., Pfaltz, M., Farooqi, S. R., Khan, I., Galán, C. A., & Vostanis, P. (2024). Association of childhood sexual abuse with adolescent's psychopathology: A systematic review and meta-analysis. *Trauma, Violence, & Abuse*, 26(3), 483-496. <https://doi.org/10.1177/15248380241281365>
- *Haviland, M. G., Sonne, J. L., & Woods, L. R. (1995). Beyond posttraumatic stress disorder: Object relations and reality testing disturbances in physically and sexually abused adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*, 34(8), 1054-1059. <https://doi.org/10.1097/00004583-199508000-00015>
- *Hébert, M., Amédée, L. M., Blais, M., & Gauthier-Duchesne, A. (2019). Child sexual abuse among a representative sample of Quebec high school students: Prevalence and association with mental health problems and health-risk behaviors. *Canadian Journal of Psychiatry*, 64(12), 846-854. <https://doi.org/10.1177/0706743719861387>
- Herman, S. (2010). The role of corroborative evidence in child sexual abuse evaluations. *Journal of Investigative Psychology and Offender Profiling*, 7(3), 189-212. <https://doi.org/10.1002/jip.122>
- Hershkowitz, I., Melkman, E. P., & Zur, R. (2018). When is a child's forensic statement deemed credible? A comparison of physical and sexual abuse cases. *Child Maltreatment*, 23(2), 196-206. <https://doi.org/10.1177/1077559517734059>
- *Hetzel, M. D., & McCanne, T. R. (2005). The roles of peritraumatic dissociation, child physical abuse, and child sexual abuse in the development of posttraumatic stress disorder and adult victimization. *Child Abuse & Neglect*, 29(8), 915-930. <https://doi.org/10.1016/j.chiabu.2004.11.008>

- *Hidalgo, M. A., Kuhns, L. M., Kwon, S., Mustanski, B., & Garofalo, R. (2015). The impact of childhood gender expression on childhood sexual abuse and psychopathology among young men who have sex with men. *Child Abuse & Neglect*, 46, 103-112. <https://doi.org/10.1016/j.chiabu.2015.05.005>
- *Hsieh, Y. P., Shen, A. C. T., Wei, H. S., Feng, J. Y., Huang, S. C. Y., & Hwa, H. L. (2016). Associations between child maltreatment, PTSD, and internet addiction among Taiwanese students. *Computers in Human Behavior*, 56, 209-214. <https://doi.org/10.1016/j.chb.2015.11.048>
- *Huang, G., Zhang, Y., Momartin, S., Huang, X., & Zhao, L. (2008). Child sexual abuse, coping strategies and lifetime posttraumatic stress disorder among female inmates. *International Journal of Prisoner Health*, 4(1), 54-63. <https://doi.org/10.1080/17449200701875840>
- Hunter, J. E., Schmidt, F. L., & Jackson, G. B. (1982). *Meta-analysis: Cumulating research findings across studies*. Sage.
- *Hyland, P., Murphy, J., Shevlin, M., Vallières, F., McElroy, E., Elklit, A., Christoffersen, M., & Cloitre, M. (2017). Variation in post-traumatic response: The role of trauma type in predicting ICD-11 PTSD and CPTSD symptoms. *Social Psychiatry and Psychiatric Epidemiology*, 52(6), 727-736. <https://doi.org/10.1007/s00127-017-1350-8>
- Irish, L., Kobayashi, I., & Delahanty, D. L. (2010). Long-term physical health consequences of childhood sexual abuse: A meta-analytic review. *Journal of Pediatric Psychology*, 35(5), 450-461. <https://doi.org/10.1093/jpepsy/jsp118>
- Jonas, S., Bebbington, P., McManus, S., Meltzer, H., Jenkins, R., Kuipers, E., Cooper, C., King, M., & Brugha, T. (2011). Sexual abuse and psychiatric disorder in England: Results from the 2007 adult psychiatric morbidity survey. *Psychological Medicine*, 41(4), 709-719. <https://doi.org/10.1017/S003329171000111X>
- *Kamen, C., Bergstrom, J., Koopman, C., Lee, S., & Gore-Felton, C. (2012). Relationships among childhood trauma, posttraumatic stress disorder, and dissociation in men living with HIV/AIDS. *Journal of Trauma & Dissociation*, 13(1), 102-114. <https://doi.org/10.1080/15299732.2011.608629>
- Kane, A. W., & Dvoskin, J. A. (2011). *Evaluation for personal injury claims*. Oxford University Press.
- Kessler, R. C., Chiu, W. T., Demler, O., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62(6), 617-627. <https://doi.org/10.1001/archpsyc.62.6.617>
- *Khadr, S., Clarke, V., Wellings, K., Villalta, L., Goddard, A., Welch, J., Bewley, S., Kramer, T., & Viner, R. (2018). Mental and sexual health outcomes following sexual assault in adolescents: A prospective cohort study. *Lancet Child & Adolescent Health*, 2(9), 654-665. [https://doi.org/10.1016/S2352-4642\(18\)30202-5](https://doi.org/10.1016/S2352-4642(18)30202-5)
- Kilimnik, C. D., Pulverman, C. S., & Meston, C. M. (2018). Methodologic considerations for the study of childhood sexual abuse in sexual health outcome research: A comprehensive review. *Sexual Medicine Reviews*, 6(2), 176-187. <https://doi.org/10.1016/j.sxmr.2017.11.006>
- *Kisely, S., Strathearn, L., Mills, R., & Najman, J. M. (2021). A comparison of the psychological outcomes of self-reported and agency-notified child abuse in a population-based birth cohort at 30-year-follow-up. *Journal of Affective Disorders*, 280(Pt A), 167-172. <https://doi.org/10.1016/j.jad.2020.11.017>
- Kiser, L. J., Stover, C. S., Navalta, C. P., Dorado, J., Vogel, J. M., Abdul-Adil, J. K., Kim, S., Lee, R. C., Vivrette, R., & Briggs, E. C. (2014). Effects of the child-perpetrator relationship on mental health outcomes of child abuse: It's (not) all relative. *Child Abuse & Neglect*, 38(6), 1083-1093. <https://doi.org/10.1016/j.chiabu.2014.02.017>
- Koçtürk, N., & Yüksel, F. (2019). Characteristics of victims and perpetrators of intrafamilial sexual abuse. *Child Abuse & Neglect*, 96(4), 104-122. <https://doi.org/10.1016/j.chiabu.2019.104122>
- *Koenen, K. C., & Widom, C. S. (2009). A prospective study of sex differences in the lifetime risk of posttraumatic stress disorder among abused and neglected children grown up. *Journal of Traumatic Stress*, 22(6), 566-574. <https://doi.org/10.1002/jts.20478>
- Konstantopoulou, G., Rapatzikou, K., Karnampatidis, P., Karaivazoglou, K., & Georgiou, E. (2024). The comorbidity of depression and PTSD in sexually abused children: A systematic review. *European Journal of Social Sciences Studies*, 10(4). <https://doi.org/10.46827/ejss.v10i4.1845>
- Labadie, C., Godbout, N., Vaillancourt-Morel, M. P., & Sabourin, S. (2018). Adult profiles of child sexual abuse survivors: Attachment insecurity, sexual compulsivity, and sexual avoidance. *Journal of Sex & Marital Therapy*, 44(4), 354-369. <https://doi.org/10.1080/0092623X.2017.1405302>
