96 Percent of Children Who Report Sexual Abuse Are Telling the Truth

By Steve Volk

First, former Penn State football coach Jerry Sandusky was accused of sexually abusing a series of children over decades. Now, even closer to home, *Daily News* sports writer Bill Conlin—a local legend—is accused of molesting kids decades ago. But after all the coverage, are any of us better prepared to protect our own children or recognize suspicious behavior on the part of the adults in our midst?

In Philadelphia, the Joseph J. Peters Institute[1], a non-profit mental health agency focused on sexual abuse, tries to counsel sex offenders and educate the public to prevent further victims. I spoke to Michael Stinson, director of prevention services at the Peters Institute, to try and figure out what we should take away from these recent, tragic stories.

To what degree do pedophiles focus on any one gender?
Stinson: Let's back up and talk about that word, "pedophile." People seem to lump all child sex offenders into the pedophile category. But there are different pathologies involved, and it's very complicated. For our purposes, in this interview, it's not even very useful to try and define child sex offenders in these narrower categories. Generally, ***pedophiles*** will manipulate people and situations and environments to satisfy a sexual attraction they have toward children. And they will often order their life around gaining that access to a specific type of child. A ***child molester*** is more of what we might call an all-purpose offender—a situation arises and they decide to act on the impulse they feel in that moment. I don't want to talk specifically about Jerry Sandusky or Bill Conlin. Because those stories aren't fully told yet, and the allegations aren't resolved.

There are sex offenders, child molesters, who do not necessarily focus on any particular gender or even age. And stranger danger is a smaller percentage of child sex-abuse cases. The majority of cases really are children who are close, in some way, to the person abusing them. When we're talking about actual pedophiles, then we're talking about people, often, who go seeking victims. And they can be very difficult to treat because to them their behavior is not strange. It's part of the way they live, the way they behave, and peer pressure—other people thinking it's wrong, society declaring it wrong—has less effect on them.

To answer your original question, when you look at adult offenders they usually offend against the opposite sex. But not always. And when it's a matter of convenience and access, they might offend against either gender.

One of the things I found most striking about the Conlin story is that he cried when he was confronted about his behavior. I understand you can't comment on Conlin, but in general, are child sex offenders ashamed of their own behavior? Or would tears generally be associated with fear about their own future—being found out, sent to prison, that sort of thing?
Stinson: Well, some offenders do realize their desires and their behaviors, if they are acting on them, are wrong. But without commenting on the Conlin allegation, in particular, tears can be very complicated: real remorse, as well as fear of being found out, fear of punishment, and shame over their desires and what they've done. All those things might be in the mix.

Does anyone ever call the institute and say 'I'm having these desires and I don't want to act on them. I need help.'
Stinson: Yes. We do get those calls here. And of course we try to help. If offenders are in treatment, they are far less likely to commit the crime again. Particularly in teenagers and young people who have started treatment, the recidivism rate is somewhere around four percent to eight percent. When we over-criminalize these offenses in young people by being overly punitive, with something like Megan's Law now subjecting teen-age offenders to

registration, being labeled in this way causes a whole other host of problems and may be counterproductive. It encourages them not to seek help.

It's often said that most child abusers were sexually abused themselves, as children. True?
Stinson: No. People who are abused as children, somewhere between 20 percent and 30 percent of them will either become abusive themselves or carry a re-victimization pattern forward—meaning they will always see themselves as a victim in every situation. But certainly much less than half of sex offenders who abuse children were themselves abused as children.

The last thing we want to do is start a witch hunt. But are there any behaviors, in adults, that should make us ask questions? What might we see that should, rightfully, make us suspicious of an adult in our lives?
Stinson: I think there are things we should be a lot more vigilant of and more deliberate in asking questions about, when an adult's behavior just doesn't look right. Sometimes, it's right to go with your gut feeling. I agree, we don't want to have witch hunts, and there really are people out there who take a sincere interest in the well-being of children. But if someone is showing overt interest in a particular child or teenager, it is not inappropriate to ask why. What you should really look out for are people who insist on alone time with a child—deliberate alone time, behind closed doors, no one can ask about it, that kind of thing. Let's say someone singles out a specific child and they accompany them everywhere, often without any other adults or children. That seems to be a deliberate act, a deliberate attempt to create this sort of alone time.

Also, we should be cautious of someone who encourages silence from children or enlists them in secret-keeping. Children do keep secrets—with other children. Not with 45-year-old men or women. Another might be an adult referring to a child as their "friend." Relationships between adults and children aren't normally "friend" relationships. So if you have an adult expressing these sorts of sentiments in a way that seems inappropriate, that's something you should pay attention to.

