



# Understanding the Complex Psychological, Emotional, and Neurobiological Consequences of Sexual Trauma on Mental Health

Gautam Makwana<sup>1\*</sup>, H Elizabeth<sup>2</sup>

<sup>1</sup>Research Scholar Ph.D, School of Social Sciences, Department of Social Work, Mizoram University (A Central University), Aizawl 796004, Mizoram, India

<sup>2</sup>Associate Professor, School of Social Sciences, Department of Social Work, Mizoram University (A Central University), Aizawl 796004, Mizoram, India

## ARTICLE INFO

### \*Correspondence:

Gautam Makwana  
gautam\_makwana@  
hotmail.com

Research Scholar  
Ph.D, School of Social  
Sciences, Department  
of Social Work, Mizoram  
University (A Central  
University), Aizawl  
796004, Mizoram, India .

### Dates:

Received: 27-02-2025

Accepted: 17-06-2025

Published: 20-06-2025

### Keywords:

Sexual trauma,  
Mental health, PTSD,  
Neurobiology, Literature  
review, Therapeutic  
interventions.

### How to Cite:

Makwana G., Elizabeth  
H, Understanding the  
Complex Psychological,  
Emotional, and  
Neurobiological  
Consequences of Sexual  
Trauma on Mental  
Health. Indian Journal  
of Health, Sexuality and  
Culture. 2025;11(1): 28-35.

DOI: 10.21590/ijhsc.11.01.05

## Abstract

Sexual trauma is a widespread public health issue with profound, lasting effects on survivors' mental, emotional, and neurobiological well-being. It is commonly associated with psychological disorders such as PTSD, depression, anxiety, and dissociative conditions. Survivors also face emotional challenges, including shame, guilt, and emotional dysregulation. Neurobiological impacts, including changes in brain structure and stress response systems, can hinder coping and recovery. The associated social stigma further isolates survivors and exacerbates distress. According to the World Health Organization, one in three women globally experiences sexual violence in their lifetime. Male and non-binary survivors are also affected but often underrepresented due to cultural stigma and systemic barriers. Early intervention and trauma-informed care are essential to reduce long-term effects. This narrative review synthesizes existing literature on the multifaceted impacts of sexual trauma and evaluates effective treatments, including trauma-focused cognitive-behavioral therapy (TF-CBT), eye movement desensitization and reprocessing (EMDR), and integrative holistic methods. The review highlights the importance of implementing trauma-informed practices, identifies gaps in current research—particularly the need for inclusive and longitudinal studies—and underscores the urgency for comprehensive policy support to enhance recovery, resilience, and systemic change for all survivors.

## INTRODUCTION

Sexual trauma is a profound public health issue with lasting psychological, emotional, and neurobiological consequences. The American Psychiatric Association (2013). [1] links it to enduring mental health disorders such as PTSD, major depressive disorder, and generalized anxiety disorder. These conditions often interfere with survivors' functioning in personal, social, and occupational areas. Herman JL (1992) [2] emphasizes how trauma disrupts fundamental beliefs about safety, trust, and autonomy. Her trauma theory highlights the deep emotional scars and neurobiological changes—such as altered activity in the amygdala, hippocampus, and prefrontal cortex—that impair emotion

regulation, memory, and executive function. This review synthesizes current evidence through a multidimensional lens, examining the psychological, emotional, neurobiological, and social ramifications of sexual trauma. It evaluates therapeutic interventions, such as trauma-focused cognitive-behavioral therapy (TF-CBT), eye movement desensitization and reprocessing (EMDR), and emerging somatic and integrative approaches, analyzing their efficacy and limitations. Sexual violence transcends age, gender, and socio-economic status. While women and girls are disproportionately affected, men and gender-diverse individuals are also impacted, though often underrepresented. The stigma, shame, and silence surrounding sexual trauma exacerbate its effects and hinder recovery. Families, communities, institutions, and systems bear emotional and economic burdens, including healthcare costs, lost productivity, and systemic inefficiencies. Addressing sexual trauma requires a paradigm shift—from viewing it as a personal tragedy to understanding it as a complex, chronic social issue. Prevention, survivor-centered care, trauma-informed policies, and education are essential for meaningful change. The next sections delve into the multidimensional impact of trauma and evaluate evidence-based treatment approaches.