- *Lamoureux, B. E., Palmieri, P. A., Jackson, A. P., & Hobfoll, S. E. (2012). Child sexual abuse and adulthood-interpersonal outcomes: Examining pathways for intervention. *Psychological Trauma: Theory, Research, Practice, and Policy*, 4(6), 605-613. <https://doi.org/10.1037/a0026079>
- *Leck, P., Difede, J., Patt, I., Giosan, C., & Szkodny, L. E. (2006). Incidence of male childhood sexual abuse and psychological sequelae in disaster workers exposed to a terrorist attack. *International Journal of Emergency Mental Health*, 8(4), 267-274. <https://doi.org/10.1080/15224820601016513>
- Letourneau, E. J., Brown, D. S., Fang, X., Hassan, A., & Mercy, J. A. (2018). The economic burden of child sexual abuse in the United States. *Child Abuse & Neglect*, 79, 413-422. <https://doi.org/10.1016/j.chiabu.2018.02.020>
- *Libby, A. M., Orton, H. D., Novins, D. K., Beals, J., & Manson, S. M. (2005). Childhood physical and sexual abuse and subsequent depressive and anxiety disorders for two American Indian tribes. *Psychological Medicine*, 35(3), 329-340. <https://doi.org/10.1017/S0033291704003599>
- *Livingston, R., Lawson, L., & Jones, J. G. (1993). Predictors of self-reported psychopathology in children abused repeatedly by a parent. *Journal of the American Academy of Child & Adolescent Psychiatry*, 32(5), 948-953. <https://doi.org/10.1097/00004583-199309000-00009>
- *Maalouf, O., Daigneault, I., Dargan, S., McDuff, P., & Frappier, J. Y. (2020). Relationship between child sexual abuse, psychiatric disorders and infectious diseases: A matched-cohort study. *Journal of Child Sexual Abuse*, 29(7), 749-768. <https://doi.org/10.1080/10538712.2019.1709242>
- Macdonald, A., Danielson, C. K., Resnick, H. S., Saunders, B. E., & Kilpatrick, D. G. (2010). PTSD and comorbid disorders in a representative sample of adolescents: The risk associated with multiple exposures to potentially traumatic events. *Child Abuse & Neglect*, 34(10), 773-783. <https://doi.org/10.1016/j.chiabu.2010.03.006>
- *Maikovitch, A. K., Koenen, K. C., & Jaffee, S. R. (2009). Posttraumatic stress symptoms and trajectories in child sexual abuse victims: An analysis of sex differences using the National Survey of Child and Adolescent Well-Being. *Journal of Abnormal Child Psychology*, 37(5), 727-737. <https://doi.org/10.1007/s10802-009-9300-x>
- Marshall, R. D., Olsson, M., Hellman, F., Blanco, C., Guardino, M., & Struening, E. L. (2001). Comorbidity, impairment, and suicidality in subthreshold PTSD. *American Journal of Psychiatry*, 158(9), 1467-1473. <https://doi.org/10.1176/appi.ajp.158.9.1467>
- Mathews, B., & Collin-Vézina, D. (2019). Child sexual abuse: Toward a conceptual model and definition. *Trauma, Violence, & Abuse*, 20(2), 131-148. <https://doi.org/10.1177/1524838017738726>
- *Mathews, S., Abrahams, N., & Jewkes, R. (2013). Exploring mental health adjustment of children post sexual assault in South Africa. *Journal of Child Sexual Abuse*, 22(6), 639-657. <https://doi.org/10.1080/10538712.2013.811137>
- *McClellan, J., Adams, J., Douglas, D., McCurry, C., & Storck, M. (1995). Clinical characteristics related to severity of sexual abuse: A study of seriously mentally ill youth. *Child Abuse & Neglect*, 19(10), 1245-1254. [https://doi.org/10.1016/0145-2134\(95\)00087-0](https://doi.org/10.1016/0145-2134(95)00087-0)
- McCloskey, L. A., & Walker, M. (2000). Posttraumatic stress in children exposed to family violence and single-event trauma. *Journal of the American Academy of Child & Adolescent Psychiatry*, 39(1), 108-115. <https://doi.org/10.1097/00004583-200001000-00023>
- *McDonagh-Coyle, A., McHugo, G. J., Friedman, M. J., Schnurr, P. P., Zayfert, C., & Descamps, M. (2001). Psychophysiological reactivity in female sexual abuse survivors. *Journal of Traumatic Stress*, 14(4), 667-683. <https://doi.org/10.1023/A:1013081803429>
- McLaughlin, K. A., Colich, N. L., Rodman, A. M., & Weissman, D. G. (2020). Mechanisms linking childhood trauma exposure and psychopathology: A transdiagnostic model of risk and resilience. *BMC Medicine*, 18, Article 96. <https://doi.org/10.1186/s12916-020-01561-6>
- *McLean, C. P., Morris, S. H., Conklin, P., Jayawickreme, N., & Foa, E. B. (2014). Trauma characteristics and posttraumatic stress disorder among adolescent survivors of childhood sexual abuse. *Journal of Family Violence*, 29(5), 559-566. <https://doi.org/10.1007/s10896-014-9613-6>
- *McLeer, S. V., Deblinger, E., Henry, D., & Orvaschel, H. (1992). Sexually abused children at high risk for post-traumatic stress disorder. *Journal of the American Academy of Child & Adolescent Psychiatry*, 31(5), 875-879. <https://doi.org/10.1097/00004583-199209000-00015>
- *McNair, F. D., Havens, J., Surko, M., Weinberger, E., Baetz, C., Moaveni, M., Bart, A., Marr, M., Quinlan, C., & Horwitz, S. M. (2019). Post-traumatic stress and related symptoms among juvenile detention residents: Results from intake screening. *Child Abuse & Neglect*, 92, 22-31. <https://doi.org/10.1016/j.chiabu.2019.03.011>
- McTavish, J. R., Sverdlichenko, I., MacMillan, H. L., & Wekerle, C. (2019). Child sexual abuse, disclosure and PTSD: A systematic and critical review. *Child Abuse & Neglect*, 92, 196-208. <https://doi.org/10.1016/j.chiabu.2019.04.006>
- Melton, G. B., Petrila, J., Poythress, N. G., Slobogin, C., Otto, R. K., Mossman, D., & Condie, L. O. (2017). *Psychological evaluations for the courts: A handbook for mental health professionals and lawyers* (4th ed.). Guilford.
- *Merry, S. N., & Andrews, L. K. (1994). Psychiatric status of sexually abused children 12 months after disclosure of abuse. *Journal of the American Academy of Child & Adolescent Psychiatry*, 33(7), 939-944. <https://doi.org/10.1097/00004583-199409000-00002>
- Mii, A. E., Coffey, H. M., McCoy, K., Sonnen, E., Meidlinger, K., Huit, T. Z., May, G. C., Flood, M. F., & Hansen, D. J. (2024). Sleep, emotional, and behavioral problems among youth presenting to treatment following sexual abuse. *Journal of Child & Adolescent Trauma*, 17(2), 411-423. <https://doi.org/10.1007/s40653-023-00590-6>
- Miller-Graff, L. E., & Howell, K. H. (2015). Posttraumatic stress symptom trajectories among children exposed to violence. *Journal of Traumatic Stress*, 28(1), 17-24. <https://doi.org/10.1002/jts.21989>
- Mitra, S., Lee, W., Hayashi, K., Boyd, J., Milloy, M. J., Dong, H., Wood, E., & Kerr, T. (2021). A gender comparative analysis of post-traumatic stress disorder among a community-based cohort of people who use drugs in Vancouver, Canada. *Addictive Behaviors*, 115, Article 106793. <https://doi.org/10.1016/j.addbeh.2020.106793>

