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Childhood Sexual Abuse: Epidemiology, Clinical Effects, Assessment, and Treatment

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Narrative Clinical Review

Abstract—Childhood sexual abuse is a heterogeneous exposure rather than a diagnosis or a uniform life course. Prevalence estimates vary with definitions, sampling, and disclosure methods, and clinical outcomes range from little observable disturbance to post-traumatic stress disorder (PTSD), depression, anxiety, dissociation, behavioral change, sexual-health concerns, self-harm, substance use, somatic symptoms, and relationship difficulties. This review integrates research evidence and official clinical and safeguarding guidance publicly available through 28 February 2025. The review distinguishes epidemiology from case identification, safeguarding from treatment, medical findings from forensic conclusions, and childhood exposure from adult presentation. Normal physical findings are common and do not exclude abuse; symptoms and sexualized behavior warrant assessment but cannot establish that abuse occurred. Assessment should be developmentally appropriate, minimally repetitive, and coordinated with trained safeguarding and forensic services. Initial responses to disclosure should protect safety, dignity, choice, and accurate information without leading questions or pressure for a complete narrative. For symptomatic children and adolescents, developmentally adapted trauma-focused cognitive behavioral therapy has the most established evidence, often with involvement of a safe non-offending caregiver; treatment should nevertheless address current symptoms, functioning, and preferences rather than exposure alone. The review proposes two integrative frameworks: four levels of inference separating population, clinical, medical, and safeguarding/forensic conclusions, and four outcome domains separating safety, health, developmental and relational functioning, and justice-related processes. Alliance, caregiver response, and communication across services influence whether evidence-based treatment becomes usable care.

Index Terms—childhood sexual abuse, child safeguarding, disclosure, forensic assessment, trauma-focused cognitive behavioral therapy, therapeutic alliance, caregiver support

I. INTRODUCTION

Childhood sexual abuse encompasses sexual acts, contact, exploitation, or exposure involving a person under 18 who cannot freely consent or who is subject to an age, power, trust, or developmental asymmetry. Its clinical significance cannot be reduced to a single act category, symptom profile, or expected narrative. Some children disclose promptly; others disclose partially, indirectly, after a delay, or only in adulthood. Some show acute fear or behavioral change, whereas others continue ordinary activities or present with difficulties that are not specific to abuse. No stereotyped response can confirm or exclude what occurred.

Clinical care is particularly vulnerable to role confusion. A child may need immediate protection, medical assessment, forensic interviewing, psychological treatment, and support for a non-offending caregiver, but these functions are not interchangeable. Therapy should not become repeated evidence collection. Medical examination can identify injury, infection, pregnancy risk, pain, and other health needs, yet normal findings are common and do not exclude abuse (Adams et al., 2016; Kellogg et al., 2023). Safeguarding decisions, forensic conclusions, and psychiatric diagnoses also rely on different questions, thresholds, and legal frameworks.

This review adopts a developmental and relationship-centered approach. It considers what happened and may still be happening, the child's current health and functioning, the safety and response of caregivers, and communication among the child, family, clinicians, and agencies. Childhood sexual abuse is associated with increased risk across later domains, but it does not determine a single adult diagnosis or define a person's identity. The clinical task is to provide accurate, compassionate care without minimizing danger or overstating certainty.

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Core clinical propositions (author-developed clinical synthesis; not a validated instrument)

- Childhood sexual abuse is an exposure, not a diagnosis; outcomes are heterogeneous, and PTSD is neither universal nor exhaustive.
- A normal physical examination or delayed, partial disclosure does not exclude abuse.
- Safeguarding, forensic interviewing, medical care, and psychotherapy should be coordinated while retaining distinct purposes and thresholds.
- Communication should be developmentally appropriate, minimally repetitive, non-leading, and transparent about limits of confidentiality.
- Treatment should be matched to current symptoms, development, safety, and preferences, with a safe caregiver involved when useful and acceptable.

II. SCOPE AND REVIEW METHOD

This narrative review addresses sexual abuse occurring before age 18 in two clinical contexts: the care of a child or adolescent who may have been abused and the care of an adult for whom childhood abuse is relevant to current health. It does not examine assessment or treatment of people who perpetrate sexual offenses, prevention programs in detail, or legal standards for proving an allegation. Sexual exploitation and technology-facilitated abuse are included conceptually, although service pathways may differ. Child includes adolescents unless age distinctions are clinically relevant; patient is used in clinical contexts and survivor where agency and lived experience are emphasized.

Sources publicly available through 28 February 2025 were eligible, allowing a one-month interval before the issue date of 31 March 2025. Priority was given to WHO and NICE guidance, pediatric consensus statements and medical-interpretation reviews, systematic reviews and meta-analyses, and randomized or comparative treatment studies. Search topics included prevalence, long-term outcomes, disclosure, medical findings, differential diagnosis, safeguarding, trauma-focused treatment, caregiver involvement, and therapeutic alliance. One review assigned to a June 2021 issue was included because it was first available online on 31 October 2019; eligibility followed first public availability rather than issue assignment.

This is a narrative review and does not calculate pooled prevalence or treatment effects. Definitions vary by age, contact, coercion, relationship to the person who abused, and method of ascertainment. Much outcome research is retrospective and cannot isolate sexual abuse from co-occurring maltreatment and adversity. Clinical recommendations must be adapted to jurisdiction, local safeguarding procedures, time since exposure, pubertal status, disability, culture, and the patient's wishes and decision-making capacity. Because medical, infectious-disease, and reporting guidance changes, clinicians should consult current local standards before practice.