## METHODOLOGY

This study employed a narrative literature review design to synthesize current knowledge on the psychological, emotional, neurobiological, and social consequences of sexual trauma. This methodological approach was chosen to facilitate a comprehensive and multidimensional exploration of the topic, integrating findings from diverse disciplines, including psychology, psychiatry, neuroscience, and social work.

### Data Sources and Search Strategy

A systematic search was conducted across reputable academic databases, including PubMed, PsycINFO, Scopus, and Google Scholar. These databases were selected for their broad coverage of relevant literature in mental health, trauma studies, and clinical interventions. The search spanned publications from 1990 to 2024, offering both historical and contemporary perspectives.

The search utilized combinations of keywords and Boolean operators, such as: “sexual trauma,” “psychological impact,” “emotional consequences,” “neurobiological changes,” “PTSD,” “trauma therapy,” and “resilience in survivors.” Medical Subject Headings (MeSH) terms were also incorporated where applicable.

### Inclusion and Exclusion Criteria

The inclusion criteria were as follows:

- Peer-reviewed journal articles, book chapters, and institutional publications.
- Studies published in English.
- Research focusing on psychological, emotional, neurobiological, or social impacts of sexual trauma.
- Articles involving either adult or child survivors.
- Studies that assessed therapeutic interventions and trauma recovery.

Exclusion criteria included:

- Grey literature such as dissertations or conference abstracts.
  - Studies have focused solely on physical injury without considering its psychological context.
- Non-peer-reviewed or anecdotal sources

### Selection and Analysis

An initial pool of studies was identified through title and abstract screening. Full texts of potentially relevant studies were then reviewed for methodological rigor and relevance to the core themes of the review. A total of 93 articles were selected based on alignment with the inclusion criteria and the richness of their contributions to understanding trauma outcomes.

To ensure inclusivity and intersectionality, special attention was given to studies representing diverse populations across age, gender identity, ethnicity, geography, and socio-economic backgrounds. Cross-cultural and marginalized community perspectives were prioritized where available.

### Synthesis Approach

A thematic analysis was conducted to synthesize findings. Five primary domains were established as analytical categories:

1. Psychological effects

2. Emotional and behavioral responses
3. Neurobiological and physiological impacts
4. Social and interpersonal challenges
5. Therapeutic interventions

This structure enabled the integration of interdisciplinary evidence into a coherent, layered narrative, supporting a more holistic understanding of the long-term and systemic impacts of sexual trauma.

## Findings

This narrative literature review utilized a structured yet adaptable methodological framework to examine the complex mental health consequences of sexual trauma. A systematic search was conducted across academic databases—PubMed, PsycINFO, Scopus, and Google Scholar—chosen for their extensive coverage of psychology, psychiatry, neuroscience, and social work literature. Sources included peer-reviewed articles, book chapters, and official publications from 1990 to 2024, providing both historical context and contemporary insights. A comprehensive keyword strategy, including Boolean operators and MeSH terms, was employed. Keywords included combinations such as “sexual trauma,” “psychological impact,” “emotional consequences,” “neurobiological changes,” “PTSD,” “trauma therapy,” and “resilience in survivors.”

The inclusion criteria were as follows:

- Published in English;
- Focused on psychological, emotional, neurobiological, or social impacts of sexual trauma;
- Empirically based or systematic reviews;
- Included adult or child survivors;
- Discussed therapeutic approaches to trauma recovery.