- Molnar, B. E., Berkman, L. F., & Buka, S. L. (2001). Psychopathology, childhood sexual abuse and other childhood adversities: Relative links to subsequent suicidal behaviour in the US. *Psychological Medicine*, 31(6), 965-977. <https://doi.org/10.2105/ajph.91.5.753>
- *Molnar, B. E., Buka, S. L., & Kessler, R. C. (2001). Child sexual abuse and subsequent psychopathology: Results from the National Comorbidity Survey. *American Journal of Public Health*, 91(5), Article 753. <https://doi.org/10.2105/AJPH.91.5.753>
- Monteiro, A., Vázquez, M. J., Seijo, D., & Arce, R. (2018). Are the reality criteria valid to classify and to discriminate between memories of self-experienced events and memories of video-observed events? *Revista Iberoamericana de Psicología y Salud*, 9(2), 149-160. <https://doi.org/10.23923/j.rips.2018.02.020>
- Montes, A., Sanmarco, J., Novo, M., Cea, B., & Arce, R. (2022). Estimating the psychological harm consequence of bullying victimization: A meta-analytic review for forensic evaluation. *International Journal of Environmental Research and Public Health*, 19(21), Article 13852. <https://doi.org/10.3390/ijerph192113852>
- *Moreland, A. D., Walsh, K., Hartley, C., Hanson, R., Danielson, C. K., Saunders, B., & Kilpatrick, D. G. (2018). Investigating longitudinal associations between sexual assault, substance use, and delinquency among female adolescents: Results from a nationally representative sample. *Journal of Adolescent Health*, 63(3), 320-326. <https://doi.org/10.1016/j.jadohealth.2018.04.002>
- *Muesser, K. T., & Taub, J. (2008). Trauma and PTSD among adolescents with severe emotional disorders involved in multiple service systems. *Psychiatric Services*, 59(6), 627-634. <https://doi.org/10.1176/ps.2008.59.6.627>
- *Münzer, A., Fegert, J. M., & Goldbeck, L. (2016). Psychological symptoms of sexually victimized children and adolescents compared with other maltreatment subtypes. *Journal of Child Sexual Abuse*, 25(3), 326-346. <https://doi.org/10.1080/10538712.2016.1137667>
- Mureşanu, I. A., Grad, D. A., Mureşanu, D. F., Dobran, S. A., Hapca, E., Strilciuc, Ş., Bnedek, I., Capris, D., Popescu, B. O., Perju-Dumbravă, L., & Cherecheş, R. M. (2022). Evaluation of post-traumatic stress disorder (PTSD) and related comorbidities in clinical studies. *Journal of Medicine and Life*, 15(4), Article 436. <https://doi.org/10.25122/jml-2022-0120>
- *Murat, Y., Karabekiroğlu, K., Yildirim, Z., Şahin, S., Sapmaz, D., Babadağı, Z., Turla, A., & Aydin, B. (2015). The psychiatric consequences of child and adolescent sexual abuse. *Nöro Psikiyatri Arşivi*, 52(4), 393-399. <http://doi.org/10.5152/npa.2015.7472>
- Nagtegaal, M. H., & Boonmann, C. (2022). Child sexual abuse and problems reported by survivors of CSA: A meta-review. *Journal of Child Sexual Abuse*, 31(2), 147-176. <https://doi.org/10.1080/10538712.2021.1985673>
- *Noll, J. G., Horowitz, L. A., Bonanno, G. A., Trickett, P. K., & Putnam, F. W. (2003). Revictimization and self-harm in females who experienced childhood sexual abuse: Results from a prospective study. *Journal of Interpersonal Violence*, 18(12), 1452-1471. <https://doi.org/10.1177/0886260503258035>
- Nomamiukor, F. O., Suresky, R. A., May, C. L., & Wisco, B. E. (2024). Understanding internalizing and externalizing symptoms in trauma exposed community members. *Psychological Trauma: Theory, Research, Practice, and Policy*, 16(1), 98-106. <https://doi.org/10.1037/tra0001388>
- Novo, M., & Seijo, D. (2010). Judicial judgement-making and legal criteria of testimonial credibility. *European Journal of Psychology Applied to Legal Context*, 2(2), 91-115. <https://journals.copmadrid.org/ejpalc/art/0b7e926154c1274e8b602f0d7c133d7>
- O'Donnell, M. L., Creamer, M., Bryant, R. A., Schnyder, U., & Shalev, A. (2006). Posttraumatic disorders following injury: Assessment and other methodological considerations. In G. Young, A. W. Kane, & K. Nicholson (Eds.), *Psychological knowledge in courts. PTSD, pain and TBI* (pp. 70-84). Springer.
- O'Donnell, M. L., Varker, T., Creamer, M., Fletcher, S., McFarlane, A. C., Silove, D., Bryant, R. A., & Forbes, D. (2013). Exploration of delayed-onset posttraumatic stress disorder after severe injury. *Psychosomatic Medicine*, 75(1), 68-75. <https://doi.org/10.1097/PSM.0b013e3182761e8b>
- *O'Leary, P. J. (2009). Men who were sexually abused in childhood: Coping strategies and comparisons in psychological functioning. *Child Abuse & Neglect*, 33(7), 471-479. <https://doi.org/10.1016/j.chiabu.2009.02.004>
- Olff, M. (2017). Sex and gender differences in post-traumatic stress disorder: An update. *European Journal of Psychotraumatology*, 8(Sup4), Article 1351204. <https://doi.org/10.1080/2008198.2017.1351204>
- *Ombok, C. A., Obondo, A., Kangethe, R., & Atwoli, L. (2013). The prevalence of post-traumatic stress disorder among sexually abused children at Kenyatta National Hospital in Nairobi, Kenya. *East African Medical Journal*, 90(10), 332-337.
- *O'Neill, K., & Gupta, K. (1991). Post-traumatic stress disorder in women who were victims of childhood sexual abuse. *Irish Journal of Psychological Medicine*, 8(2), 124-127. <https://doi.org/10.1017/S0790966700015044>
- Oquendo, M. A., Friend, J. M., Halberstam, B., Brodsky, B. S., Burke, A. K., Grunebaum, M. F., Malone, K. M., & Mann, J. J. (2003). Association of comorbid posttraumatic stress disorder and major depression with greater risk for suicidal behavior. *American Journal of Psychiatry*, 160(3), 580-582. <https://doi.org/10.1176/appi.ajp.160.3.580>
- *Orozco, R., Borges, G., Benjet, C., Medina-Mora, M. E., & López-Carrillo, L. (2008). Traumatic life events and posttraumatic stress disorder among Mexican adolescents: Results from a survey. *Salud Pública de México*, 50(1), 29-37. <https://doi.org/10.1590/S0036-36342008000700006>
- *Owens, G. P., & Chard, K. M. (2003). Comorbidity and psychiatric diagnoses among women reporting child sexual abuse. *Child Abuse & Neglect*, 27(9), 1075-1082. [https://doi.org/10.1016/S0145-2134\(03\)00168-6](https://doi.org/10.1016/S0145-2134(03)00168-6)
- *Ozbaran, B., Erermis, S., Bukusoglu, N., Bildik, T., Tamar, M., Ercan, E. S., Aydin, C., & Cetin, S. K. (2009). Social and emotional outcomes of child sexual abuse: A clinical sample in Turkey. *Journal of Interpersonal Violence*, 24(9), 1478-1493. <https://doi.org/10.1177/0886260508323663>
- *Palo, A. D., & Gilbert, B. O. (2015). The relationship between perceptions of response to disclosure of childhood sexual abuse and later outcomes. *Journal of Child Sexual Abuse*, 24(5), 445-463. <https://doi.org/10.1080/10538712.2015.1042180>
- Pereda, N., & Arch, M. (2012). Exploración psicológica forense del abuso sexual en la infancia: Una revisión de procedimientos e instrumentos [Forensic psychological assessment of child sexual abuse: A review of procedures and instruments]. *Papeles del Psicólogo*, 33(1), 36-47. <https://www.papelesdelpsicologo.es/pdf/2034.pdf>
- *Pérez-Fuentes, G., Olsson, M., Villegas, L., Morcillo, C., Wang, S., & Blanco, C. (2013). Prevalence and correlates of child sexual abuse: A national study. *Comprehensive Psychiatry*, 54(1), 16-27. <https://doi.org/10.1016/j.comppsy.2012.05.010>
- *Pittenger, S. L., Schreier, A., Meidlinger, K., Pogue, J. K., Theimer, K., Flood, M. F., & Hansen, D. J. (2019). Psychological distress and revictimization risk in youth victims of sexual abuse. *Journal of Interpersonal Violence*, 34(9), 1930-1960. <https://doi.org/10.1177/0886260516658755>
- Pozzulo, J. D., Dempsey, J. L., & Crescini, C. (2010). Factors affecting juror decisions in historic child sexual abuse cases involving continuous memories. *Criminal Justice and Behavior*, 37(9), 951-964. <https://doi.org/10.1177/0093854810373587>
- Puente-López, E., Pina, D., Daugherty, J. C., Pérez-García, M., & Merten, T. (2024). Simulación y validez de la información de síntomas psicopatológicos en España: conceptos, métodos y desafíos [Malingering and validity of reported psychopathological symptoms in Spain: concepts, methods and challenges]. *Revista Iberoamericana de Psicología y Salud*, 15(2), 66-79. <https://doi.org/10.23923/j.rips.2024.02.077>
- Pulverman, C. S., Kilimnik, C. D., & Meston, C. M. (2018). The impact of childhood sexual abuse on women's sexual health: A comprehensive review. *Sexual Medicine Reviews*, 6(2), 188-200. <https://doi.org/10.1016/j.sxmr.2017.12.002>
- Putnam, F. W. (2003). Ten-year research update review: Child sexual abuse. *Journal of the American Academy of Child & Adolescent Psychiatry*, 42(3), 269-278. <https://doi.org/10.1097/00004583-200303000-00006>
- Putnam, F. W., & Trickett, P. K. (1993). Child sexual abuse: A model of chronic trauma. *Psychiatry*, 56(1), 82-95. <https://doi.org/10.1080/00327471993.11024623>
- Quas, J. A., & Goodman, G. S. (2012). Consequences of criminal court involvement for child victims. *Psychology, Public Policy, and Law*, 18(3), 392-414. <https://doi.org/10.1037/a0026146>
- *Raghavan, C., & Kingston, S. (2006). Child sexual abuse and posttraumatic stress disorder: The role of age at first use of substances and lifetime traumatic events. *Journal of Traumatic Stress*, 19(2), 269-278. <https://doi.org/10.1002/jts.20117>
- *Rincón, P., Cova, F., Bustos, P., Aedo, J., & Valdivia, P. (2010). Estrés posttraumático en niños y adolescentes abusados sexualmente [Post-traumatic stress disorder among sexually abused children and adolescents]. *Revista Chilena de Pediatría*, 81(3), 234-240. <https://doi.org/10.4067/S0370-41062010000300006>
- *Rizo Martínez, L. E., Guevara Pérez, M. A., Hernández González, M., & Sánchez Sosa, J. J. (2018). A preliminary study of the prevalence of post-traumatic stress disorder, depression and anxiety symptoms in female adolescents maltreatment victims in Mexico. *Salud Mental*, 41(3), 139-144. <https://doi.org/10.17711/sm.0185-3325.2018.018>
- *Rodríguez, N., Ryan, S. W., Rowan, A. B., & Foy, D. W. (1996). Posttraumatic stress disorder in a clinical sample of adult survivors of childhood sexual abuse. *Child Abuse & Neglect*, 20(10), 943-952. [https://doi.org/10.1016/0145-2134\(96\)00083-X](https://doi.org/10.1016/0145-2134(96)00083-X)
- Rosenthal, R. (1994). Parametric measures of effect size. In H. Cooper & L. V. Hedges (Eds.), *The handbook of research synthesis* (pp. 231-244). Russell Sage Foundation.
- *Rowan, A. B., Foy, D. W., Rodríguez, N., & Ryan, S. (1994). Posttraumatic stress disorder in a clinical sample of adults sexually abused as children. *Child Abuse & Neglect*, 18(1), 51-61. [https://doi.org/10.1016/0145-2134\(94\)90095-7](https://doi.org/10.1016/0145-2134(94)90095-7)
- *Ruggiero, K. J., Smith, D. W., Hanson, R. F., Resnick, H. S., Saunders, B. E., Kilpatrick, D. G., & Best, C. L. (2004). Is disclosure of childhood rape associated with mental health outcome? Results from the National Women's Study. *Child Maltreatment*, 9(1), 62-77. <https://doi.org/10.1177/1077559503260309>
- *Runyon, M. K., & Kenny, M. C. (2002). Relationship of attributional style, depression, and posttrauma distress among children who suffered physical or sexual abuse. *Child Maltreatment*, 7(3), 254-264. <https://doi.org/10.1177/1077559502007003007>