III. DEFINITION, EPIDEMIOLOGY, AND MEASUREMENT

Prevalence estimates depend heavily on what is asked, how it is asked, and who is sampled. A systematic review of contemporary studies reported wide variation by sex, region, and type of sexual abuse, with behaviorally specific self-report generally identifying more exposure than official records (Barth et al., 2013). A later international review of self-reported child maltreatment found similar heterogeneity in definitions and survey methods (Moody et al., 2018). Population estimates establish the scale of the public-health problem; they cannot determine whether abuse occurred in an individual case.

Definitions should specify contact and non-contact acts, attempted and completed acts, exploitation, use of sexual images, and relevant age or power asymmetry. Abuse may involve adults, older youth, peers who use force or exploit developmental differences, family members, trusted adults, or people known online. Affection, gifts, compliance, physiological response, delayed resistance, or continued contact does not constitute consent. Grooming may involve attention, secrecy, boundary testing, access, threats, or manipulation of the child's relationships. Describing these processes should not imply that the child or caregiver could reliably have prevented them.

Recorded incidence is shaped by disclosure, recognition, reporting law, access to services, and institutional response. Additional barriers may affect boys who anticipate disbelief; LGBTQ+ youth threatened with outing; disabled children who depend on caregivers or use alternative communication; children in care or custody; and children whose family, immigration, or community circumstances make disclosure carry substantial personal or family consequences. Population research should describe these limitations rather than fill missing data with assumptions.

Clinically useful definitions relate the act or exploitative process to age, power, capacity to consent, and relationship. They avoid euphemisms such as an 'affair' between an adult and a child. They also avoid classifying every sexual behavior between children as abuse without considering developmental stage, coercion, persistence, harm, and power. Harmful sexual behavior involving another child may require specialist assessment.

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Table 1. Four levels of inference in clinical and safeguarding work (author-developed clinical synthesis; not a validated instrument)

Level	What it can establish	What it cannot establish alone
Population prevalence	Frequency of defined experiences in a sampled population	Whether a particular child was abused
Clinical symptoms	Current distress, impairment, and treatment need	Whether abuse occurred or who was responsible
Medical findings	Present health needs and differential interpretation of observed findings	That abuse did not occur when the examination is normal
Safeguarding/forensic evidence	Information relevant to protection and investigation under applicable standards	A psychiatric diagnosis or inevitable prognosis

IV. DEVELOPMENTAL AND CLINICAL EFFECTS

Children may present with fear, nightmares, sleep disturbance, regression, irritability, concentration problems, avoidance, depressed mood, anxiety, somatic complaints, sexualized behavior, aggression, withdrawal, school difficulties, self-harm, or substance use. None of these features is specific to sexual abuse, and some children show little observable disturbance. Presentation varies with age, developmental understanding, relationship to the person who abused, secrecy, threat, chronicity, family response, co-occurring violence, and events after disclosure. Formulation should explain current difficulties without allowing the abuse history to become a complete theory of the child's personality.

Post-traumatic stress is one important pathway. Re-experiencing may appear in play, dreams, sensory fragments, or distress at reminders; avoidance may involve places, people, bodily sensations, or discussion; hyperarousal may include disturbed sleep and irritability. Depression, generalized anxiety, separation anxiety, obsessive-compulsive symptoms, eating problems, dissociation, pain, and externalizing behavior require separate assessment. Sexual behavior must be interpreted developmentally because it may reflect exposure, curiosity, imitation, coercion, or another context; it is not diagnostic proof.

Evidence on long-term outcomes is broad but heterogeneous. Hailes et al. (2019) found associations between childhood sexual abuse and numerous adult psychiatric, psychosocial, and physical outcomes, while also identifying variable review quality and no basis for deterministic prediction. Neurobiological reviews describe plausible stress-related adaptations, but group-level differences should not be used as an individual explanation without caution (Teicher & Samson, 2016). The clinically supportable conclusion is increased risk across several domains, not inevitable or irreversible damage.

Development changes both the expression and the meaning of distress. A preschool child may show regression or recurring play themes; a school-age child may struggle with attention, bodily fears, or peer belonging; an adolescent may confront questions of sexuality, privacy, loyalty, or substance use. Symptoms or questions that emerge later do not necessarily indicate a new event, treatment failure, or unreliability of an earlier account. They may reflect new capacities to understand what occurred and what it means. Planned reassessment at developmental transitions can identify emerging needs without assuming pathology, particularly when it addresses current safety, functioning, relationships, and the young person's priorities rather than merely repeating a trauma screen.

Relationships may carry both the effects of injury and the conditions for recovery. Abuse can involve betrayal by a trusted person, secrecy enforced through attachment, or failure of protection, but later relationships are not destined to reproduce those patterns. Safe caregiving, peer connection, therapeutic alliance, and respectful adult partnership can support recovery. Care should allow grief, anger, ambivalence, loyalty, and ordinary developmental needs without requiring the child to organize identity around victimization.

V. DISCLOSURE AND SUPPORTIVE COMMUNICATION

Disclosure often unfolds as a process rather than a single event. Systematic reviews identify barriers including shame, self-blame, fear of consequences, loyalty, threats, limited language, uncertainty that the act was wrong, concern for family, and previous negative reactions (Lemaigre et al., 2017; Alaggia et al., 2019). A child may test a listener, retract part of an account, correct details, or disclose in fragments. None of these patterns is a reliable test of truthfulness. Pressure for a complete linear account can increase distress and compromise later interviewing.