I really felt shook up about the allegations against Conlin because, it's naïve, but you'd like to think these people reveal themselves in some way, even if it's only in retrospect. I'd like to think of these people as somehow dysfunctional in some obvious way. But, I read Bill Conlin for many years. I watched him on *The Sports Reporters* on ESPN, and he seemed such a funny, social, bright guy—and a great writer, the quintessential sports writer. And it's just stunning …
Stinson: Yeah, well, it's really not like that. I mean, I agree—we all want to think of a sex offender as scraggly haired and one-toothed. But they really can be anybody. And they can be hugely successful and high-functioning in other areas of their life. And that's why it's important we learn about these things, however uncomfortable the topic might make us, and talk about it so that people understand. We have public and private selves. And people don't talk about their sexual impulses over a beer and they certainly don't talk about them at work. So that "work self" is a construction. The person you are privately, at home, away from work—that's who we really are.

What behaviors should people look out for, from their children, to suggest they may be withholding information about being abused?
Stinson: What we like to get across to people is they need to be engaged with their children, all the time, so they can recognize when their behavior is off somehow. Some indicators might be they don't want to go to sleep. Or they don't want to stay asleep. Or they start having nightmares. Maybe they shut down at odd times. They are there with you, engaged with you and whatever's happening, and then suddenly they just go blank and shut down. It could be because something has just happened, in the environment, that has reminded them of the behaviors that take place immediately before the abuse.

As for sleeping problems … the process of getting ready for bed can be a sort of ritual that goes on around the abuse. The adult offender often does the same things. They put them in bed, they turn the lights down, they read them a story, and then maybe they say, 'Oh, I'm just going to lay here a while until you fall asleep'—and then the abuse occurs. That can spark a lot of changes in the sleep patterns of an abused child. Maybe they have flashbacks when they go to sleep, or nightmares.

Other signs can be regressive behavior. They stopped wetting the bed two years ago, and now they have started again. Or they start defecating again, in their clothes. Also, oversexualized behavior—doing things that are

ahead of where they should be, developmentally.

What is the proper first response we give a child if they tell us they've been abused? By that I really mean, the first response—what do we say to the child right there in the moment?
Stinson: The first response is to take a deep breath. Then support their decision to disclose. Say "It's good you're telling me this," and stay calm, and stay comforting. Include yourself in the situation and the solution in the language you use. And what I mean is, say things like, 'We will get through this,' and 'You're not alone.' 'We're in this together.' Don't lead them or provide extra words or concepts. Let them tell the story in their own language and don't re-label anything. This part can be a little hard because sometimes the way children tell a story like this, it can sound fantastical. In young children, their brains aren't developed yet, and they don't know how to compartmentalize the story in the way adults would so. The beginning, middle and end may be told out of order or they connect things in odd ways.

Maybe they'd say: 'I was put in the dark room, no one was around, and they were screaming at me, and then someone was touching me.' That sounds satanic, and really odd. But the dark room may turn out to be their bedroom, and it was bedtime, and before the lights were turned out the abuser or someone else read them a story, and they screamed when they acted out what they were reading to the child, and then the abuse occurred. So, you have to let them tell the story in their own words and worry about sorting it out later. It needs to be authentic to the child.

Something else to keep in mind is that children do not generally spill out the whole story—it may take several hours or even days for them to share everything. What they do is, they tell you a little bit, and then they stop. The reason is because they're waiting to see how you react: Are they going to get in trouble for sharing this story? Do you believe them? Once they see you believe them and they won't get in trouble they feel safe enough to share a little bit more. What people need to know is that, according to the literature on the subject, if a child discloses abuse, about 96 percent of the time some sort of abuse did occur. That's the figure—around 96 percent.

Endnotes:

1. Joseph J. Peters Institute: http://jjp.org/

Source URL: https://www.phillymag.com/news/2011/12/22/96-percent-children-report-sexual-abuse-telling-truth/

Susanne Babbel MFT, PhD
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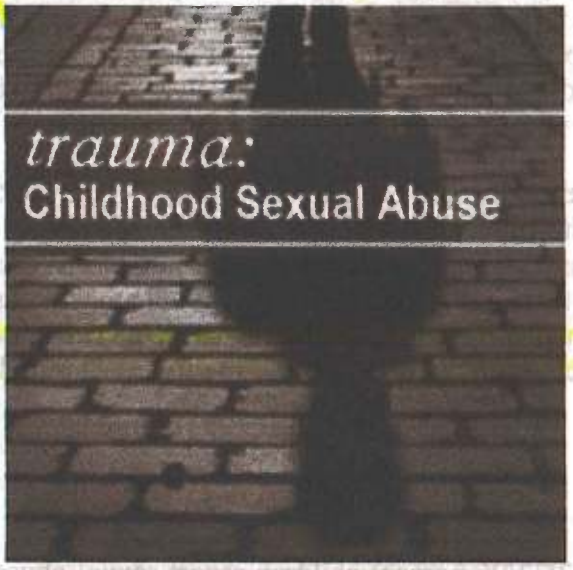
Trauma: Childhood Sexual Abuse

Sexual abuse can lead to Post Traumatic Stress Disorder (PTSD).