- *Sadeh, A., Hayden, R. M., McGuire, J. P., Sachs, H., & Civita, R. (1994). Somatic, cognitive and emotional characteristics of abused children in a psychiatric hospital. *Child Psychiatry and Human Development*, 24(3), 191-200. <https://doi.org/10.1007/BF02353196>
- *Salazar, A. M., Keller, T. E., Gowen, L. K., & Courtney, M. E. (2013). Trauma exposure and PTSD among older adolescents in foster care. *Social Psychiatry and Psychiatric Epidemiology*, 48(4), 545-551. <https://doi.org/10.1007/s00127-012-0563-0>
- *Say, G. N., Babadağı, Z., Karabekiroğlu, K., Yüce, M., & Akbaş, S. (2015). Abuse characteristics and psychiatric consequences associated with online sexual abuse. *Cyberpsychology, Behavior, and Social Networking*, 18(6), 333-336. <https://doi.org/10.1089/cyber.2014.0494>
- *Schaaf, K. K., & McCanne, T. R. (1998). Relationship of childhood sexual, physical, and combined sexual and physical abuse to adult victimization and posttraumatic stress disorder. *Child Abuse & Neglect*, 22(11), 1119-1133. [https://doi.org/10.1016/S0145-2134\(98\)00090-8](https://doi.org/10.1016/S0145-2134(98)00090-8)
- Scheeringa, M. S., Zeanah, C. H., Drell, M. J., & Larrieu, J. A. (1995). Two approaches to the diagnosis of posttraumatic stress disorder in infancy and early childhood. *Journal of the American Academy of Child & Adolescent Psychiatry*, 34(2), 191-200. <https://doi.org/10.1097/00004583-199502000-00014>
- *Schiff, M., Levit, S., & Cohen-Moreno, R. (2010). Childhood sexual abuse, post-traumatic stress disorder, and use of heroin among female clients in Israeli methadone maintenance treatment programs (MMTPS). *Social Work in Health Care*, 49(9), 799-813. <https://doi.org/10.1080/00981381003745103>
- Schmidt, F. L., & Hunter, J. E. (2015). *Methods of meta-analysis: Correcting error and bias in research findings* (3rd ed.). Sage.
- *Schneider, R., Baumrind, N., & Kimerling, R. (2007). Exposure to child abuse and risk for mental health problems in women. *Violence and Victims*, 22(5), 620-631. <https://doi.org/10.1891/088667007782312140>
- *Sesar, K., Šimić, N., & Barišić, M. (2010). Multi-type childhood abuse, strategies of coping, and psychological adaptations in young adults. *Croatian Medical Journal*, 51(5), 406-416. <https://doi.org/10.3325/cmj.2010.51.406>
- Seymour, F., Blackwell, S., Calvert, S., & McLean, B. (2013). Counterintuitive expert psychological evidence in child sexual abuse trials in New Zealand. *Psychiatry, Psychology and Law*, 21(4), 511-522. <https://doi.org/10.1080/13218719.2013.839930>
- *Silva, R. R., Alpert, M., Munoz, D. M., Singh, S., Matzner, F., & Dummit, S. (2000). Stress and vulnerability to posttraumatic stress disorder in children and adolescents. *American Journal of Psychiatry*, 157(8), 1229-1235. <https://doi.org/10.1176/appi.ajp.157.8.1229>
- *Silverman, A. B., Reinherz, H. Z., & Giaconia, R. M. (1996). The long-term sequelae of child and adolescent abuse: A longitudinal community study. *Child Abuse & Neglect*, 20(8), 709-723. [https://doi.org/10.1016/0145-2134\(96\)00059-2](https://doi.org/10.1016/0145-2134(96)00059-2)
- *Sim, L., Friedrich, W. N., Davies, W. H., Trentham, B., Lengua, L., & Pithers, W. (2005). The Child Behavior Checklist as an indicator of posttraumatic stress disorder and dissociation in normative, psychiatric, and sexually abused children. *Journal of Traumatic Stress*, 18(6), 697-705. <https://doi.org/10.1002/jts.20078>
- Simon, J., Luetzow, A., & Conte, J. R. (2020). Thirty years of the convention on the rights of the child: Developments in child sexual abuse and exploitation. *Child Abuse & Neglect*, 110(1), Article 104399. <https://doi.org/10.1016/j.chiabu.2020.104399>
- *Sowmya, B. T., Seshadri, S. P., Srinath, S., Girimaji, S., & Sagar, J. V. (2016). Clinical characteristics of children presenting with history of sexual abuse to a tertiary care centre in India. *Asian Journal of Psychiatry*, 19, 44-49. <https://doi.org/10.1016/j.ajp.2015.12.007>
- *Soylu, N., Alpaslan, A. H., Ayaz, M., Esenyel, S., & Oruç, M. (2013). Psychiatric disorders and characteristics of abuse in sexually abused children and adolescents with and without intellectual disabilities. *Research in Developmental Disabilities*, 34(12), 4334-4342. <https://doi.org/10.1016/j.ridd.2013.09.010>
- Soylu, N., Ayaz, M., Gökten, E. S., Alpaslan, A. H., Dönmez, Y. E., Özcan, Ö. Ö., Ayaz, A. B., & Tufan, A. E. (2016). Gender differences in sexually abused children and adolescents: A multicenter study in Turkey. *Journal of Child Sexual Abuse*, 25(4), 415-427. <https://doi.org/10.1080/10538712.2016.1143073>
- *Spinazzola, J., Van der Kolk, B., & Ford, J. D. (2018). When nowhere is safe: Interpersonal trauma and attachment adversity as antecedents of posttraumatic stress disorder and developmental trauma disorder. *Journal of Traumatic Stress*, 31(5), 631-642. <https://doi.org/10.1002/jts.22320>
- *Steine, I. M., Winje, D., Skogen, J. C., Krystal, J. H., Milde, A. M., Bjorvatn, B., Nordhus, I. H., Grønli, J., & Pallesen, S. (2017). Posttraumatic symptom profiles among adult survivors of childhood sexual abuse: A longitudinal study. *Child Abuse & Neglect*, 67, 280-293. <https://doi.org/10.1016/j.chiabu.2017.03.002>
- *Subica, A. M. (2013). Psychiatric and physical sequelae of childhood physical and sexual abuse and forced sexual trauma among individuals with serious mental illness. *Journal of Traumatic Stress*, 26(5), 588-596. <https://doi.org/10.1002/jts.21845>
- Suliman, S., Mkabile, S. G., Fincham, D. S., Ahmed, R., Stein, D. J., & Seedat, S. (2009). Cumulative effect of multiple trauma on symptoms of posttraumatic stress disorder, anxiety, and depression in adolescents. *Comprehensive Psychiatry*, 50(2), 121-127. <https://doi.org/10.1016/j.comppsy.2008.06.006>
- Taubman-Ben-Ari, O., Rabinowitz, J., Feldman, D., & Vaturi, R. (2001). Post-traumatic stress disorder in primary-care settings: Prevalence and physicians' detection. *Psychological Medicine*, 31(3), 555-560. <https://doi.org/10.1017/S0033291701003658>
- *Trowell, J., Ugarte, B., Kolvin, I., Berelowitz, M., Sadowski, H., & Le Couteur, A. (1999). Behavioural psychopathology of child sexual abuse in schoolgirls referred to a tertiary centre: A North London study. *European Child & Adolescent Psychiatry*, 8(2), 107-116. <https://doi.org/10.1007/s007870050091>
- *Tsang, V. M., Verlinden, E., van Duin, E. M., Twisk, J. W., Brilleslijper-Kater, S. N., Gigengack, M. R., Verhoeff, A. P., & Lindauer, R. J. L. (2021). The Amsterdam sexual abuse case: What scars did it leave? Long-term course of psychological problems for children who have been sexually abused at a very young age, and their parents. *Child Psychiatry & Human Development*, 52(5), 891-902. <https://doi.org/10.1007/s10578-020-01067-5>
- *Twaite, J. A., & Rodriguez-Srednicki, O. (2004). Childhood sexual and physical abuse and adult vulnerability to PTSD: The mediating effects of attachment and dissociation. *Journal of Child Sexual Abuse*, 13(1), 17-38. https://doi.org/10.1300/J070v13n01_02
- Ullman, S. E., & Filipas, H. H. (2005). Gender differences in social reactions to abuse disclosures, post-abuse coping, and PTSD of child sexual abuse survivors. *Child Abuse & Neglect*, 29(7), 767-782. <https://doi.org/10.1016/j.chiabu.2005.01.005>
- *Ullman, S. E., Najdowski, C. J., & Filipas, H. H. (2009). Child sexual abuse, post-traumatic stress disorder, and substance use: Predictors of revictimization in adult sexual assault survivors. *Journal of Child Sexual Abuse*, 18(4), 367-385. <https://doi.org/10.1080/10538710903035263>
- United Nations (UN, 1985, November 29). *Declaration of basic principles of justice for victims of crime and abuse of power*. Assembly of the United Nations. <https://www.ohchr.org/Documents/ProfessionalInterest/victims.pdf>
- United Nations (UN, 1989, November 20). *Convention on the rights of the child*. Assembly of the United Nations. <https://www.ohchr.org/es/instruments-mechanisms/instruments/convention-rights-child>
- Urquiza, A. J., & Keating, L. M. (1990). The prevalence of sexual victimization of males. In M. Hunter (Ed.), *The sexually abused male: Vol. 1. Prevalence, impact, and treatment* (pp. 89-103). Lexington Books/D.C. Heath and Company.
- Utzon-Frank, N., Breinegaard, N., Bertelsen, M., Borritz, M., Eller, N. H., Nordentoft, M., Olesen, K., Rod, N. H., Rugulies, R., & Bonde, J. P. (2014). Occurrence of delayed-onset post-traumatic stress disorder: A systematic review and meta-analysis of prospective studies. *Scandinavian Journal of Work, Environment & Health*, 40(3), 215-229. <https://doi.org/10.5271/sjweh.3420>
- Vale, M., Gomes, J. P., & Matos, M. (2024). Forensic psychological procedures in cases of technology-facilitated sexual abuse among adolescents: A scoping review. *Behavioral Sciences & the Law*, 42(4), 313-337. <https://doi.org/10.1002/bsl.2658>
- Vallano, J. P. (2013). Psychological injuries and legal decision making in civil cases: What we know and what we do not know. *Psychological Injury and Law*, 6(2), 99-112. <https://doi.org/10.1007/s12207-013-9153-z>
- Vallano, J. P., Winter, R. J., & Charman, S. D. (2013). Is this injury reasonable? Do psychological injury expectations affect mock jurors' legal decisions in a sexual harassment case? *Psychiatry, Psychology and Law*, 20(6), 834-852. <https://doi.org/10.1080/13218719.2012.744626>
- Vilarino, M., Arce, R., & Fariña, F. (2013). Forensic-clinical interview: Reliability and validity for the evaluation of psychological injury. *European Journal of Psychology Applied to Legal Context*, 5(1), 1-21. <https://journals.copmadrid.org/ejpalc/archivos/articulo20180219092235.pdf>
- Walker, J. L., Carey, P. D., Mohr, N., Stein, D. J., & Seedat, S. (2004). Gender differences in the prevalence of childhood sexual abuse and in the development of pediatric PTSD. *Archives of Women's Mental Health*, 7(2), 111-121. <https://doi.org/10.1007/s00737-003-0039-z>
- Wang, S. J., Chang, J. J., Cao, L. L., Li, Y. H., Yuan, M. Y., Wang, G. F., & Su, P. Y. (2023). The relationship between child sexual abuse and sexual dysfunction in adults: A meta-analysis. *Trauma, Violence, & Abuse*, 24(4), 2772-2788. <https://doi.org/10.1177/1524838022113780>
- *Ward, C. L., Artz, L., Leoschut, L., Kassanjee, R., & Burton, P. (2018). Sexual violence against children in South Africa: A nationally representative cross-sectional study of prevalence and correlates. *Lancet Global Health*, 6(4), e460-e468. [https://doi.org/10.1016/S2214-109X\(18\)30060-3](https://doi.org/10.1016/S2214-109X(18)30060-3)
- *Watts, J. R., Lazzareschi, N. R., Liu, Y., & O'Sullivan, D. (2023). Childhood psychological maltreatment, sense of self, and PTSD symptoms in emerging adulthood. *Journal of Counseling & Development*, 101(1), 96-105. <https://doi.org/10.1002/jcad.12455>
- *Weierich, M. R., & Nock, M. K. (2008). Posttraumatic stress symptoms mediate the relation between childhood sexual abuse and nonsuicidal self-injury. *Journal of Consulting and Clinical Psychology*, 76(1), 39-44. <https://doi.org/10.1037/0022-006X.76.1.39>
- Wicker, A. W. (1975). An application of a multitrait-multimethod logic to the reliability of observational records. *Personality and Social Psychology Bulletin*, 1(4), 575-579. <https://doi.org/10.1177/014616727500100405>