The initial response should be calm, attentive, and proportionate. Thank the child for speaking, state that the child is not in trouble or to blame, assess immediate safety and health needs, and explain what will happen next in understandable language. Avoid expressions of shock or disbelief, promises of secrecy, repeated 'why' questions, and praise that creates pressure to maintain a particular account. Open prompts such as 'Tell me more about that' are preferable to questions that suggest acts, people, or motives. Detailed investigative interviewing should be left to trained services working under local protocol.

Communication also includes what adults say in the child's presence. Caregivers and professionals may discuss evidence, legal action, or family conflict within hearing. Repeatedly introducing someone as 'the abused child' can constrict

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identity and compromise privacy. Information sharing should be lawful, need-based, and explained. When confidentiality must be limited for safeguarding, the child should be told who will receive information, what will be shared, and what choices remain wherever feasible (World Health Organization, 2017).

The receiving adult's responsibility continues after the first conversation. Reassurance should be followed by reliable, ordinary contact: maintaining routines where safe, checking what the child wants others to know, and remaining available without making every interaction about abuse. Adults should not promise legal outcomes or family reactions they cannot control. When an earlier response involved disbelief, anger, or pressure, repair can acknowledge its effect, restate that responsibility lies with the person who acted, and explain what will change. This can reopen communication without asking the child to comfort the adult or validate an apology (Alaggia et al., 2019).

Supportive communication does not by itself ensure symptom recovery, but blaming, controlling, or disbelieving responses can constitute an additional interpersonal injury. Disclosure can create access to protection and treatment when the listener preserves dignity and choice; communication may close when the listener takes control, interrogates, or makes the child responsible for family consequences.

VI. SAFETY, SAFEGUARDING, AND IMMEDIATE CARE

Immediate assessment should address current access by the person who may have abused, acute injury or pain, bleeding, pregnancy and sexually transmitted infection risk, suicidal or self-harm risk, intoxication, threats, safe housing, and the safety of other children. Absence of acute injury does not remove a safeguarding concern. The child may still live with, visit, depend on, or communicate digitally with the person. Safety planning must not transfer responsibility for preventing adult behavior to the child.

Reporting duties vary by jurisdiction and are generally broader for children than for adults with decision-making capacity. Clinicians should know the local pathway before disclosure occurs, explain limits of confidentiality as early as possible, and make required reports promptly. WHO guidance emphasizes safety, age-appropriate autonomy, privacy, and minimization of further distress (World Health Organization, 2017). NICE likewise recommends coordinated recognition, assessment, and response rather than isolated professional judgment (National Institute for Health and Care Excellence, 2017).

Safeguarding and therapeutic alliance are not opposing aims. When reporting is required, the clinician should explain what must be done, what remains uncertain, and which choices still belong to the child. A safe caregiver should be involved when appropriate, but the accompanying adult cannot automatically be assumed to be protective or uninvolved. If notification may increase danger or pressure, safeguarding specialists should be consulted first. Documentation should distinguish reported information, observed findings, consultation, actions taken, and remaining uncertainty.

Protective action can itself be disruptive: it may involve a move, school change, separation from siblings, police contact, repeated appointments, or loss of a familiar adult. These consequences do not argue against safeguarding, but they require anticipatory care. Clinicians should explain the likely sequence, identify a responsible contact, preserve routines and valued relationships where safe, and ask what the child fears about the plan. Safety extends beyond physical separation from possible abuse. It also includes predictable caregiving, privacy, access to health care, and freedom from blame or pressure to manage adult distress. Coordinated plans should make these relational conditions explicit (National Institute for Health and Care Excellence, 2017; World Health Organization, 2017).

Broader prevention frameworks matter because individual vigilance cannot bear the entire burden. INSPIRE identifies coordinated strategies addressing law, norms, safe environments, caregiver support, economic strengthening, services, and education (World Health Organization et al., 2016). For clinical care, the corresponding principle is systemic: recovery depends partly on whether adults and institutions end unsafe access, respond consistently, and help restore ordinary life.

VII. MEDICAL ASSESSMENT AND EVIDENTIARY HUMILITY

Medical assessment should be timely, trauma-informed, and undertaken or reviewed by an experienced clinician. The health-care history is not a forensic interview; it should clarify timing, symptoms, contact relevant to injury or pregnancy and infection risk, medications, allergies, and urgent mental-health concerns without unnecessary detail. Smith et al. (2020) state that force, coercion, and restraint must never be used; if the child is reluctant or distressed, defer the examination for suspected sexual abuse. A separate urgent medical problem may require emergency care under applicable consent law but does not justify forcing a forensic examination.

Most children examined non-acutely do not have definitive genital or anal injury. Tissues heal, many abusive acts cause no injury, and normal anatomical variants are common. Kellogg et al. (2023) provide an updated framework for interpreting findings and caution against misclassifying normal or nonspecific features. A normal examination can reassure about present health but cannot establish that nothing happened. Conversely, abnormal findings may have

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differential explanations and should be interpreted by specialists rather than overstated.

Testing and prophylaxis depend on pubertal development, exposure type and timing, symptoms, local epidemiology, and current guidance. After penile–vaginal penetration, WHO recommends offering emergency contraception within 120 hours to girls who have attained menarche or reached Tanner stage 2 or 3 (World Health Organization, 2017). HIV post-exposure prophylaxis should be assessed urgently and, when indicated, started as soon as possible—ideally within 24 hours and no later than 72 hours—for 28 days (World Health Organization, 2024). STI testing or treatment and hepatitis B or HPV vaccination should follow current specialist and jurisdictional protocols.

