Prevalence and Consequences of Child Sexual Abuse Compared with Other Childhood Experiences

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Prevalence and Consequences of Child Sexual Abuse Compared with Other Childhood Experiences

CHILD SEXUAL ABUSE: THE PUBLIC IS UNAWARE OF ITS MAGNITUDE

It is likely that the public is not fully aware of the magnitude of the problem of child sexual abuse. This is because:

- The majority of children do not disclose their experiences of child sexual abuse for many years.
- The public is not typically aware of disclosed or reported cases of abuse because of professional privacy standards.
- Child sexual abuse does not leave a visible, physical mark. The devastating consequences of child sexual abuse are emotional and psychological, often worsening over time.

One of the most important elements in connecting with the public is a statement of the magnitude of the problem of child sexual abuse. Without it, the child sexual abuse organization/practitioner's ability to engage the public and funders is limited.

COMMUNICATING THE MAGNITUDE OF THE PROBLEM

In order to make people understand the magnitude of the problem, *Darkness to Light* makes the following statement.

> *"Child sexual abuse is likely the most prevalent health problem with the most serious array of consequences that children face."*

In order to support this claim, this paper will compare the prevalence and consequences of child sexual abuse with other adverse child experiences.

The information presented on each childhood condition or experience is largely based in science, but the comparison between them is relatively subjective.

TRAUMATIZING EXPERIENCES

Child sexual abuse is just one form of trauma that children face. Children are at varying degrees of risk for a number of traumatizing experiences as they grow up. These include (but are not limited to):

- Child sexual abuse
- Emotional abuse or neglect

- Physical abuse
- Death of a parent or other close family member
- Foster care
- Homelessness

CONSEQUENSES OF TRAUMATIC EXPERIENCES

Children who experience trauma resulting from any of these conditions may experience none to a whole host of diverse consequences. Common consequences of trauma include:

- Post Traumatic Stress Disorder [1,2,3,4,5,6,7]
- Anxiety and depression [1,2,3,4,5,9,10,11,12,13,14,64]
- Substance abuse [2,7,9,10,11,14,15,16,17,64]
- Aggression, oppositionality and defiance [1,2,4,5,6,8,10,11,13,18,19,20,21,22]
- Withdrawal and Social Isolation [23]
- Attention Deficit Hyperactivity Disorder [24]
- Self inflicted harm, [6,21,25,26,27,28,29,30] including suicide ideation [14,21,25,31]
- Delinquency [5,22,32]
- Runaway behavior [15,32]
- Decreased school performance, [1,8] and drop out [33,34]
- Criminal behavior and violent offenses [6,13,15,22,32,35,36]
- Obesity [2,5,11,18]

DEGREE OF TRAUMA

The degree to which a child experiences these consequences varies. Some of the factors that influence individual responses to trauma include:

- The severity of the traumatic event
- The duration of the traumatic event
- The age of the child

The resiliency of a child is also an important factor in the degree to which a child experiences consequences associated with trauma. Resiliency is a product of:

- High self-esteem [37]
- A repertoire of adaptive coping skills [37]
- Positive attachment with a primary caregiver [37]
- A strong social support network [37]
- Reliable adult mentors [37]
- Supportive school and community environment [37]

CONSEQUENCES SPECIFIC TO TYPE OF TRAUMA

Some childhood experiences can result in consequences that are specific to that type of trauma.

Child Sexual Abuse (10% prevalence rate)

- Overly sexualized behavior [4,6,7,15,38]
- HIV and sexually transmitted diseases [2,3]
- Teen pregnancy and motherhood [4,10]
- Guilt and self-blame [39,40]
- Fear of healthy affection and relationships [39,40]

- Lack of self-worth and self-esteem [39,40,41]
- Vulnerability to other victimization [42,43]

Emotional Abuse (11.1% prevalence rate)

- Guilt and self-blame [39,40]
- Fear of healthy affection and relationships [39,40]
- Lack of self-worth and self-esteem [39,40,41]
- Vulnerability to other victimization [42,43]

Physical Abuse (9.1% prevalence rate)

- Physical injuries and scars [2,44]
- Guilt and self-blame [39,40]
- Fear of healthy affection and relationships [39,40]
- Low self-worth and self-esteem [39,40,41]
- Vulnerability to other victimization [42,43]

Death of a parent or other close family member

- Emotional shock [45]
- Regressive (immature) behaviors [45]
- Explosive emotions and acting out behavior [45]
- Asking the same questions over and over, [45]
- Vulnerability to victimization crimes [42,43]