- *Widom, C. S. (1999). Posttraumatic stress disorder in abused and neglected children grown up. *American Journal of Psychiatry*, 156(8), 1223-1229. <https://doi.org/10.1176/ajp.156.8.1223>
- *Wolfe, D. A., Sas, L., & Wekerle, C. (1994). Factors associated with the development of posttraumatic stress disorder among child victims of sexual abuse. *Child Abuse & Neglect*, 18(1), 37-50. [https://doi.org/10.1016/0145-2134\(94\)90094-9](https://doi.org/10.1016/0145-2134(94)90094-9)
- World Health Organization (WHO, 1999, March 29-31). *Report of the consultation on child abuse prevention*. World Health Organization. https://iris.who.int/bitstream/handle/10665/65900/WHO_HSC_PVI_99.1.pdf?sequence=1&isAllowed=y
- Young, G., Bailey, T., Giromini, L., Soble, J. R., Rogers, R., & Levitt, B. E. (Eds.). (2025). *Handbook of psychological injury and law*. Springer.
- *Yüce, M., Karabekiroğlu, K., Yildirim, Z., Şahin, S., Sapmaz, D., Babadağı, Z., Turla, A., & Aydın, B. (2015). The psychiatric consequences of child and adolescent sexual abuse. *Nöro Psikiyatri Arşivi*, 52(4), 393-399. <https://doi.org/10.5152/npa.2015.7472>
- *Zajac, K., Ralston, M. E., & Smith, D. W. (2015). Maternal support following childhood sexual abuse: Associations with children's adjustment post-disclosure and at 9-month follow-up. *Child Abuse & Neglect*, 44, 66-75. <https://doi.org/10.1016/j.chiabu.2015.02.011>