Medical records may later be scrutinized. Documentation should use precise anatomical terms, objective descriptions, appropriate photographic protocols, and clear attribution. The phrase 'consistent with abuse' should not be used without qualification when a finding is normal or nonspecific. Clinicians who lack the required expertise should document that limitation and seek review. Evidentiary humility does not weaken concern; it aligns conclusions with what the examination can establish and protects both care and fairness.

Explanation of findings is part of medical care. A child or caregiver may hear 'normal examination' as disbelief unless the clinician explains that normal findings are common, that the examination addresses present health needs, and that it cannot determine by itself whether abuse occurred. Conversely, an uncertain or nonspecific finding should not acquire diagnostic certainty through repeated retelling. A clear explanation shared across services can reduce unnecessary repeat examinations and conflicting messages. The health value of the encounter—comfort, treatment, testing, reassurance, and follow-up—should remain explicit even when forensic yield is limited (Adams et al., 2016; Kellogg et al., 2023).

Clinical benefit should also be distinguished from evidential yield. A calm, well-explained examination can reassure, treat symptoms, and connect the family with follow-up even when no diagnostic finding is expected. Acute and non-acute pathways have different priorities, and repeat examination should have a defined health or expert-review purpose rather than serve as a response to adult uncertainty. Multidisciplinary guidance supports coordinated specialist care while preserving assent, privacy, and the limits of physical findings (Adams et al., 2016).

VIII. PSYCHIATRIC ASSESSMENT AND DIFFERENTIAL DIAGNOSIS

Psychiatric assessment begins with current symptoms, development, functioning, safety, and context, not with a requirement to recount the abuse. Relevant domains include sleep, intrusive memories, avoidance, arousal, mood, anxiety, dissociation, concentration, school, play, relationships, sexual health, eating, self-harm, suicidal thinking, substance use, and somatic complaints. Caregiver and school information may be useful, but each informant observes different settings and may have incomplete knowledge or conflicts of interest.

Differential diagnosis includes PTSD, acute stress disorder, adjustment disorder, depressive and anxiety disorders, obsessive-compulsive symptoms, attention and learning difficulties, autism-related distress, disruptive behavior, eating disorders, substance-use disorders, sleep disorders, psychosis, bipolar disorder, neurological or endocrine illness, medication effects, and other forms of maltreatment. Diagnosis should follow established criteria and clinically significant impairment (American Psychiatric Association, 2022). The abuse history may contribute to several formulations without being the sole cause of current symptoms.

Dissociation, memory gaps, and inconsistent detail require careful description rather than automatic interpretation. Memory is developmental and reconstructive, and stress can affect encoding and retrieval; inconsistency alone proves neither fabrication nor trauma. Psychosis or developmental disability may complicate communication without making victimization impossible. Suicidal ideation, self-harm, aggression, or severe neglect of basic needs requires direct risk assessment rather than attribution to 'just trauma.'

A child may meet no diagnostic criteria and still require safety planning, information, caregiver support, and follow-up. Conversely, symptoms may predate the identified abuse or reflect several adversities. A useful formulation states what is present, what remains uncertain, what requires safeguarding or medical action, and which outcomes will be monitored. It avoids treating PTSD as inevitable or its absence as evidence that abuse did not occur.

Measures can organize symptoms and track change, but their cutoffs do not determine whether abuse occurred. Instruments should be validated for the child's age, language, developmental profile, and intended purpose, and caregiver and child reports should remain distinguishable when they diverge. Reassessment should include functioning and safety: a lower trauma score may coexist with continued access by the person of concern, whereas an elevated score may reflect more than one exposure. The clinical record should preserve these distinctions.

IX. CLINICAL, FORENSIC, AND THERAPEUTIC ROLES

This review proposes a role-separated model of coordinated care in which each professional function is explicit. Safeguarding services determine protective action under law and policy. Trained forensic interviewers seek an evidential account using structured, non-leading methods. Medical clinicians assess health, document findings, and provide

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treatment. Therapists address distress and restore development and functioning. In some systems, one professional may hold more than one role, but the patient and caregiver should understand when the purpose and evidential threshold change.

Role confusion can harm both evidence and therapy. Repeated detailed questioning may increase distress and introduce suggestion. A therapist who promises to prove an allegation can make ordinary uncertainty feel like betrayal, while a forensic process that disregards the child's emotional state can impair participation. Communication across services should therefore convey necessary information, avoid redundant interviewing, and preserve a therapeutic space in which the child is not treated primarily as a witness.

Treating clinicians may be asked for opinions about credibility, custody, criminal responsibility, or future risk. Unless qualified and formally instructed for that task, they should describe sources, observations, diagnoses, treatment, and limits rather than offer global judgments about credibility. Clinical support does not require evidential overstatement: the child's distress and safety can be taken seriously while conclusions remain proportionate to the evidence.

A shared plan should specify who will explain decisions to the child and caregiver, who is responsible for each referral, and which information must move between services. Without named responsibility, coordination can become repeated disclosure without continuity. WHO health-sector guidance supports communication that is developmentally appropriate, supportive, and linked to safety and services (World Health Organization, 2019). A minimum-necessary record can protect privacy without allowing essential care to be missed.