Posted Mar 12, 2013



Source: Susanne Babbel, PHD LMFT, Trauma: Childhood Sexual Abuse

There are various types of traumatic events that can lead to Post Traumatic Stress Disorder (PTSD).

Sexual abuse is a particularly sinister type of trauma because of the shame it instills in the victim. With childhood sexual abuse, victims are often too young to know how to express what is happening and seek out help. When not properly treated, this can result in a lifetime of PTSD, depression and anxiety.

The trauma that results from sexual abuse is a syndrome that affects not just the victim and their family, but all of our society. Because sexual abuse, molestation and rape are such shame-filled concepts, our culture tends to suppress information about them.

According to childtrauma.org, in the U.S. one out of three females and one out of five males have been victims of sexual abuse before the age of 18 years. And according to the American Academy of Experts in Traumatic Stress (AAETS), 30% of all male children are molested in some way, compared to 40% of females.

Some of the most startling statistics unearthed during research into sexual abuse are that children are three times as likely to be victims of rape than adults, and stranger abuse constitutes by far the minority of cases. It is more likely for a child to experience sexual abuse at the hands of a family member or another supposedly trustworthy adult.

Sexual abuse is a truly democratic issue. It affects children and adults across ethnic, socioeconomic, educational, religious, and regional lines.

Exactly what constitutes "sexual abuse"?The Incest Survivors Resource Network states that "the erotic use of a child, whether physically or emotionally, is sexual exploitation in the fullest meaning of the term, even if no bodily contact is ever made." It's important to notice this clause about "no sexual contact." Often, victims of sexual abuse will try to downplay their experience by saying that it "wasn't that bad." It's vital to recognize that abuse comes in many shapes, colors and sizes and that all abuse is bad.

Outcomes of sexual abuse

By far the most common effect of sexual abuse is Post Traumatic Stress Disorder. Symptoms can extend far into adulthood and can include withdrawn behavior, reenactment of the traumatic event, avoidance of circumstances that remind one of the event, and physiological hyper-reactivity.

3x *children* are **three times** as likely to be victims of rape than *adults*

Source: Susanne Babbel, PHD LMFT, Trauma: Childhood Sexual Abuse

- Sexual components to drawings and games
- Neurotic reactions (obsessions, compulsiveness, phobias)
- Habit disorders (biting, rocking)
- Unusual sexual knowledge or behavior
- Prostitution
- Forcing sexual acts on other children
- Extreme fear of being touched
- Unwillingness to submit to physical examination

Studies have shown that children who experience sexual abuse tend to recover quicker and with better results if they have a supportive, caring adult (ideally a parent) consistently in their life.

It's crucial for every victim of sexual abuse to seek counseling to decrease or to prevent PTSD symptoms. Since 35% of child sexual abusers (http://www.ncbi.nlm.nih.gov/pubmed/11731348) were once abused (higher in males), counseling might also help to reduce the possibility of a victim repeating the abusive pattern.

unfortunately common reactions to early sexual abuse.

Substance abuse is a common outcome of sexual abuse. In fact, according to the AAETS, "specialists in the addiction field (alcohol, drugs and eating disorders) estimate that up to 90 percent of their patients have a known history of some form of abuse."

Specific symptoms of sexual abuse:
(citation, the American Academy of Experts in Traumatic Stress)

- Withdrawal and mistrust of adults
- Suicidality
- Difficulty relating to others except in sexual or seductive ways
- Unusual interest in or avoidance of all things sexual or physical
- Sleep problems, nightmares, fears of going to bed
- Frequent accidents or self-injurious behaviors
- Refusal to go to school, or to the doctor, or home
- Secretiveness or unusual aggressiveness

About the Author

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Long-term health outcomes of childhood sexual abuse

Psychological consequences of trauma were first seen in veterans of war and described in the literature as *shell shock*. By 1980, the diagnosis of post-traumatic stress disorder (PTSD) was listed in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, which guides healthcare practitioners with diagnosis, treatment, and reimbursement. For years we have been studying the *psychological* changes that are the sequelae of childhood trauma. These long-term consequences include a higher incidence of depression, intrusive flashback memories, hypervigilance, maladaptive coping skills, dysfunctional social skills, and an overactive stress response. Research examining the more holistic effect of trauma has exploded due to recent events, such as 9/11, terrorism, and traumatized troops returning from war.