Appendix

Summary Table of Primary Studies Characteristics

Study Cite	PTSD measure	r_{yy}	CSA measure	r_{xx}	Moderator	N_{GE}	N_{GC}	d [95% CI]
Ackerman et al. (1998)	DICA-R	–	Interview	–	Total (diagnosis) Female Male	127 100 27		1.87 [1.79, 1.95] 1.99 [1.89, 2.07] 1.39 [1.23, 1.55]
Adam et al. (1992)	DICA-R	–	Interview	–	Total (diagnosis) Female Male	16 8 8		2.04 [1.80, 2.28] 2.22 [1.87, 2.57] 1.86 [1.52, 2.20]
Alix et al. (2017)	CITES II	.95	HVF	–	Total (diagnosis, female)	147		2.70 [2.62, 2.78]
Arata (2000)	IES	.87	Adhoc questionnaire	–	Total (symptom severity, female)	81	138 ¹	0.33 [0.28, 0.38]
Asberg and Renk (2014)	TSI	.86	Singleitem self-report	–	Total (symptom severity, female)	24	15	0.51 [0.33, 0.69]
Auslander et al. (2018)	CPSS	.90	CTQ	.92	Total (symptom severity, female)	150	84	0.65 [0.60, 0.70]
Aydin et al. (2015)	DSM-IV	–	Official records	–	Total	1002		1.36 [1.33, 1.39]
Bahali et al. (2010)	DSM-IV	–	Clinical records	–	Total (diagnosis) No contact abuse Contact abuse Penetration	97 3 47 47		2.32 [2.22, 2.42] 1.74 [1.21, 2.27] 2.37 [2.23, 2.51] 2.37 [2.23, 2.51]
Baker et al. (2009)	CES-D	.82	Interview	–	Total (symptom severity) Female Male	159 119 40	2018 1280 738	0.43 [0.42, 0.44] 0.52 [0.50, 0.54] 0.20 [0.17, 0.23]
Ballard et al. (2015)	CIDI	–	DAST	.84	Total (diagnosis)	120		1.69 [1.61, 1.77]
Bernard-Bonnin et al. (2008)	CITES-R	.81	HVF	–	Total (diagnosis, female)	67		2.12 [2.00, 2.24]
Boney-McCoy and Finkelhor (1996)	SCL-90-R	.75	Interview	–	Total (symptom severity) Female Male	91 67 24	1366 619 747	0.66 [0.64, 0.68] 0.61 [0.58, 0.64] 0.74 [0.71, 0.77]
Boroughs et al. (2015)	SCID	–	Structured interview	–	Total (diagnosis)	162		2.12 [2.04, 2.20]
Brabant et al. (2014)	CITES-R	.88	Adhoc questionnaire	–	Total (diagnosis, female)	74		2.18 [2.10, 2.26]
Brand et al. (1996)	DICA	–	WSHI – modified	–	Total (diagnosis)	24		2.10 [1.90, 2.30]
Briere et al. (2003)	TSI	.85	TES	.92	Total (symptom severity)	220	721	0.67 [0.65, 0.69]
Cantón-Cortes et al. (2012)	PSS	.84	Adhoc questionnaire	–	Total (symptom severity, female)	151	463 ¹	0.36 [0.34, 0.38]
Caravaca et al. (2019)	TSQ	.96	CTQ	.94	Total (symptom severity, female)	97	846	0.61 [0.59, 0.63]
Carey et al. (2008)	DSM-IV	–	CTQ	.94	Total (diagnosis)	50		3.44 [3.35, 3.53]
Celbis et al. (2020)	DSM-IV-TR	–	Clinical records	–	Total (diagnosis, intrafamilial) Contact abuse Penetration	40 25 15		2.58 [2.43, 2.73] 2.62 [2.43, 2.81] 2.51 [2.26, 2.76]
Chaplo et al. (2017)	PTSD-RI	.94	PTSD-RI	–	Total (symptom severity) Female Male	165 109 56	661 105 556	0.90 [0.88, 0.92] 0.79 [0.73, 0.84] 0.75 [0.72, 0.78]
Choi et al. (2017)	UADADIS-5	–	CTQ / ACE – modified	–	Total (diagnosis)	1674	13064	0.44 [0.43, 0.45]
Collin-Vezina et al. (2005)	CITES-R	.81	Clinical records	–	Total (symptom severity, female) Total (diagnosis, female) Intrafamilial Extrafamilial Contact abuse Penetration	131 67 67 21 46 42 22	67	2.12 [2.00, 2.24] 0.71 [0.66, 0.76] 0.85 [0.74, 0.96] 0.77 [0.69, 0.85] 0.47 [0.39, 0.55] 1.19 [1.08, 1.30]
Conway et al. (2013)	DSM-IV	–	Clinical records	–	Total (diagnosis)	20		1.31 [1.13, 1.49]
Costa et al. (2019)	PSS-SR	.96	CTQ	.94	Total (symptom severity, female)	480	287	4.84 [4.81, 4.87] ²
Crouch et al. (1999)	TSCC	.85	Clinical records	–	Total (symptom severity)	97	1357 ¹	2.24 [2.22, 2.26]
Cutajar et al. (2010)	Psychiatric diagnosis (clinical records)	–	Forensic assessment	–	Total (diagnosis) Female Male	2688 2153 535	2677 2055 622	0.95 [0.94, 0.96] 1.09 [1.08, 1.10] 0.43 [0.42, 0.44]
Daigneault et al. (2006)	TSCC	.84	SARS	.93	Total (diagnosis, female)	103		2.43 [2.33, 2.53]

Appendix

Summary Table of Primary Studies Characteristics

Study Cite	PTSD measure	r_{yy}	CSA measure	r_{xx}	Moderator	N_{GE}	N_{GC}	d [95% CI]
De Rose et al. (2016)	DSM-IV-TR K-SADS-PL	–	Clinical records	–	Total (diagnosis)	40		2.43 [2.28, 2.58]
Deblinger et al. (1989)	DIS-III-R	–	Official records	–	Total (diagnosis)	96		1.86 [1.76, 1.96]
Dias et al. (2017)	PDS	.93	CTQ-SF	.94	Total (diagnosis)	14		1.36 [1.15, 1.57]
					Intrafamilial	6		1.74 [1.36, 2.12]
					Extrafamilial	8		1.02 [0.79, 1.25]
Dodson and Beck (2019)	PTCI	.92	LEC	.76	Total (symptom severity)	96	178 ¹	1.42 [1.38, 1.46]
Dykman et al. (1997)	DICA	–	Clinical records	–	Total (diagnosis)	58		2.51 [2.38, 2.64]
Elklit et al. (2014)	HTQ	.90	Adhoc questionnaire	–	Total (symptom severity)	480	213	0.91 [0.89, 0.93]
Ellenbogen et al. (2018)	TSCC	.87	CTQ	.92	Total (symptom severity)	151	1357 ¹	1.53 [1.51, 1.55]
Epstein et al. (1997)	NWS	–	ICI – modified	–	Total (diagnosis, female)	288		1.50 [1.45, 1.55]
Farley and Patsalides (2001)	PCL	.97	Interview	–	Total (symptom severity, female)	27	26	1.03 [0.88, 1.18]
Feerick and Snow (2005)	SCID	–	CSAI – modified	.82	Total (symptom severity, female)	98	215	0.57 [0.53, 0.61]
Fergusson et al. (2013)	DIS-IV	–	Interview	–	Total (symptom severity)	144	840	0.57 [0.55, 0.59]
					No contact abuse	28	809	0.70 [0.67, 0.73]
					Contact abuse	52	809	0.36 [0.33, 0.39]
					Penetration	64	809	0.71 [0.69, 0.73]
Fis et al. (2010)	DSM-IV	–	Official records	–	Total (diagnosis)	83		1.61 [1.51, 1.71]
Fitzpatrick et al. (2010)	TSI	.87	CTQ	.94	Total (symptom severity)	60	138	1.05 [0.99, 1.11]
	SCID	–			Total (diagnosis)	60		1.79 [1.67, 1.91]
Fondacaro and Holt (1999)	DIS-III-R	–	SAQ – modified	–	Total (diagnosis, male)	86		2.22 [2.11, 2.33]
Ford et al. (2010)	DIS-IV	–	Ad-hoc questionnaire	–	Total (diagnosis)	124		1.69 [1.61, 1.77]
Frounfelker et al. (2013)	DSM-IV-TR	–	Clinical records	–	Total (diagnosis)	41	84	2.46 [2.31, 2.61]
Gauthier et al. (2017)	CITES-II	.92	HVF	.86	Total (symptom severity)	447	214	1.22 [1.20, 1.24]
					Female	319	214	1.48 [1.45, 1.51]
					Male	128	214	1.13 [1.09, 1.17]
Giaconia et al. (1995)	DIS-III-R	–	DIS-III-R	–	Total (diagnosis)	8		2.22 [1.87, 2.57]
Glod and Teicher (1996)	K-SADS-E	–	Official records	–	Total (diagnosis)	9		2.38 [2.06, 2.70]
Gokten and Duman (2016)	DSM-IV-TR	–	Official records	–	Total (diagnosis)	482		1.95 [1.91, 1.99]
					Female	396		2.05 [2.00, 2.10]
					Male	86		1.46 [1.37, 1.55]
					Intrafamilial	81		1.92 [1.81, 2.03]
					Extrafamilial	401		1.95 [1.90, 2.00]
					No contact abuse	17		1.80 [1.57, 2.03]
					Contact abuse	251		1.99 [1.93, 2.05]
					Penetration	211		1.90 [1.83, 1.97]
Gospodarevskaya (2013)	CIDI	–	CIDI	–	Total (diagnosis)	952		1.54 [1.51, 1.57]
Grassi-Oliveira and Stein (2008)	PCL-C	.91	CTQ	.93	Total (symptom severity)	17	316 ¹	0.84 [0.79, 0.89]
Gudjonsson et al. (2021)	PTSD-RI	.94	Forensic assessment	–	Total (symptom severity)	180	661	1.12 [1.10, 1.14]
					Intrafamilial	97	661	1.46 [1.44, 1.48]
					Extrafamilial	83	661	0.72 [0.70, 0.74]
Guerra et al. (2018)	CPSS	.89	Ad-hoc questionnaire	–	Total (symptom severity, female)	106	56 ¹	0.90 [0.84, 0.96]
Gwandure (2007)	IES-R	.86	Official records	–	Total (symptom severity)	40	40	6.86 [5.71, 7.03] ²
Harding et al. (2012)	PPTSD-R	.91	CTQ	.90	Total (symptom severity, female)	127	50	0.58 [0.52, 0.64]
Haviland et al. (1995)	CPTSD-RI	.88	Structured interview	–	Total (symptom severity)	23	25	2.94 [2.76, 3.12]
Hébert et al. (2019)	PTSD-RI	.89	Ad-hoc questionnaire	–	Total (diagnosis)	1102		1.58 [1.55, 1.61]
					Female	933		1.64 [1.61, 1.67]
					Male	169		1.21 [1.15, 1.27]