Exclusion criteria eliminated studies focused solely on physical injuries or lacking psychological context, as well as grey literature such as theses or non-peer-reviewed materials. After thorough screening, 93 studies were included. Abstracts and full texts were manually reviewed for relevance and methodological quality. Special attention was paid to studies involving diverse populations by age, gender identity, ethnicity, and geographic region. Where available, cross-cultural studies and research involving marginalized communities were prioritized to enhance inclusivity. A thematic analysis of

the selected literature was conducted across five broad domains: psychological effects, emotional responses, neurobiological alterations, social implications, and therapeutic interventions. This thematic structure enabled a nuanced and layered synthesis of interdisciplinary findings, contributing to a more comprehensive understanding of the varied and long-term impacts of sexual trauma. The following section presents the findings organized within these thematic categories, offering critical insight into both individual and systemic dimensions of trauma.

## Psychological Effects

Sexual trauma exerts profound and lasting psychological effects, shaping survivors' mental health across the lifespan. American Psychiatric Association (2013) [1] states that it is a major risk factor for psychiatric disorders such as PTSD, depression, anxiety, and dissociative disorders. These conditions often co-occur, contributing to complex PTSD—characterized by emotional dysregulation, negative self-perception, and relational difficulties.

Kessler *et al.* (1995) [3] state a hallmark of PTSD is the re-experiencing of trauma through intrusive thoughts and nightmares, and Shalev *et al.* (2017) [4] show that the vivid flashbacks these symptoms severely impair functioning (In children, such symptoms may manifest as developmental regression, dissociation, or re-enactments, D'Andrea *et al.* (2012) [5] requiring age-sensitive diagnostic approaches.

Najmi *et al.* (2009) [6] note that survivors frequently engage in avoidance behaviors to escape reminders of trauma, leading to isolation and functional decline. Herman (1992) [2] further explains that cognitive distortions—such as self-blame, hopelessness, or perceiving the world as unsafe—are often reinforced by shame and chronic exposure to trauma.

D'Andrea *et al.* (2012)[5] describe dissociative symptoms such as depersonalization, derealization, and amnesia as short-term coping mechanisms that may become maladaptive, disrupting memory and emotional regulation over time. Courtois *et al.* (2009) [7] also discuss these effects in detail. Felitti *et al.* (1998) [8] described childhood trauma significantly elevates the risk for long-term psychiatric distress, including anxiety, depression, and suicidality

Psychological distress often follows a self-perpetuating cycle—intrusive symptoms lead to avoidance, which impedes emotional processing and reinforces trauma responses. Survivors, especially youth, face heightened risks of self-harm and suicidal ideation, worsened by stigma, lack of support, and limited mental health access.

These challenges impact daily life, disrupting education, employment, and relationships. Trauma-informed care must be holistic, culturally responsive, and survivor-centered, fostering safety, healing, and empowerment.

## Emotional and Behavioral Consequences

The emotional aftermath of sexual trauma is intense, prolonged, and often deeply disruptive to a survivor's identity and relationships. Common emotional responses include shame, guilt, anger, grief, self-blame, and emotional numbness. These emotions may persist for years, shaping behavior, worldview, and interpersonal functioning. Herman *et al.* (1998) [2]; and D'Andrea *et al.* (2012) [5] underscore the centrality of shame and guilt in trauma survivors. Shame erodes self-worth, leading individuals to view themselves as inherently flawed or unlovable. Guilt often stems from misplaced self-blame, reinforced by societal attitudes that stigmatize survivors. Such internalized narratives discourage disclosure and delay help-seeking. The emotional toll is especially complex when the perpetrator is a trusted figure—such as a family member, partner, or authority figure—resulting in feelings of betrayal, confusion, and dissociation. Survivors may struggle to process or even acknowledge the trauma due to emotional entanglement. Survivors often develop maladaptive coping strategies to manage unresolved trauma and emotional pain. The DSM-5 (APA, 2013) [1] identifies behaviors such as substance abuse, compulsive acts, eating disorders, self-harm, and emotional withdrawal as common outcomes of trauma exposure. Felitti *et al.* (1998) [9] further link early adverse experiences to a heightened risk of these behaviors in adulthood, while Foa *et al.* (1998) [10] emphasize that such coping strategies, though offering temporary relief, tend to reinforce emotional distress and increase vulnerability to