As holistic nurses, we understand that even when the effect seems to be psychological, social or biology is also influenced. The mind and body interact on every level. The ripple effect of early childhood trauma has more than psychological effects. Biology of the brain and immune function are influenced. The child is forever changed. Here we examine the influence of childhood sexual abuse on the long-term health and the nursing care of adult survivors.

Stress

Walter Cannon first described the fight-or-flight response in 1914 as the complex physiological response that prepares the body for fighting or fleeing. The sympathetic nervous system responds to a stressor, suppressing the calming effects of the parasympathetic system. The hypothalamus in the brain secretes hormones that in turn influence the kidneys and the brain. The cascade of chemicals has a ripple effect on many systems, including the respiratory, gastric, cardiovascular, endocrine, renal, and immune. A major part of the brain/hormone/immune interaction, the hypothalamic-pituitary-adrenal axis, becomes involved and further influences physical and psychological functioning.

Adrenocorticotropic hormone is released from the brain and anti-inflammatory steroids such as cortisol suppress the immune system. Ability for healing and even normal cell maintenance is reduced. With altered immune cell levels, the body has increased inflammation, susceptibility to infection, allergic response, and cell mutation. Natural killer cells, for example, whose job it is to correct the cell mutation of cancer, diminish in number. The effect is cumulative: The longer the stress is perceived, the greater the severity of imbalance.

Early trauma changes the brain

When trauma and stress happen early in life, the effects are far more profound and long-lasting. Biological brain development is influenced by genetics, nutrition, social interaction, and experiences. Almost no new brain neurons are formed after birth. There is, instead, a constant rewiring of the existing neurons. New connections are made and old connections are disconnected. This understanding of the plasticity of the brain is what drives rehabilitation after a stroke.

Trauma and early negative experiences affect the development and even structure of the brain. Women who were sexually abused as children show significantly diminished brain volume on brain scans. The structure and function of the hippocampus (responsible for learning and memory), for example, are different when compared to individuals who weren't

traumatized. The medial prefrontal cortex, amygdala, and other neural circuitry of the brain are also changed. The brain shows a sustained and pervasive stress response as the child grows, and this has a long-term effect on immune function. Brain wave patterns change. The brain's response to inflammation and healing is altered. Neurotransmitter levels adapt to these new abnormal levels. The biological changes in the brain are even more profound if the abuse was early, pervasive, or severe.

Long-term health issues for survivors of childhood sexual abuse

The range of potential adverse health outcomes is extensive and childhood sexual abuse can be seen as a risk factor for many diseases. Those who experienced childhood sexual abuse are one and a half times more likely to report serious health problems.

The figure below shows common long-term sequelae of childhood sexual abuse. Because of the holistic nature, it's difficult to categorize the conditions into traditional systems or paradigms.

Childhood Sexual Abuse

(Click to download PDF (https://www.americannursetoday.com/goto/https://americannursetoday.com/uploaded10/Childhoodabusefigure 1.pdf))

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Psychological issues for this population often include anxiety, poor self-esteem, dysfunctional relationships, eating disorders, and PTSD. PTSD results from a threat to self or others accompanied by "intense fear, horror, or helplessness," according to the Veteran's Administration National Center for PTSD. Maladaptive coping such as denial is overused. Those with a history of childhood sexual abuse have increased reports of fear, anxiety, insomnia, headaches, aggression, anger, hostility, poor self-esteem, and suicide attempts. Higher rates of depression are reported. Depression has also been shown to be associated with impaired immune functioning. Increased cytokines (inflammation) and cortisol (stress) have been identified as mechanisms by which immune system function is impaired and related to depression. Incidences of dysfunctional relationships, intimate partner violence, and self-destructive behavior are higher.

Higher rates of some physical diseases, such as sexually transmitted diseases, hepatitis, or pelvic inflammatory disease, can be attributed to the common behavioral issues for this population that include promiscuity, substance abuse, and/or sexual dysfunction. But for those traumatized early in life, there exists a clear and increased risk of lung disease, ulcers, cardiac disease, diabetes, and cardiac disorders. The high incidence of inflammatory disorders, such as rheumatoid arthritis and allergies, is an example of the imbalanced immune system's overreaction. Prolonged stress and exposure to cortisol, for instance, cause wounds to heal slowly, indicating an underreacting immune system.