Appendix

Summary Table of Primary Studies Characteristics

Study Cite	PTSD measure	r_{yy}	CSA measure	r_{xx}	Moderator	N_{GE}	N_{GC}	d [95% CI]
Hetzel and McCanne (2005)	PTSD-Q	.93	CSEQ – modified	–	Total (diagnosis)	38		2.52 [2.36, 2.68]
Hidalgo et al. (2015)	CIDIS-IV	–	ESE	.92	Total (diagnosis, male)	449		1.16 [1.13, 1.19]
Hsieh et al. (2016)	PTSD-RI	.89	CEVQ	.92	Total (symptom severity)	573	5660	0.41 [0.40, 0.42]
Huang et al. (2008)	CAPS	–	TLEQ	–	Total (diagnosis)	37		2.41 [2.25, 2.57]
Hyland et al. (2017)	ICD-11	–	Singleitem self-report	–	Total (diagnosis)	66	2525	0.74 [0.73, 0.74]
Kamen et al. (2012)	IES-R	.94	THQ	.71	Total (symptom severity, male)	59	108	0.39 [0.32, 0.45]
Khadr et al. (2018)	DSM-IV-TR	–	Forensic assessment	–	Total (diagnosis)	135		3.51 [3.46, 3.56]
Kisely et al. (2021)	CIDI	–	CTQ	.94	Total (diagnosis)	198	2227	0.62 [0.61, 0.63]
Koenen and Widom (2009)	DIS-III-R	–	Official records	–	Total (diagnosis)	94		1.89 [1.79, 1.99]
					Female	75		2.05 [1.94, 2.16]
					Male	19		1.16 [1.00, 1.32]
Lamoureux et al. (2012)	PSS-I	.96	CTQ	.94	Total (symptom severity, female)	271	422	0.68 [0.66, 0.70]
Leck et al. (2006)	PCL	.94	TEI	–	Total (symptom severity, male)	92	2030	0.37 [0.36, 0.38]
Libby et al. (2005)	DSM-IV	–	Ad-hoc questionnaire	–	Total – sample 1 (diagnosis)	77	1369	1.25 [1.23, 1.27]
					Total – sample 2 (diagnosis)	55	1583	1.34 [1.32, 1.36]
Livingston et al. (1993)	DICA-6-R	–	Clinical records	–	Total (diagnosis)	26		2.44 [2.25, 2.63]
Maalouf et al. (2020)	ICD-10	–	Official records	–	Total (diagnosis)	882		1.43 [1.40, 1.46]
Maikovich et al. (2009)	TSCC	.84	Official records	–	Total (symptom severity)	389	667 ¹	0.88 [0.86, 0.90]
					Female	300	354 ¹	0.89 [0.87, 0.91]
					Male	89	313 ¹	0.91 [0.88, 0.84]
Mathews et al. (2013)	PCL	.95	Clinical records	–	Total (diagnosis, female)	31		2.73 [2.57, 2.89]
McClellan et al. (1995)	Psychiatric diagnosis (clinical records)	–	Clinical records	–	Total (diagnosis)	273		1.73 [1.67, 1.79]
McDonagh et al. (2001)	CAPS	.94	ETI	–	Total (diagnosis)	37		3.38 [3.27, 3.49]
McLean et al. (2014)	CPSS	.70	THI	.90	Total (symptom severity, female)	83	44 ¹	2.25 [2.17, 2.33]
McLeer et al. (1992)	K-SADS-E	–	Official records	–	Total (diagnosis)	92		2.04 [1.94, 2.14]
					Intrafamilial	72		2.18 [2.06, 2.30]
					Extrafamilial	10		0.91 [0.72, 1.10]
McNair et al. (2019)	PTSD-RI	.91	PTSD-RI	–	Total (diagnosis)	795		1.30 [1.27, 1.33]
Merry and Andrews (1994)	DSM-III-R	–	Official records	–	Total (diagnosis)	66		1.25 [1.16, 1.34]
					Female	55		1.25 [1.15, 1.35]
					Male	11		1.25 [1.02, 1.48]
Molnar et al. (2001)	CIDI	–	NCS	–	Total (diagnosis)	469		1.86 [1.82, 1.90]
					Female	395		1.91 [1.86, 1.96]
					Male	74		1.63 [1.53, 1.73]
Moreland et al. (2018)	DSM-IV	–	NSA	.99	Total (diagnosis, female)	200	3414	0.35 [0.34, 0.36]
Mueser and Taub (2008)	ChIPS	–	Clinical records	–	Total (diagnosis)	18		2.54 [2.31, 2.77]
Münzer et al. (2016)	K-SADS-PL-G	–	JVQ	.80	Total (diagnosis)	70		1.26 [1.17, 1.35]
Murat et al. (2015)	K-SADS-PL-T	–	Singleitem self-report	–	Total (diagnosis)	590		1.69 [1.65, 1.73]
Noll et al. (2003)	DSM-IV	–	CTI	–	Total (symptom severity, female)	6	70	0.37 [0.22, 0.52]
O’Leary (2009)	GHQ-28	–	Adhoc questionnaire	–	Total (diagnosis, male)	146		1.83 [1.75, 1.91]

Appendix

Summary Table of Primary Studies Characteristics (continued)

Study Cite	PTSD measure	r_{yy}	CSA measure	r_{xx}	Moderator	N_{GE}	N_{GC}	d [95% CI]
Ombok et al. (2013)	PTSD-RI	.91	Ad-hoc questionnaire (SAP)	–	Total (diagnosis) Female Male Intrafamilial Extrafamilial	149 127 22 96 47		2.19 [2.11, 2.27] 2.19 [2.10, 2.28] 2.22 [2.01, 2.43] 2.16 [2.06, 2.26] 2.34 [2.20, 2.48]
O'Neill and Gupta (1991)	SIPTSD	–	Semistructured interview	–	Total (diagnosis, female) Intrafamilial Extrafamilial Contact abuse Penetration	26 11 15 6 20		2.90 [2.73, 3.07] 3.58 [3.41, 3.75] 2.51 [2.26, 2.76] 1.19 [0.89, 1.49] 3.53 [3.40, 3.66]
Orozco et al. (2008)	CIDI	–	CIDI	–	Total (diagnosis)	163		0.81 [0.77, 0.85]
Owens and Chard (2003)	CAPS	.85	Interview	–	Total (diagnosis, female)	89		3.48 [3.41, 3.55]
Ozbaran et al. (2009)	DSM-IV	–	Forensic assessment	–	Total (diagnosis)	20		1.79 [1.58, 2.00]
Palo and Gilbert (2015)	PCL-S	.91	SAIS – modified	–	Total (symptom severity, female)	38	92	3.52 [3.43, 3.61]
Pérez-Fuentes et al. (2013)	DSM-IV	–	CTQ – modified	–	Total (diagnosis)	3786		0.89 [0.89, 0.89]
Pittenger et al. (2019)	CITES-R	.59	Clinical records	–	Total (symptom severity)	166	67 ¹	1.22 [1.17, 1.27]
Raghavan and Kingston (2006)	PDS	.92	PDS	–	Total (symptom severity, female)	206	438	0.87 [0.85, 0.89]
Rincon et al. (2010)	CPSS	.89	Forensic assessment	–	Total (diagnosis)	75		1.36 [1.27, 1.45]
Rizo et al. (2018)	CPSS	.89	Official records	–	Total (diagnosis, female)	34		2.47 [2.30, 2.64]
Rodriguez et al. (1996)	SCID	–	SAEQ	.94	Total (diagnosis)	117		2.88 [2.80, 2.96]
Rowan et al. (1994)	SCID	–	SAEQ	.93	Total (diagnosis)	42		2.77 [2.63, 2.91]
Ruggiero et al. (2004)	NWS	–	ICI – modified	–	Total (diagnosis, female)	288		1.43 [1.38, 1.48]
Runyon and Kenny (2002)	PTSD-RI	.84	Official records	–	Total (symptom severity)	31	25	1.89 [1.74, 2.04]
Sadeh et al. (1994)	DSM-III-R	–	Clinical records	–	Total (diagnosis)	49		2.91 [2.79, 3.03]
Salazar et al. (2013)	CIDI	–	CIDI	–	Total (diagnosis) Contact abuse Penetration	219 199 128		1.74 [1.68, 1.80] 0.90 [0.88, 0.92] 0.98 [0.96, 1.00]
Say et al. (2015)	DSM-IV	–	Clinical records	–	Total (diagnosis)	662		2.09 [2.05, 2.13]
Schaaf and McCanne (1998)	DSM-IV	–	CSEQ	.90	Total (diagnosis, female)	27		1.12 [0.99, 1.25]
Schiff et al. (2010)	PDS	.92	PDS	–	Total (diagnosis, female)	104		2.22 [2.12, 2.32]
Schneider et al. (2007)	PC-PTSD	.79	TSS – modified	–	Total (diagnosis, female)	145	2792	0.96 [0.95, 0.97]
Sesar et al. (2010)	TSC-40	.84	CCMSA	.94	Total (symptom severity)	91	142	0.67 [0.62, 0.72]
Silva et al. (2000)	KID-SCID	–	KID-SCID	–	Total (diagnosis)	13		1.14 [0.94, 1.34]
Silverman et al. (1996)	DIS-III-R	–	Interview	–	Total (diagnosis, female)	23		1.78 [1.59, 1.97]
Sim et al. (2005)	TSCC	.87	Official records	–	Total (symptom severity)	409	1356 ¹	0.83 [0.82, 0.84]
Sowmya et al. (2016)	ICD-10	–	Clinical records	–	Total (diagnosis)	40		1.48 [1.35, 1.61]
Soylu et al. (2013)	DSM-IV	–	Forensic assessment	–	Total (diagnosis)	102		2.19 [2.09, 2.29]
Spinazzola et al. (2018)	KSADS/PL	–	TESI	–	Total (diagnosis)	48	188	0.30 [0.25, 0.35]
Steine et al. (2017)	IES-R	.95	CTQ-SF	.85	Total (symptom severity)	138	99	2.31 [2.26, 2.36]
Subica (2013)	PCL-S	.96	TAA-R	.80	Total (symptom severity)	51	121	0.68 [0.62, 0.74]
Trowell et al. (1999)	K-SADS	–	Clinical records	–	Total (diagnosis, female)	21		2.85 [2.66, 3.04]
Tsang et al. (2021)	CRIS-13	.80	Official records	–	Total (diagnosis)	45		0.86 [0.78, 0.94]
Twaite et al. (2014)	IES-R	.91	Adhoc questionnaire	–	Total (symptom severity)	56	207	0.50 [0.45, 0.55]
Ullman et al. (2009)	PDS	.91	SES	.73	Total (symptom severity, female)	300	255	0.41 [0.39, 0.43]
Ward et al. (2018)	TSCYC	.93	JVQ	.80	Total (diagnosis)	678	4953	0.57 [0.56, 0.58]
Watts et al. (2023)	SPRINT	.92	CTQ	.95	Total (symptom severity)	134	124	0.41 [0.39, 0.43]