re-victimization. Many trauma survivors also adopt deeply ingrained negative cognitive schemas—such as “I am unlovable” or “The world is unsafe”—which shape their identity and worldview. Shalev *et al.* (2017) [4] indicate persistent PTSD symptoms reinforce these distorted beliefs and D'Andrea *et al.* (2012) [5] the dissociative processes described as a result, emotional regulation becomes compromised, making recovery more difficult and relationships harder to sustain. These beliefs intensify emotional suffering and hinder recovery, limiting trust and emotional expression. Emotional responses evolve over time, influenced by life events and the support of others. Supportive, trauma-informed interventions can help survivors reframe their experiences, develop adaptive coping mechanisms, and restore emotional balance. Effective care requires an integrative, culturally sensitive approach. Briere *et al.* (2014) [11] emphasize a phase-oriented treatment model that includes stabilization, trauma processing, and reintegration. Therapies like dialectical behavior therapy (DBT), emotion-focused therapy (EFT), and compassion-focused therapy (CFT) are effective in addressing emotional dysregulation and self-destructive behaviors. Survivor-led peer groups and community-based support systems also play a critical role in reducing isolation and fostering emotional healing. In sum, the emotional and behavioral consequences of sexual trauma are multifaceted and enduring. Addressing them with empathy, clinical skill, and holistic strategies is essential for long-term resilience and recovery.

## Neurobiological and Physiological Impact

Advancements in neuroscience over the past two decades have significantly deepened our understanding of the neurobiological and physiological consequences of sexual trauma. Far from being solely psychological, trauma leaves a measurable imprint on brain structure, neurochemistry, and systemic bodily functions. Research by Herman *et al.* (1992) [2], Courtois *et al.* (2009) [7], Felitti *et al.* [8], and van der Kolk *et al.* [12] (2014) highlights key alterations in three core brain regions. The amygdala, which is responsible for processing fear, becomes hyperactive, leading to hypervigilance and exagger-

ated startle responses. The hippocampus, critical for memory and context, often exhibits atrophy and dysfunction, contributing to fragmented memories and temporal disorientation. The prefrontal cortex, which regulates decision-making and emotional control, may show reduced activity, impairing adaptive responses. These disruptions compromise the hypothalamic-pituitary-adrenal (HPA) axis, the body's central stress response system. "These disruptions compromise the hypothalamic-pituitary-adrenal (HPA) axis, the body's central stress response system. van der Kolk *et al.* (1996) [13] emphasize that traumatic experiences become biologically embedded, disrupting the integration of sensory, emotional, and cognitive functions—often resulting in somatic symptoms and emotional dysregulation that persist long after the trauma has passed. Yehuda *et al.* (2002) [14] also elaborates on how prolonged dysregulation of this axis influences PTSD development. American Psychiatric Association (2013) [1], Kessler *et al.* [15]; Shalev *et al.* [4] have shown that chronic dysregulation of cortisol release leads to persistent states of hyperarousal or hypoarousal, manifesting in symptoms such as anxiety, fatigue, insomnia, and emotional blunting. These physiological disturbances are further compounded by neurotransmitter imbalances involving serotonin, dopamine, norepinephrine, and GABA, which heighten vulnerability to a range of psychiatric conditions including depression, anxiety disorders, substance use, and impulse-control disorders. Bremner JD (2006) [15] and Kessler *et al.* (1995) [3] state that neuroimaging techniques, such as MRI and PET scans, corroborate these findings, revealing hippocampal atrophy and amygdala hyperactivity during emotional tasks—tangible evidence of trauma's biological basis. Physiologically, long-term trauma exposure elevates inflammatory cytokines, weakening immune function and raising risks for cardiovascular disease, obesity, type 2 diabetes, gastrointestinal disorders, and autoimmune conditions. Emerging epigenetic research suggests that trauma may even alter gene expression, with potential intergenerational effects. Many survivors experience somatic dissociation, including numbness or hypersensitivity, reflecting disruptions in sensory integration and body awareness. These symptoms

often hinder daily functioning and intimacy. Pharmacological treatments such as SSRIs, SNRIs, and prazosin can alleviate symptoms by targeting altered neurotransmitter pathways but are most effective when combined with psychotherapy. Sexual trauma profoundly alters neurobiological systems. Understanding these changes is critical for developing compassionate, evidence-based, trauma-informed care that addresses both psychological and physiological dimensions of healing.