Long-term foster care and chronic homelessness (1.6% prevalence rate)

- Vulnerability to sexual abuse and other victimization [42,43,46]
- Academic difficulties or school dropout [47,48]
- Lack of opportunity and less earning potential [49]
- Criminal activity [50]
- Homelessness [49]

DEBILITATING EXPERIENCES

In addition to traumatic experiences, there are other conditions that can be debilitating for children. These include, but are not limited to:

- Childhood sensory or movement difficulty
- Childhood cognitive difficulty, including autism
- Childhood ADHD
- Morbid obesity
- Other debilitating conditions, such as cancer, diabetes, accident, etc.

CONSEQUENCES SPECIFIC TO TYPE OF DEBILITATING CONDITION

Debilitating conditions often result in consequences that are specific to that type of condition.

Childhood sensory or movement difficulty (5% prevalence rate)

- Family stress [51]
- Economic hardship [51]
- Mental and physical health [51]

- Social adjustment problems [52]
- Psychiatric disorders [52]
- Vulnerability to sexual abuse and other victimization [53]

Childhood cognitive difficulty, including autism (9% prevalence rate)

- Family stress [51]
- Economic hardship [51]
- Mental and physical health [51]
- Social adjustment problems [52]
- Psychiatric disorders [52]
- Vulnerability to sexual abuse and other victimization [53]

Childhood ADHD (9% prevalence rate)

- Poor academic performance [54]
- Trouble with relationships [54]
- Family stress [54]
- Impulsivity [54]
- Hyperactivity [54]
- Difficulty with attention [54]

Morbid obesity in childhood (2% prevalence rate)

- Orthopedic issues [55]
- Endocrine issues [56]

- Cardiovascular issues [56]
- Poor health [57]
- Low self-worth [56]

Other Debilitating Conditions

There are a myriad of other devastating experiences and conditions that have not been analyzed here because their consequences are not as severe, or their prevalence is very low. Among these are diabetes, cancer, serious accidents, and the like.

DISCUSSION

Individual Experiences are Different

For an individual child, no one can say whether one traumatizing or debilitating experience is worse than another. Additionally, the consequences typically associated with a condition may or may not apply to a particular child. This discussion is not meant to devalue any child's or family's experience, nor is it meant to label all who suffer these experiences as victims.

Polyvictimzation

Many children are victimized or traumatized in more than one way.[58] For example, because of their overall vulnerability, a child that is emotionally abused may also be sexually victimized. Children with a cognitive or sensory difficulty are at high risk for emotional or sexual abuse.[53] Children who are homeless or in foster care are at exceptionally high risk for other victimizations.[46] Polyvictimization exponentially increases the level of trauma for a child.

COMPARISON OF DIFFERENT TYPES OF TRAUMATIC OR DEBILITATING EXPERIENCES

Given the level of information about prevalence and consequences of various adverse childhood experiences, it is possible to evaluate the consequences and prevalence of various conditions in comparison to one another.

How Traumatic is Child Abuse?

About 9.1% of children are physically abused.[43] 11.1% of children are emotionally abused and 3.6% are neglected.[43] About 10% of children are sexually abused.[59]

Data indicates that 68% of physically abused children meet a standard of harm that is roughly equivalent to a standard of trauma.[46] 49% of emotionally abused children meet this standard of harm, and 75% of sexually abused children are harmed to the point of traumatization.[46]

Complicating matters, a large percentage of victims of child abuse are also victims of other forms of abuse.[58] Polyvictimization dramatically increases the level of trauma children experience. For instance, sexually abused children who have experienced more than one victim crime exhibit six times the trauma symptoms as children who are not polyvictimized.[58]

On the whole, sexually, physically and emotionally abused children suffer from the same basic set of negative consequences.

In addition to standard trauma consequences, child abuse victims also suffer consequences that are unique to the type of abuse suffered. For instance, physically abused children suffer from physical injuries, [2,44] and emotionally abused children suffer from "withdrawal" symptoms, like low self-esteem.[39,40,41]

Child sexual abuse victims suffer from consequences that can follow the victim throughout life. Many victims exhibit overly sexualized behavior.[4, 6,7,15,38] This can lead to HIV and sexually transmitted diseases,[2,3] and teen pregnancy and motherhood.[4,10]

There can be no doubt that child abuse is a serious societal issue.

How Traumatic is the Death of a Loved One?