Table 2. Distinct functions in role-separated coordinated care (author-developed clinical synthesis; not a validated instrument)

Function	Primary question	Communication safeguard
Safeguarding	What protection or statutory action is required now?	Explain duties, decisions, and who will be informed
Forensic interview	What account can be obtained reliably under evidential protocol?	Use trained, non-leading methods and avoid duplication
Medical care	What health need requires assessment or treatment now?	Seek assent, explain each step, and state the limits of findings
Psychotherapy	Which symptoms, meanings, relationships, and functions should treatment address?	Do not turn treatment into repeated investigation
Caregiver support	How can a safe adult strengthen protection, regulation, and treatment continuity?	Avoid blame and assess whether involvement is safe

X. TREATMENT EVIDENCE AND INDIVIDUALIZATION

Treatment should be offered for current symptoms, impairment, developmental disruption, or family needs—not solely because exposure is known. A 2012 Cochrane review found cognitive-behavioral approaches promising for sexually abused children but noted a limited and heterogeneous trial base (Macdonald et al., 2012). Reviews of meta-analyses and randomized studies likewise support treatment while emphasizing variation in outcomes, effect estimates, and study quality (Benuto & O'Donohue, 2015; Tichelaar et al., 2020). A later network meta-analysis rated the comparative evidence as very uncertain and did not support a universal ranking of therapies (Caro et al., 2023). The practical implication is to use evidence-informed, developmentally adapted treatment with explicit outcome monitoring rather than to select a protocol from the exposure label alone.

Trauma-focused cognitive behavioral therapy (TF-CBT) has the most developed pediatric evidence, particularly for clinically significant PTSD symptoms. Common components include psychoeducation, regulation skills, cognitive work, gradual trauma processing, in vivo mastery when appropriate, safety skills, and parallel caregiver work. A randomized effectiveness trial found TF-CBT superior to therapy as usual for traumatized youth (Jensen et al., 2014), and a broader pediatric PTSD meta-analysis supports trauma-focused psychological treatment (Morina et al., 2016). These studies include several trauma types; sexual-abuse-specific reviews support cautious use of trauma-focused CBT while continuing to identify important evidence gaps (McTavish et al., 2021; Caro et al., 2023).

Developmentally adapted cognitive processing therapy reduced PTSD symptoms in adolescents and young adults with histories of childhood sexual or physical abuse in a randomized trial (Rosner et al., 2019). Treatment choice should consider age, symptoms, language, cognition, safety, family context, access, and preference. Trauma narration is not an evidence-extraction procedure; it belongs within a coherent therapeutic rationale, adequate preparation, consent, and alliance. A child should not be required to recount details before safety is established or simply because adults want a complete account.

Treatment goals should be developed collaboratively in language appropriate to the young person's development. A caregiver may prioritize sleep or school attendance, while the young person seeks fewer intrusive images, less shame, or one relationship that feels ordinary. Both perspectives can inform the plan without making the adult's priorities decisive. Early sessions should explain the purpose of each task, how distress will be monitored, and how the child can pause or correct the therapist. Trauma processing is then a method linked to agreed symptoms and meanings, not a test of courage, completeness of memory, or credibility. This distinction protects the

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therapeutic alliance and role boundaries while retaining active elements of evidence-based care (Cohen et al., 2018; Ormhaug et al., 2014).

Medication is not a treatment for the exposure itself. It may be appropriate for a diagnosed depressive, anxiety, sleep, attention, or other disorder after pediatric assessment, but it should not displace trauma-focused or relational care when those are indicated. Crisis stabilization, restoration of sleep, school support, pain treatment, substance-use intervention, and practical protection may need to precede or accompany trauma processing. Sequencing should be reconsidered if symptoms worsen, attendance becomes unsafe, family conflict escalates, or the treatment rationale is not understood.

A child who is functioning well may need information, caregiver guidance, and planned review rather than intensive therapy. Preventive treatment without a defined target can inadvertently communicate that permanent damage is expected. Severe or complex symptoms may require longer and multidisciplinary care. Both approaches are compatible with taking the abuse seriously.

Table 3. Match treatment to the current clinical problem (author-developed clinical synthesis; not a validated instrument)

Active problem	Evidence-informed response	Avoid
PTSD symptoms and impairment	Developmentally adapted trauma-focused psychotherapy with outcome monitoring	Applying identical trauma-narrative work to every exposed child
Depression, self-harm, or substance use	Direct risk management and condition-specific treatment integrated with context	Relabeling every symptom as PTSD
Unsafe or destabilizing environment	Protection, caregiver and systems intervention, and practical stabilization	Using therapy to adapt the child to continuing abuse
Caregiver distress or blame	Parallel caregiver support when involvement is safe	Making the child responsible for adult regulation
Few current symptoms	Information, support, ordinary development, and planned review	Treatment without a patient-defined or clinical target

XI. CAREGIVERS, THERAPEUTIC ALLIANCE, AND RELATIONSHIP REPAIR

A safe non-offending caregiver can help regulate distress, restore routines, support attendance, correct self-blame, and strengthen protection. TF-CBT explicitly includes work with children and caregivers, and family components are integral to its rationale (Cohen et al., 2018). Involvement should not be automatic. The clinician must assess whether the caregiver believes and protects the child, is overwhelmed or blaming, remains aligned with the person who abused, or presents another risk. Adolescents may also require carefully negotiated privacy.

Caregivers may experience shock, guilt, grief, anger, financial dependence, divided family loyalties, or activation of their own trauma. Supporting them is not a diversion from the child's treatment because unmanaged adult distress can affect safety and meaning. Caregivers need a space that does not require the child to provide comfort or hear investigative speculation. Practical help with sleep, routines, school, appointments, sibling questions, and legal processes may be as important as psychological interpretation.