## Social and Interpersonal Challenges

Sexual trauma significantly impairs survivors' social functioning and interpersonal relationships, often resulting in isolation, mistrust, and stigma. Human beings are inherently relational, and trauma's disruption of social bonds can hinder recovery and contribute to re-traumatization. As Herman (1992) [2], Courtois CA *et al.* (2009) [7], Bremner *et al.* (2009) [15], Felitti VJ *et al.* (1998) [8] note, survivors frequently encounter societal stigma and victim-blaming, ranging from overt shaming to subtle invalidation by family, peers, and institutions. Ullman *et al.* (2007) [16] state that such responses often lead to secondary victimization, compounding psychological harm. Fear of judgment or disbelief discourages disclosure, reinforcing silence, shame, and social withdrawal—factors associated with worse mental health outcomes. Disclosure, when it occurs, is deeply influenced by social context. Supportive responses can promote healing, while dismissive or accusatory reactions often deepen emotional wounds. According to Shalev *et al.* (2017) [4], Foa *et al.* (1998) [10], and Bremner *et al.* (2006) [15], trauma survivors may struggle to interpret social cues or form secure attachments, particularly when the trauma occurs during formative developmental years. The effects of trauma ripple through families and communities. Survivors who are parents may grapple with emotional distancing, overprotectiveness, or fear of transmitting trauma to their children. Intimate relationships often suffer due to difficulties with trust, emotional regulation, or physical intimacy. In educational and workplace settings, symptoms like anxiety, dissociation, and concentration issues can impair performance and lead to further alienation. Cultural and gender norms also



shape survivors' experiences. In patriarchal societies, women may be viewed as dishonored, while male survivors often face emasculation or homophobic stigmas. LGBTQ+ survivors, in particular, face intersectional challenges, including heightened vulnerability and fewer safe spaces for disclosure. Institutional responses—particularly in legal and healthcare systems—often fail to accommodate trauma sensitively. Adversarial procedures, lack of trauma-informed training, and systemic barriers disproportionately affect marginalized groups, including ethnic minorities, people with disabilities, and the economically disadvantaged. Nevertheless, social support remains one of the most protective factors in trauma recovery. Empathetic, nonjudgmental, and informed communities play a vital role in fostering resilience and restoring relational safety.

## Therapeutic Interventions

Effective treatment for survivors of sexual trauma requires a multidimensional, individualized approach that addresses psychological, neurobiological, emotional, and social impacts. Interventions must be tailored to each survivor's experiences, symptoms, cultural background, and readiness for healing.

Evidence-based therapies such as Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) are widely used, particularly among children. Deblinger *et al.* (2006) [9] and Resick *et al.* (2016) [17] state that TF-CBT incorporates psychoeducation, cognitive restructuring, and exposure techniques to help survivors reduce self-blame and build coping skills. Eye Movement Desensitization and Reprocessing (EMDR) is another validated modality, effective for processing traumatic memories with reduced distress—even when verbal expression is difficult. Cognitive Processing Therapy (CPT) targets guilt and shame, while Dialectical Behavior Therapy (DBT) is beneficial for emotional dysregulation through mindfulness and distress tolerance.

As mentioned by van der Kolk *et al.* (1996) [17] and Deblinger *et al.* (2006) [9], somatic and body-based therapies, such as Somatic Experiencing, Sensorimotor Psychotherapy, and trauma-sensitive yoga, are increasingly used to address trauma stored in the body. Pharmacological treatments—including SSRIs, prazosin, and mood stabilizers—can support

symptom management but are most effective when combined with psychotherapy.