The death of a loved one is particularly traumatizing for some children. Others seem to deal with it and move on. Those who experience extreme trauma and grief find it every bit as debilitating as the trauma suffered by abused children. However, in comparison, the death of someone close to a child is relatively rare, and many children who are affected get counseling. On the whole, the grieving experience does not rise to the level of a serious societal issue.

How Traumatic is Foster Care and Homelessness?

Data indicates that about 1.4% of children are in foster care for more than two years.[60] About .2% of children experience homelessness.

Long-term foster care and homelessness, in tandem with other inevitable victimizations, are probably the most traumatizing experiences children can experience. Children who enter foster care are usually highly traumatized victims of abuse before they arrive. Their vulnerability sets them up for continued abuse and victimization. For instance, children in foster care are ten times more likely to be sexually victimized than children who live with both biological parents.[46] Research also shows that chronically homeless and foster children do not, on the whole, overcome their traumatic experiences as they enter adulthood. 25% of those that age out of foster care do not have either a high school degree or GED.[47,48] Less than 2% finish college.[61] Over 50% experience homelessness, and 30% are incarcerated as they become adults.[50] In fact, three out of 10 of the United States homeless are former foster children. These individuals also face higher rates of unemployment and are less likely to have health insurance.[49]

The only factor that keeps foster care and homelessness from being a societal problem of greater magnitude is that it is likely that less than 2% of the child population is chronically homeless or in long-term foster care. [60]

How Challenging are Childhood Disabilities?

About 5% of children have movement or sensory disabilities.[62] About 9% of children have cognitive disabilities, including autism.[62]

Children with disabilities face many challenges. Many children with disabilities meet these challenges head on and carve out their place in the world. Others do not fare so well. Some are frustrated or angry. Children with disabilities are also at increased risk for sexual victimization and victim crimes.[53]

While many families and support systems work hard to provide positive life experiences for children with disabilities, some children face a lifetime of diminished opportunity and limited life experience.

Even though a surprising large number of children are labeled as disabled, the overall societal impact of disability does not rise to the level of some other traumatic or debilitating experiences.

How Challenging are ADHD and Obesity?

About 2% of children are morbidly obese (although another 14% suffer from obesity). About 9% of children are diagnosed with Attention Deficit Hyperactivity Disorder.[63]

While ADHD and obesity can negatively impact the development of children, these conditions are not as widespread, debilitating or traumatic as child abuse, homelessness or foster care.

RANKING TRAUMATIC EXPERIENCES

Based on the research and this review, there are four conditions or experiences that are particularly traumatizing or debilitating for children.

- Chronic foster care or homelessness
- Child sexual abuse
- Child physical abuse
- Child emotional abuse and neglect

If you weight the consequences of these adverse experiences by their prevalence rates, chronic foster care and homelessness are not as impactful on society as child abuse.

It is impossible to scientifically rank the level of societal harm caused by each of the different forms of child abuse. All are equally prevalent and all produce similar generalized traumatic consequences.

However, child sexual abuse victims often suffer from the effects of overly sexualized behavior in addition to generalized trauma. In fact, this is a prevailing consequence of child sexual abuse. Overly sexualized behavior can lead to serious, irreparable, lifelong consequences, such as sexually transmitted diseases, teenage parenthood, school dropout, poverty, health issues and untold loss of potential. Other forms of child abuse do not share these consequences at the same level.

Given these specific consequences, and the level of trauma suffered by child sexual abuse victims, it appears as if there is sufficient evidence to support the statement:

> *"Child sexual abuse is likely the most prevalent health problem with the most serious array of consequences that children face."*