Caregiver support is a clinical resource, but it does not guarantee recovery and should not be contingent on the child earning it. Belief and protection may coexist with confusion, grief, or practical dependence; the care plan should therefore specify the actions that matter now, including ending unsafe access, attending appointments, protecting privacy, and responding without blame. When relational repair is safe, it should focus on changed behavior rather than requiring the child to forgive or reassure. The caregiver may need separate treatment or advocacy, but the child should not become the messenger between services. This preserves useful family involvement and a distinct therapeutic space for the young person (Cohen et al., 2018).

The therapeutic alliance is not merely a background condition for technique. In a randomized youth trial, alliance predicted outcome in TF-CBT, a treatment that requires active participation in demanding tasks (Ormhaug et al., 2014). Alliance develops through credible explanations, collaborative goals, pacing, reliability, respect for silence and correction, and acknowledgment of power. Clinicians can be warm without becoming suggestive and structured without taking control.

Relational recovery may also involve peers, siblings, school, and later intimate partners. Some children need help deciding what to disclose and how to respond to questions. The goal is neither universal disclosure nor indiscriminate trust. It is a graduated capacity to recognize safer relationships, communicate boundaries and needs, tolerate appropriate closeness, and maintain a coherent sense of self beyond what occurred.

XII. ADOLESCENCE, TRANSITION, AND ADULT PRESENTATION

Adolescent care requires simultaneous attention to protection and emerging autonomy. Sexual health, consent, pregnancy, STI care, relationships, digital contact, substance use, self-harm, school, and confidentiality may all be relevant. An adolescent may resist caregiver involvement for sound reasons while still needing access to a safe adult. Clinicians should explain which decisions belong to the adolescent, what must be shared, and how records or billing may disclose care. Continued contact with the person who abused should not be interpreted as consent or refusal of treatment.

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Transitions between child and adult services can interrupt care just as legal, educational, and family demands intensify. Transfer records should identify active symptoms, effective strategies, medication, safety and safeguarding status, relevant disclosures, and the patient's preferences without reproducing unnecessary intimate detail. Continuity should not depend on the young person retelling the entire history.

Adults may first disclose childhood sexual abuse while seeking treatment for depression, anxiety, PTSD, sexual difficulties, pain, substance use, parenting concerns, or relationship distress. The history may clarify vulnerability or meaning, but current assessment should remain broad. Hailes et al. (2019) support attention to psychiatric, psychosocial, and physical domains. An adult survivor need not recover additional memories, confront family, forgive, report, or adopt a trauma-based identity to receive care.

Adult treatment should follow current diagnoses, functioning, safety, and preference. NICE guidance supports trauma-focused CBT and eye movement desensitization and reprocessing (EMDR) for adults with PTSD while recognizing complex presentations and relationship difficulties (National Institute for Health and Care Excellence, 2018). Treatment of depression, pain, substance use, sexual health, or interpersonal problems need not wait until trauma-focused work is complete. Communication with a current partner may be useful when chosen and safe, but the survivor determines what is shared.

Later-life transitions may change the salience and meaning of the history without implying that new memories must be recovered or that prior treatment has failed. Parenting, a child's age, bereavement, intimate commitment, fertility care, or contact with an older family member may bring new questions. The clinician can explore present triggers and choices without directing confrontation or family reconciliation. When partner involvement is requested, private assessment should precede joint work, and the purpose should be specific: communication about boundaries, support, intimacy, or care rather than adjudication of the past.

XIII. EQUITY, CULTURE, DISABILITY, AND INSTITUTIONAL CONTEXT

Culture shapes language, family structure, help-seeking, and trust in services, but it cannot justify sexual exploitation. Clinicians should ask what the child and family expect to happen after disclosure and which community relationships are protective or risky. Interpreters should be independent, trained, and safe; family members should not interpret a sexual-abuse history. Religious or cultural advisers may support care when the patient wants them involved, but they do not replace safeguarding or health services.

Disabled children may be exposed through dependence on care, communication barriers, institutional settings, or anticipated disbelief. Assessment should provide accessible communication and avoid attributing behavioral change automatically to disability. Neurodivergent children may describe events concretely, interpret questions differently, or need predictable pacing; these differences are not tests of credibility. Boys, gender-diverse youth, and LGBTQ+ youth may face stereotypes about victimization, sexuality, or masculinity that delay disclosure.

Institutional responses can distribute responsibility appropriately or shift it back to the child. Schools, residential settings, sports organizations, faith communities, health systems, and child-protection agencies require clear boundaries, reporting routes, information governance, and protection from retaliation. WHO health-sector guidance emphasizes supportive communication, safety assessment, and coordinated action (World Health Organization, 2019). Requiring a child to navigate conflicting agencies is a failure of service coordination.

Equity also concerns the applicability of treatment evidence. Trial participants who can attend weekly therapy with a supportive caregiver may not represent children facing unstable housing, ongoing proceedings, language barriers, or rural scarcity. Adaptation should preserve active treatment ingredients while modifying delivery, access, examples, and supports. Limited resources do not justify lower standards of dignity, consent, or evidentiary caution.

XIV. MEASUREMENT, FOLLOW-UP, AND RECOVERY

Outcome measurement should follow the treatment target. PTSD scales can track trauma symptoms but do not capture all relevant change; depression, anxiety, dissociation, sleep, self-harm, pain, sexual health, school attendance, peer relationships, caregiver functioning, and safety may require separate review. Scores should supplement clinical assessment and must not be used to determine whether abuse occurred. Behavior can improve while danger persists or remain difficult after safety has improved.