Holistic and expressive therapies, such as narrative therapy, art, and music, promote healing through non-verbal channels. Peer support groups provide validation and connection. For marginalized populations, culturally adapted interventions that integrate traditional practices and community engagement are essential. Multidisciplinary collaboration across mental health, medical, legal, and social sectors, Courtois *et al.* (2009) [7]; Foa *et al.* (2009) [10]; Felitti *et al.* (1998) [8] is vital for survivor-centered care, recovery is non-linear and must honor each individual's pace and autonomy.

## DISCUSSION

This review underscores the profound and multidimensional impacts of sexual trauma—spanning psychological, emotional, neurobiological, social, and behavioral domains. Survivors often face lifelong challenges that affect identity, relationships, health, and socio-economic well-being. These impacts are deeply interconnected, forming reinforcing cycles of suffering that are difficult to break without comprehensive support.

A key finding is the interplay between trauma's neurobiological and psychological effects. Dysregulation of the HPA axis and hippocampal dysfunction intensify PTSD symptoms, impair emotional regulation, and promote negative cognitive patterns. These disruptions impair the ability to trust and connect with others, thereby undermining recovery and overall functioning. Therefore, trauma care must be holistic, addressing symptoms across all domains.

Bassuk *et al.* (2001) [18] states despite strong evidence supporting trauma-focused therapies and body-based interventions, access to quality care is uneven. Survivors in marginalized communities face provider shortages, financial constraints, and systemic discrimination. Addressing this gap requires policy reforms that ensure equitable access to trauma-informed services.

Healing from sexual trauma is not only a clinical concern but a societal one. Broader social change is needed to dismantle the root causes—gender

inequality, stigma, and institutional neglect. Trauma-informed practices must extend into schools, healthcare, legal systems, and workplaces. Educating professionals to respond empathetically can reduce re-traumatization and promote recovery.

Prevention and early intervention are also crucial. Investing in sex education, community awareness, and bystander programs can reduce incidence and support timely recovery—especially for children and adolescents. Many survivors exhibit resilience and growth, and care systems must recognize and foster these strengths.

Ultimately, addressing sexual trauma requires interdisciplinary collaboration and survivor-led approaches. Their voices are vital to shaping policies and interventions that are inclusive, effective, and respectful. Healing is possible with sustained, systemic, and survivor-centered action.

## **LIMITATIONS**

This review has several limitations that warrant consideration. First, as a narrative review, it is inherently subject to selection bias due to the absence of systematic inclusion criteria and the potential for subjective study selection. The exclusive focus on English-language publications further narrows the scope, potentially omitting important findings from non-English sources that might offer valuable cultural or regional insights.

Second, the included studies demonstrate considerable methodological heterogeneity, with variations in sample characteristics, trauma definitions, assessment instruments, and intervention modalities. This diversity restricts the generalizability and comparability of results across populations and settings. Furthermore, there is a notable paucity of longitudinal research tracking survivors' recovery trajectories over extended periods. This gap limits understanding of the long-term effectiveness of interventions, the natural healing process, and potential relapse patterns. Future research should prioritize the inclusion of diverse and underrepresented populations to improve cultural relevance and equity. Employing mixed-methods designs that combine quantitative outcomes with rich qualitative data will provide a deeper understanding of trauma experiences and treatment mechanisms. Addition-

ally, rigorous evaluation of integrative, culturally grounded therapies and emerging digital interventions is essential to advance evidence-based, accessible, and holistic care for survivors of sexual trauma.

## **CONCLUSION**

Sexual trauma has profound and enduring effects across psychological, emotional, neurobiological, social, and economic domains. Survivors face not only personal suffering but also stigma, marginalization, and systemic obstacles that hinder recovery. Addressing this complexity requires integrated, culturally sensitive approaches that consider the intersections of gender, culture, and socio-economic status.

Effective healing involves trauma-informed, interdisciplinary strategies that combine evidence-based psychological treatment with physical healthcare, social support, and economic empowerment. Central to this is the active involvement of survivors in designing and guiding services to ensure relevance and respect for lived experience.