REFERENCES

1. Grayson, J. (2006). Maltreatment and its effects on early brain development. *Virginia Child Protection Newsletter, 77*, 1-16.
2. Leeb, R., Lewis, T., & Zolotor, A. J. (2011). A review of physical and mental health consequences of child abuse and neglect and implications for practice. *American Journal of Lifestyle Medicine, 5*(5), 454-468.
3. Trickett, P. K., Noll, J. G., & Putnam, F. W. (2011). The impact of sexual abuse on female development: Lessons from a multigenerational, longitudinal research study. *Development and Psychopathology*, *23*(2), 453-476.
4. Olafson, E. (2011). Child sexual abuse: Demography, impact, and interventions. *Journal of Child & Adolescent Trauma*, *4*(1), 8-21.
5. Lansford, J. E., Dodge, K. A., Pettit, G. S., Bates, J. E., Crozier, J., & Kaplow, J. (2002). A 12-year prospective study of the long-term effects of early child physical maltreatment on psychological, behavioral, and academic problems in adolescence. *Archives of Pediatrics & Adolescent Medicine, 156*(8), 824-830.
6. Mullers, E. S., & Dowling, M. (2008). Mental health consequences of child sexual abuse. *British Journal of Nursing, 17*(22), 1428-1433.
7. De Bellis, M. D. (2001). Developmental traumatology: The psychobiological development of maltreated children and its implications for research, treatment, and policy. *Development and Psychopathology*, *13*(3), 539-564.
8. Cohen, E., Groves, B., & Kracke, K. (2009). Understanding children's exposure to violence. *The Safe Start Center Series on Children Exposed to Violence, 1,* 1-8.
9. Lanier, P., Jonson-Reid, M., Stahlschmidt, M. J., Drake, B., & Constantino, J. (2010). Child maltreatment and pediatric health outcomes: A longitudinal study of low-income children. *Journal of Pediatric Psychology, 35*(5), 511-522.
10. Gilbert, R., Widom, C. S., Browne, K., Fergusson, D., Webb, E., & Janson, S. (2009). Burden and consequences of child maltreatment in high-income countries. *Lancet, 373*(9657), 68-81.
11. Hussey, J. M., Chang, J. J., & Kotch, J. B. (2006). Child maltreatment in the United States: Prevalence, risk factors, and adolescent health consequences. *Pediatrics*, *118(*3), 933-942.
12. Dubowitz, H. (2006). E_ect of early childhood adversity on child health. *Archives of Pediatrics &Adolescent Medicine, 160*(12), 1232-1238.
13. Herrera, V. M., & McCloskey, L. A. (2003). Sexual abuse, family violence, and female delinquency: Findings from a longitudinal study. *Violence and Victims*, *18*(3), 319-334.
14. Daigneault, I., Hebert, M., & Tourigny, M. (2006). Attributions and coping in sexually abused adolescents referred for group treatment. *Journal of Child Sexual Abuse*, *15*(3), 35-59.
15. Flaherty, E. G., Thompson, R., Litrownik, A. J., Theodore, A., English, D. J., Black, M. M., Dubowitz, H. (2006). Effect of early childhood adversity on child health. *Archives of Pediatrics & Adolescent Medicine, 160*(12), 1232-1238.

16. Dube, S. R., Felitti, V. J., Dong, M., Chapman, D. P., Giles, W. H., & Anda, R. F. (2003). Childhood abuse, neglect, and household dysfunction and the risk of illicit drug use: The adverse childhood experiences study. *Pediatrics*, *111*(3), 564-572.

17. Rogosch, F. A., Oshri, A., & Cicchetti, D. (2010). From child maltreatment to adolescent cannabis abuse and dependence: A developmental cascade model. *Development and Psychopathology*, *22*(4), 883-897.

18. Zimmerman, F., & Mercy, J. A. (2010). Child maltreatment prevention as a public health priority. *Zero to Three*, *May*, 4-10.

19. Cyr, M., McDu_, P., & Wright, J. (2006). Prevalence and predictions of dating violence among adolescent female victims of child sexual abuse. *Journal of Interpersonal Violence*, *21*(8),1000-1017.

20. Kotch, J. B., Lewis, T., Hussey, J. M., English, D., Thompson, R., Litrownik, A. J., Dubowitz, H. (2008). Importance of early neglect for childhood aggression. *Pediatrics*, *121*(4), 725-731.

21. Duke, N. N., Pettingell, S. L., McMorris, B. J., & Borowsky, I. W. (2010). Adolescent violence perpetration: Associations with multiple types of adverse childhood experiences. *Pediatrics*, *125(*4), e778-786.

22. Maas, C., Herrenkohl, T. I., & Sousa, C. (2008). Review of research on child maltreatment and violence in youth. *Trauma, Violence, & Abuse*, *9*(1), 56-67.

23. Elliott, G., Cunningham, S.M., Linder, M., Colangelo, M., Gross, M. (2005) Child physical abuse and self-perceived social isolation among adolescents. *Journal of Interpersonal Violence 20*(12) x-x.

24. Dubowitz, H., Black, M., Harrington, D., Verschoore, A. (1993). A follow-up study of behavior problems associated with child sexual abuse. *Child Abuse & Neglect*, *17*, 743-754.