Follow-up should assess whether the intervention is understandable, tolerable, accessible, and producing meaningful change. Deterioration may indicate renewed contact, family retaliation, legal stress, a poorly paced trauma task, a missed diagnosis, substance use, or ordinary developmental change. The appropriate response is renewed assessment rather than automatic intensification. Treatment fidelity matters, but fidelity includes consent, collaboration, and developmental adaptation.

Recovery is not defined by forgetting, complete symptom absence, or a required positive transformation. It may be reflected in safety, restored routines, sleep, play, learning, friendships, bodily autonomy, confidence, and the capacity to approach valued relationships. Ordinary development is itself a meaningful outcome. Clinicians should not treat apparent

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resilience as evidence that follow-up is unnecessary; later difficulty does not prove that treatment failed.

Research should report adverse events and outcomes beyond treatment completers and PTSD. Reviews identify marked heterogeneity and high risk of bias in parts of the intervention literature (Tichelaar et al., 2020; Caro et al., 2023). Longer follow-up, diverse participants, clearer exposure definitions, and caregiver and alliance measures are needed.

XV. LIMITATIONS AND RESEARCH NEEDS

Prevalence estimates reflect inconsistent definitions, retrospective self-report, and incomplete official records. Outcome studies struggle to separate sexual abuse from co-occurring maltreatment and adversity; group-level neurobiological findings are vulnerable to confounding; and treatment trials vary in samples, settings, caregiver involvement, and outcomes. These limitations require calibrated causal language, not clinical indifference.

Disclosure research needs prospective, culturally diverse designs that do not assume one ideal narrative. Medical research should improve the reliability of finding interpretation; service studies should measure repeated interviewing, delays, privacy breaches, family burden, and coordination. Treatment research should examine who benefits from which components, when caregiver work is useful or unsafe, and how alliance affects demanding trauma-focused tasks.

This review proposes a four-domain outcome framework: (1) ending abuse and securing safety; (2) treating medical and psychiatric conditions; (3) restoring developmental and relational functioning; and (4) supporting justice or legal processes. No single intervention can be expected to determine all four domains. Keeping them analytically separate would make research more interpretable and reduce the risk that symptom improvement is mistaken for proof of safety or for a complete response.

XVI. CONCLUSION

Childhood sexual abuse requires clinical preparedness without stereotyped expectations. It increases psychiatric, physical, developmental, and relational risks, but no symptom or symptom absence establishes abuse or predicts an inevitable outcome. Immediate care should address safety and health, respond supportively to disclosure, fulfill safeguarding duties, coordinate specialist medical and forensic services, assess current functioning, and explain next steps without unnecessary repetition.

For children and adolescents with clinically significant trauma symptoms, evidence most consistently supports developmentally adapted trauma-focused psychotherapy, often with a safe non-offending caregiver when helpful and acceptable; abuse-specific comparative evidence remains limited. The author-developed role-separated and four-domain frameworks distinguish safeguarding, forensic, medical, therapeutic, developmental, relational, and justice-related questions. Alliance and communication across services affect whether evidence-based procedures become usable care. Recovery should be judged through safety, health, development, agency, relationships, and ordinary participation rather than one score.

XVII. CONFLICTS OF INTEREST AND DISCLOSURES

Conflicts of interest—The author developed and writes about Communication-Focused Therapy (CFT), although CFT is neither presented nor evaluated as a treatment in this review. No other conflicts of interest were reported.

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Patient material—No identifiable patient material is presented. Any brief examples are generic composites used to illustrate clinical reasoning and are not case reports.

XVIII. REFERENCES

Adams, J. A., Kellogg, N. D., Farst, K. J., Harper, N. S., Palusci, V. J., Frasier, L. D., Levitt, C. J., Shapiro, R. A., Moles, R. L., & Starling, S. P. (2016). Updated guidelines for the medical assessment and care of children who may have been sexually abused. Journal of Pediatric and Adolescent Gynecology, 29(2), 81–87. https://doi.org/10.1016/j.jpag.2015.01.007

Alaggia, R., Collin-Vézina, D., & Lateef, R. (2019). Facilitators and barriers to child sexual abuse disclosures: A research update (2000–2016). Trauma, Violence, & Abuse, 20(2), 260–283. https://doi.org/10.1177/1524838017697312

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

Barth, J., Bermetz, L., Heim, E., Trelle, S., & Tonia, T. (2013). The current prevalence of child sexual abuse worldwide: A systematic review and meta-analysis. International Journal of Public Health, 58(3), 469–483. https://doi.org/10.1007/s00038-012-0426-1

Benuto, L. T., & O'Donohue, W. (2015). Treatment of the sexually abused child: Review and synthesis of recent meta-analyses. Children and Youth Services Review, 56, 52–60. https://doi.org/10.1016/j.childyouth.2015.06.009

Caro, P., Turner, W., Caldwell, D. M., & Macdonald, G. (2023). Comparative effectiveness of psychological interventions for treating the psychological consequences of sexual abuse in children and adolescents: A network meta-analysis. Cochrane Database of Systematic Reviews, 2023(6), CD013361. https://doi.org/10.1002/14651858.CD013361.pub2

Haverkampf, C. J. (2025). Childhood Sexual Abuse: Epidemiology, Clinical Effects, Assessment, and Treatment. J Psychiatry Psychotherapy Communication, 2025 Mar 31;14(1):1-10

Cohen, J. A., Deblinger, E., & Mannarino, A. P. (2018). Trauma-focused cognitive behavioral therapy for children and families. Psychotherapy Research, 28(1), 47–57. https://doi.org/10.1080/10503307.2016.1208375