Appendix

Summary Table of Primary Studies Characteristics (continued)

Study Cite	PTSD measure	r_{yy}	CSA measure	r_{xx}	Moderator	N_{GE}	N_{GC}	d [95% CI]
Weierich and Nock (2008)	K-SADS-PL-T	–	CTQ	.95	Total (diagnosis)	18		1.74 [1.52, 1.96]
Widom (1999)	DIS-III-R	–	Official records	–	Total (diagnosis)	96		1.86 [1.76, 1.96]
Wolfe et al. (1994)	CITES	.74	Official records	–	Total (diagnosis)	90		2.19 [2.09, 2.29]
					Female	69		2.37 [2.25, 2.49]
					Male	21		1.60 [1.41, 1.79]
					Intrafamilial	33		2.44 [2.27, 2.61]
					Extrafamilial	57		2.05 [1.92, 2.18]
					Contact abuse	56		2.02 [1.89, 2.15]
					Penetration	31		2.54 [2.37, 2.71]
Yüce et al. (2015)	K-SADS-PL-T	–	Forensic assessment	–	Total (diagnosis)	590		1.69 [1.65, 1.73]
Zajac et al. (2015)	TSCC	.85	Forensic assessment	–	Total (symptom severity)	118	1356 ¹	1.60 [1.58, 1.62]

Note. r_{yy} = reliability of PTSD measure instruments; r_{xx} = reliability of child sexual abuse measure instruments; N_{GE} = experimental group sample size; N_{GC} = control group sample size; d = standardized mean difference effect size; 95% CI = 95% confidence interval for d .

(¹) Control group (N_{GC}) extracted from a separate normative population study using the same PTSD measure; (²) Outlier value

Key to Acronym: DICA-R = Diagnostic Interview for Children and Adolescents Revised; CITES II = Children's Impact of Traumatic Events Scale II; IES = Impact of Event Scale; TSI = Trauma Symptom Inventory; CPSS = Child PTSD Symptom Scale; DSM-IV = Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition; CES-D = Studies Depression Scale; CID-I = Composite International Diagnostic Interview; CITES-R = Children's Impact of Traumatic Events Scale Revised; SCL-90-R = Symptom Checklist 90 Revised; SCID = Structured Clinical Interview for DSM-IV; DICA = Diagnostic Interview for Children and Adolescents; PSS = Severity of Symptoms of PTSD Scale; TSQ = Trauma Screen Questionnaire; DSM-IV-TR = Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision; PTSD-RI = UCLA Adolescent PTSD Reaction Index; UDADIS-5 = Alcohol Use Disorder and Associated Disabilities Interview Schedule; PSS-SR = Child PTSD Symptom Scale Self-Reported; TSCC = Trauma Symptom Checklist for Children; DIS-III-R = Diagnostic Interview Schedule Version III-R; DSM-III-R = Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised; K-SADS-PL = Kiddie Schedule for Affective Disorders and Schizophrenia for School-Age Children Present/Lifetime Version; PDS = Posttraumatic Diagnostic Scale; PTCI = Post-traumatic Cognitions Inventory; HTQ = Harvard Trauma Questionnaire; NWS = National Women's Study; PCL = PTSD Checklist; DIS-IV = Diagnostic Interview Schedule Version IV; K-SADS-E = Kiddie Schedule for Affective Disorders and Schizophrenia for School-Age Children Epidemiologic Version; PCL-C = PTSD Checklist Civilian Version; IES-R = Impact of Event Scale Revised; PPTSD-R = Purdue PTSD Scale Revised; CPTSD-RI = UCLA Child PTSD Reaction Index; PTSD-Q = PTSD Questionnaire; CIDIS-IV = Diagnostic Interview Schedule Computerized version; CAPS = Clinician Administered PTSD Scale; ICD-11 = International Statistical Classification of Diseases and Related Health Problems, 11th Revision; PSSI = PTSD Symptom Scale Interview; DICA-6-R = Diagnostic Interview for Children and Adolescents Version 6R; ICD-10 = International Statistical Classification of Diseases and Related Health Problems, 10th Revision; ChiPS = Children's Interview for Psychiatric Syndromes; K-SADS-PL-G = Kiddie Schedule for Affective Disorders and Schizophrenia for School-Age Children Present/Lifetime German Version; K-SADS-PL-T = Kiddie Schedule for Affective Disorders and Schizophrenia for School-Age Children Present/Lifetime Turkish Version; GHQ-28 = General Health Questionnaire; SIPTSD = Structures Interview for PTSD; PCL-S = PTSD Checklist -Specific form; PC-PTSD = Primary Care PTSD Screen; TSC-40 = Trauma Symptom Checklist 40; KIDSCID = Children's Structured Clinical Interview; CRIES-13 = Children's Revised Impact of Event Scale; TSCYC = Trauma Symptom Checklist for Young Children; SPRINT = Short Post Traumatic Stress Disorder Rating Interview; CITES = Children's Impact of Traumatic Events Scale; HVF = History of Victimization Form; CTQ = Childhood Trauma Questionnaire; DAST = Detroit Area Survey of Trauma; WSHI = Wyatt Sexual History Interview; TES = Traumatic Events Survey; ACE = Adverse Childhood Experiences; SARS = Sexual Abuse Rating Scale; CTQ-SF = Childhood Trauma Questionnaire Short Form; LEC = Life Events Checklist; ICI = Incident Classification Interview; CSAI = Childhood Sexual Abuse Interview; SAQ = Sexual Abuse Questionnaire; CSEQ = College Student Experiences Questionnaire; ESE = Early Sexual Experiences; CEVQ = Childhood Experiences Violence Questionnaire; TLEQ = Traumatic Life Event Questionnaire; THQ = Trauma History Questionnaire; TEI = Traumatic Event Interview; ETI = Early Trauma Interview; THI = Trauma History Interview; NCS = National Comorbidity Survey; NSA = National Survey of Adolescents; JVQ = Juvenile Victimization Questionnaire; CTI = Comprehensive Trauma Interview; SAP = Sexual Abuse Profile; SAIS = Sexual Abuse Interview Schedule; SAEQ = Sexual Abuse Exposure Questionnaire; TSS = Traumatic Stress Schedule; CCMS-A = Comprehensive Child Maltreatment Scales for Adults; TESI = Traumatic Events Screening Inventory; TAA-R = Trauma Assessment for Adults-Brief Revised Version; SES = Sexual Experiences Survey.