25. Sankey, M. (2003). Suicide and risk-taking deaths of children and young people. Sydney, Australia: NSW Commission for Children and Young People. Retrieved from http://www.kids.nsw.gov.au/uploads/documents/srtreport.pdf

26. Dubo, E. D., Zanarini, M. C., Lewis, R. E., & Williams, A. A. (1997). Childhood antecedents of self-destructiveness in borderline personality disorder. *Canadian Journal of Psychiatry*,*42*(1), 63-69.

27. Glassman, L. H., Weierich, M. R., Hooley, J. M., Deliberto, T. L., & Nock, M. K. (2007). Child maltreatment, non-suicidal self-injury, and the mediating role of self-criticism. *Behavior Research and Therapy*, *45*(10), 2483-2490.

28. Nock, M. K. (2009). Why do people hurt themselves? New insights into the nature and functions of self-injury. *Current Directions in Psychological Science*, *18*(2), 78-83.

29. Yates, T. M. (2004). The developmental psychopathology of self-injurious behavior: Compensatory regulation in posttraumatic adaptation. *Clinical Psychology Review, 24*(1), 35-74.

30. Yates, T. M., Carlson, E. A., & Egeland, B. (2008). A prospective study of child maltreatment and self-injurious behavior in a community sample. *Development and Psychopathology*,*20*(2), 651-671.

31. Cohen, R. T., Canino, G. J., Bird, H. R., & Celedon, J. C. (2008). Violence, abuse, and asthma in Puerto Rican children. *American Journal of Respiratory and Critical Care Medicine*, *178*(5),453-459.

32. Grogan-Kaylor, A., Rufolo, M. C., Ortega, R. M., & Clarke, J. (2008). Behaviors of youth involved in the child welfare system. *Child Abuse & Neglect*, *32*(1), 35-49.

33. Saunders, B.E., Kilpatrick, D.G., Hanson, R.F., Resnick, H.S., & Walker, M. E. (1999). Prevalence, case characteristics, and long-term psychological correlates of child rape among women: A national survey. *Child Maltreatment*, 4, 187-200.

34. Briere, J. N. & Elliott D.M. (1994). Immediate and long term impacts of child sexual abuse. *The Future of Children*, *4*, 54-69.

35. Lewis, T. L., Kotch, J., Wiley, T. R., Litrownik, A. J., English, D. J., Thompson, R., ... Dubowitz, H. (2011). Internalizing problems: A potential pathway from childhood maltreatment to adolescent smoking. Journal of Adolescent Health, 48(3), 247-252.

36. Leeb, R. T., Barker, L. E., & Strine, T. W. (2007). The effect of childhood physical and sexual abuse on adolescent weapon carrying. Journal of Adolescent Health, 40(6), 551-558.

37. NCTSN Core Curriculum on Childhood Trauma Task Force (2012). *The 12 core concepts: Concepts for understanding traumatic stress responses in children and families.* Core Curriculum on Childhood Trauma. Los Angeles, CA, and Durham, NC: UCLA-Duke University National Center for Child Traumatic Stress.

38. Brown, L. K., Houck, C. D., Hadley, W. S., & Lescano, C. M. (2005). Self-cutting and sexual risk among adolescents in intensive psychiatric treatment. *Psychiatric Services*, *56*(2), 216-218.

39. Browne, A., & Finkelhor, D. (1986). Impact of child sexual abuse: A review of the research. *Psychological Bulletin, 99*, 66-77.

40. Lisak, D. (1994). The psychological impact of sexual abuse: Content analysis of interviews with male survivors. *Journal of Traumatic Stress, 7(4)*,525-548.

42. Finkelhor, D., Ormrod, D., Turner, H., Hamby, S. (2005). The victimization of children and youth: A comprehensive, national survey. *Child Maltreatment, 10(1),* 5-25

43. Finkelhor, D., Turner, H. Ormrod, R., Hamby, S. (2009). Violence, abuse, and crime exposure in a national sample of children and youth. *Pediatrics 124*(5): 1-14.

44. Clark, D. B., Thatcher, D. L., & Martin, C. S. (2010). Child abuse and other traumatic experiences, alcohol use disorders, and health problems in adolescence and young adulthood. *Journal of Pediatric Psychology*, *35(*5), 499-510.

45. National Association of School Psychologists (2003) Helping children cope with loss, death and grief. Bethesda, MD. Retrieved from www.nasponline.org.