Hailes, H. P., Yu, R., Danese, A., & Fazel, S. (2019). Long-term outcomes of childhood sexual abuse: An umbrella review. The Lancet Psychiatry, 6(10), 830–839. https://doi.org/10.1016/S2215-0366(19)30286-X

Jensen, T. K., Holt, T., Ormhaug, S. M., Egeland, K., Granly, L., Hoaas, L. C., Hukkelberg, S. S., Indregard, T., Stormyren, S. D., & Wentzel-Larsen, T. (2014). A randomized effectiveness study comparing trauma-focused cognitive behavioral therapy with therapy as usual for youth. Journal of Clinical Child & Adolescent Psychology, 43(3), 356–369. https://doi.org/10.1080/15374416.2013.822307

Kellogg, N. D., Farst, K. J., & Adams, J. A. (2023). Interpretation of medical findings in suspected child sexual abuse: An update for 2023. Child Abuse & Neglect, 145, 106283. https://doi.org/10.1016/j.chiabu.2023.106283

Lemaigre, C., Taylor, E. P., & Gittoes, C. (2017). Barriers and facilitators to disclosing sexual abuse in childhood and adolescence: A systematic review. Child Abuse & Neglect, 70, 39–52. https://doi.org/10.1016/j.chiabu.2017.05.009

Macdonald, G., Higgins, J. P. T., Ramchandani, P., Valentine, J. C., Bronger, L. P., Klein, P., O'Daniel, R., Pickering, M., Rademaker, B., Richardson, G., & Taylor, M. (2012). Cognitive-behavioural interventions for children who have been sexually abused. Cochrane Database of Systematic Reviews, 2012(5), CD001930. https://doi.org/10.1002/14651858.CD001930.pub3

McTavish, J. R., Santesso, N., Amin, A., Reijnders, M., Ali, M. U., Fitzpatrick-Lewis, D., & MacMillan, H. L. (2021). Psychosocial interventions for responding to child sexual abuse: A systematic review. Child Abuse & Neglect, 116, 104203. https://doi.org/10.1016/j.chiabu.2019.104203

Moody, G., Cannings-John, R., Hood, K., Kemp, A., & Robling, M. (2018). Establishing the international prevalence of self-reported child maltreatment: A systematic review by maltreatment type and gender. BMC Public Health, 18, 1164. https://doi.org/10.1186/s12889-018-6044-y

Morina, N., Koerssen, R., & Pollet, T. V. (2016). Interventions for children and adolescents with posttraumatic stress disorder: A meta-analysis of comparative outcome studies. Clinical Psychology Review, 47, 41–54. https://doi.org/10.1016/j.cpr.2016.05.006

National Institute for Health and Care Excellence. (2017). Child abuse and neglect (NG76). https://www.nice.org.uk/guidance/ng76

National Institute for Health and Care Excellence. (2018). Post-traumatic stress disorder (NG116). https://www.nice.org.uk/guidance/ng116

Ormhaug, S. M., Jensen, T. K., Wentzel-Larsen, T., & Shirk, S. R. (2014). The therapeutic alliance in treatment of traumatized youths: Relation to outcome in a randomized clinical trial. Journal of Consulting and Clinical Psychology, 82(1), 52–64. https://doi.org/10.1037/a0033884

Rosner, R., Rimane, E., Frick, U., Gutermann, J., Hagl, M., Renneberg, B., Schreiber, F., Vogel, A., & Steil, R. (2019). Effect of developmentally adapted cognitive processing therapy for youth with symptoms of posttraumatic stress disorder after childhood sexual and physical abuse: A randomized clinical trial. JAMA Psychiatry, 76(5), 484–491. https://doi.org/10.1001/jamapsychiatry.2018.4349

Smith, T., Chauvin-Kimoff, L., Baird, B., & Ornstein, A. (2020). The medical evaluation of pre-pubertal children with suspected sexual abuse. Paediatrics & Child Health, 25(3), 180–186. https://doi.org/10.1093/pch/pxaa019

Teicher, M. H., & Samson, J. A. (2016). Annual research review: Enduring neurobiological effects of childhood abuse and neglect. Journal of Child Psychology and Psychiatry, 57(3), 241–266. https://doi.org/10.1111/jcpp.12507

Tichelaar, H. K., Deković, M., & Endendijk, J. J. (2020). Exploring effectiveness of psychotherapy options for sexually abused children and adolescents: A systematic review of randomized controlled trials. Children and Youth Services Review, 119, 105519. https://doi.org/10.1016/j.childyouth.2020.105519

World Health Organization. (2017). Responding to children and adolescents who have been sexually abused: WHO clinical guidelines. https://www.who.int/publications/i/item/9789241550147

World Health Organization. (2019). WHO guidelines for the health sector response to child maltreatment. https://www.who.int/publications/m/item/who-guidelines-for-the-health-sector-response-to-child-maltreatment

World Health Organization. (2024). Guidelines for HIV post-exposure prophylaxis. https://www.who.int/publications/i/item/9789240095137

World Health Organization, Centers for Disease Control and Prevention, Global Partnership to End Violence Against Children, Pan American Health Organization, President's Emergency Plan for AIDS Relief, Together for Girls, United Nations Children's Fund, United Nations Office on Drugs and Crime, United States Agency for International Development, & World Bank. (2016). INSPIRE: Seven strategies for ending violence against children. https://www.who.int/publications/i/item/9789241565356