Autoimmune disease

The role of childhood sexual abuse in the development of autoimmune disease is worthy of special attention. Trauma in early childhood predisposes the individual to autoimmune diseases in later life. Some of the strongest evidence linking autoimmune disease to childhood trauma is a retrospective study of over 15,000 adults who were enrolled in the Adverse

Childhood Experiences study. Autoimmune disease processes commonly seen in this population are fibromyalgia, Crohn's disease, irritable bowel syndrome, type 1 diabetes, and rheumatoid arthritis. Patients with a history of childhood sexual abuse may develop fibromyalgia and use outpatient health services and analgesics more frequently. Adult survivors of childhood sexual abuse also report increased pain associated with other medical conditions. Cardiovascular diseases, such as arteriosclerosis and ischemic heart disease, are directly related to maladaptive immune function and inflammation and occur in higher rates in adult survivors of childhood sexual abuse. It's important to remember that any of these disease processes can occur in people who weren't sexually abused as children.

Healing is possible

Healing from childhood sexual abuse is possible at any point in life. Nurses should be familiar with local providers for counseling, stress-management training, and holistic care of these survivors. Nurses should take an active role in advocating for the client in the referral process when the history of childhood sexual abuse is identified. The human cost of healing survivors of childhood sexual abuse is still far greater than the cost of preventing childhood sexual abuse from occurring in the first place. Being sexually abused as a child has a lifelong impact on health. Once again we are reminded that an awareness of the holistic perspective is vital for competent nursing care of victims of childhood sexual abuse.

Now that you have read the article, see how you would handle these example scenarios. There is no one right answer.

Scenario #1 Mrs. B. Raider is a 60-year-old menopausal client who presents at her physician's office following a stressful event of being laid off from her job. When reviewing her record, the nurse notices that this is Mrs. Raider's 10th visit to the clinic in the last year. She notes a history of back pain, migraine headaches, depression with use of selective serotonin reuptake inhibitors, irritable bowel syndrome, alcoholism, and fibromyalgia. Mrs. Raider has difficulty making eye contact when asked why she is here today, and states that she has been having persistent pelvic pain. She says she is unmarried, not sexually active, and divorced less than a year. ***What clues about her history might indicate sexual abuse? What support groups, stress-management training, or nursing interventions may be helpful? Note: To answer the first question, refer to the Childhood Sexual Abuse figure earlier in this article.***

Scenario #2 Miss Clarissa Kent is an 18-year-old homeless, obese woman who presents at an urban free clinic with complaints of malodorous vaginal discharge, fever, and pelvic pain for the last 48 hours. She has no contact information, is unaccompanied, and reports a history of I.V. drug abuse. She states she fears she might be HIV-positive. When the nurse inquires about her work-related status, the young woman explains that she recently chose to work for a local escort service to support her drug habit and pay the bills. She reports a long history of poor health and bulimia since she began middle school. She admits to attempting suicide in the past; following the event, she dropped out of school and ran away from home. She says she did this primarily because of the way she was being "treated" by her alcoholic stepfather for most of her life. After sharing this she looks away and states she doesn't want to talk about it, and asks to see the physician. ***What might you say to make her more comfortable continuing her story? What resources exist in your community to help this young woman? What might you say and do if she disclosed a history of sexual abuse?***

Scenario #3 Mr. Howell accompanies his wife Rebecca to labor and delivery for the birth of their first baby. The nurse notices that Mr. Howell is very protective of his wife, and that his wife isn't answering many of the questions that are being asked. Rebecca allows her husband to speak on her behalf and is resistant to changing into the hospital gown or letting the nurse put on the fetal monitors. She seems to become tense and pulls away when light touch is used to help her with relaxation. When the nurse tries to explain the need to do a vaginal exam to check the progress of cervical dilation and effacement, the couple admits that they don't understand what she is referring to and add that they only established prenatal care about a month ago. They haven't attended any prenatal classes. When the nurse attempts a vaginal exam, Rebecca is unwilling to adequately open her legs or relax her perineum sufficiently. The nurse explains that the female provider Mrs. Howell has seen for the past month isn't on call and that a male provider will instead attend their birth. Rebecca begins to suddenly sob uncontrollably, as Mr. Howell becomes angry and defensive towards the nurse. ***What changes and accommodations could the nurse have made that would have been more sensitive to the needs of Rebecca Howell. What behaviors and symptoms might indicate a possible history of sexual abuse?***

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