46. Sedlak, A.J., Mettenburg, J., Basena, M., Petta, I., McPherson, K., Greene, A., Li, S. (2010). *Fourth National Incidence Study of Child Abuse and Neglect (NIS–4): Report to Congress, Executive Summary*. Washington, DC: U.S. Department of Health and Human Services, Administration for Children &Families.

47. Kushel, M.B., Yen, Gee, L. & Courtney, M.E. (2007). Homelessness and health care access

after emancipation: Results from the Midwest evaluation of adult functioning of former foster youth. *Archives of Pediatric Medicine, 161*(10).

48. Pecora, P.J., Kessler, R.C., Williams, J., O'Brien, K., Downs, A.C., English, D., White, J., et al. (2005). *Improving foster family care: Findings from the Northwest Foster Care Alumni Study.* Casey Family Services. Seattle, WA. Retrieved from www.casey.org.
49. Courtney, M. E., Dworsky, A., Cusick, G.R., Havlicek, J., Perez, A., Keller, T. (2007). *Midwest evaluation of the adult functioning of former foster youth: Outcomes at age 21.* Chicago, IL. Chapin Hall Center for Children at the University of Chicago.
50. U.S. Department of Health and Human Services. The AFCARS Report: Preliminary Estimates for FY 2006 as of January 2008. http://www.acf.hhs.gov/programs/cb/stats_research/afcars/tar/report14.htm (accessed August 20, 2008).
51. Reichman, N.E., Corman, H., Noonan, K. (2008) Impact of child disability on the family. *Maternal and Child Health Journal, 12*(6):679-683.
52. Cadman, D., Boyle, M., Szatmari, P., Offord, D.R. (1987) Chronic illness, disability, and mental and social well-being: Findings of the Ontario Child Health Study. *Pediatrics 79*(5), 805 -813
53. National Center on Child Abuse and Neglect (1993). A report on the maltreatment of children with disabilities. U.S. Department of Health and Human Services. Washington, D.C.
54. American Academy of Child and Adolescent Psychiatry (2013). Frequently Asked Questions. Retrieved from: http://www.aacap.org/AACAP/Families_and_Youth/Resource_Centers/ADHD_Resource_Center/FAQ.aspx
55. Taylor, E.D., Theim, K.R., Mirch, M.C., Ghorbani, S., Tanofsky-Kraff, M., Adler-Wailes, D.C., Brady, S., Reynolds, J.C., Calis, K.A., Yanovski, J.A. (2006) Orthopedic complications of overweight in children and adolescents. *Pediatrics*, *117*(6):2167-2174
56. Must, A., Strauss, R.S. (1999). Risks and consequences of childhood and adolescent obesity. *Journal of the International Association for the Study of Obesity 23*(2) 2-11
57. Reilly, J.J. (2005) Descriptive epidemiology and health consequences of childhood obesity. *Clinical Endocrinology & Metabolism 19*(3):327-341
58. Finkelhor, D., Turner, H., Hamby, S., Ormrod, R. (2011) Polyvictimization: Children's exposure to multiple types of violence, crime and abuse. Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention, Washington, DC. Retrieved from https://www.ncjrs.gov/pdffiles1/ojjdp/235504.pdf
59. Townsend, C., Rheingold, A.A. (2013). *Estimating a child sexual abuse prevalence rate for practitioners: A review of child sexual abuse prevalence studies.* Charleston, S.C., Darkness to Light. Retrieved from www.D2L.org/1in10.
60. U.S. Department of Health and Human Services (2011). Adoption and Foster Care Analysis and Reporting System: FY2011 Data. Washington, D.C., Administration for Children and Families, Children's Bureau. Retrieved from

http://www.acf.hhs.gov/programs/cb/stats_research/afcars/tar/report14.htm

61. National Conference on State Legislatures, *Reauthorization of the Adoption Incentive Payments Program.* (December 2003). http://www.ncsl.org/programs/cyf/adoptact.htm

62. Pastor, P.N., Reuben, C.A., Loeb, M. (2009). Functional difficulties among school-aged children: United States, 2001–2007. National Health Statistics Reports, (19). Hyattsville, MD: National Center for Health Statistics.

63. Bloom, B., Cohen, R.A., Freeman, G. (2012). Summary health statistics for U.S. children: National Health Interview Survey, 2011. National Center for Health Statistics. Vital Health Stat 10(254).

64. De Bellis, M. D., Spratt, E. G., & Hooper, S. R. (2011). Neurodevelopmental biology associated with childhood sexual abuse. *Journal of Child Sexual Abuse*, *20*(5), 548-587.