Strengthening institutional capacity for trauma-informed care in education, healthcare, law enforcement, and social services is critical. Public health initiatives should prioritize prevention, early intervention, and awareness to reduce stigma and promote access to support services. Legal reforms must prioritize survivor dignity and reduce secondary victimization through compassionate, accessible justice systems.

Long-term support—including mental health services, housing, and employment—must be equitable, inclusive, and accessible. Recognizing sexual trauma as both a public health and human rights issue fosters not only individual healing but also societal change. Empowering survivors through education, advocacy, and leadership is essential to breaking the cycle of trauma and building resilient, inclusive communities.

## **AUTHOR CONTRIBUTIONS**

The authors independently conceptualized and designed the review, conducted the literature search and data extraction, and synthesized the results into the final manuscript. Both authors have read and approved the final version.

## FUNDING

No external funding was received for this study.

## DECLARATION OF INTEREST

The authors declare no competing interests.

## ETHICS APPROVAL

Not applicable.

## CONSENT TO PARTICIPATE

Not applicable.

## REFERENCES

1. American Psychiatric Association. *Diagnostic and statistical manual of mental disorders*. 5th ed. Arlington, VA: American Psychiatric Publishing; 2013.
2. Herman JL. *Trauma and recovery: The aftermath of violence—from domestic abuse to political terror*. New York: Basic Books; 1992.
3. Kessler RC, Sonnega A, Bromet E, Hughes M, Nelson CB. Posttraumatic stress disorder in the National Comorbidity Survey. *Arch Gen Psychiatry*. 1995;52(12):1048–60.
4. Shalev AY, Liberzon I, Marmar C. Post-traumatic stress disorder. *N Engl J Med*. 2017;376(25):2459–69.
5. D'Andrea W, Ford J, Stolbach B, Spinazzola J, van der Kolk B. Understanding interpersonal trauma in children: Why we need a developmentally appropriate trauma diagnosis. *Am J Orthopsychiatry*. 2012;82(2):187–200.
6. Najmi S, Wegner DM. Thought suppression and posttraumatic stress disorder. *J Trauma Stress*. 2009;22(6):705–708.
7. Courtois CA, Ford JD, editors. *Treating complex traumatic stress disorders: An evidence-based guide*. New York: Guilford Press; 2009.
8. Felitti VJ, Anda RF, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *Am J Prev Med*. 1998;14(4):245–58.
9. Deblinger E, Mannarino AP, Cohen JA, Steer RA. A follow-up study of a multisite, randomized controlled trial for children with sexual abuse-related PTSD symptoms. *J Am Acad Child Adolesc Psychiatry*. 2006;45(12):1474–84.
10. Foa EB, Rothbaum BO. *Treating the trauma of rape: Cognitive-behavioral therapy for PTSD*. New York: Guilford Press; 1998.
11. Briere J, Scott C. *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment*. 2nd ed. Thousand Oaks, CA: Sage; 2014.
12. van der Kolk BA. *The body keeps the score: Brain, mind, and body in the healing of trauma*. New York: Viking; 2014.
13. van der Kolk BA, McFarlane AC, Weisaeth L. *Traumatic stress: The effects of overwhelming experience on mind, body, and society*. New York: Guilford Press; 1996.
14. Yehuda R. Post-traumatic stress disorder. *N Engl J Med*. 2002;346(2):108–114.
15. Bremner JD. Traumatic stress: Effects on the brain. *Dialogues Clin Neurosci*. 2006;8(4):445–61.
16. Ullman SE. A 10-year update of review and critique of empirical studies of rape avoidance strategies. *Aggress Violent Behav*. 2007;12(1):45–60.
17. Resick PA, Monson CM, Chard KM. *Cognitive processing therapy for PTSD: A comprehensive manual*. New York: Guilford Press; 2016.
18. Bassuk EL, Dawson R, Perloff JN, Weinreb LF. Post-traumatic stress disorder in extremely poor women: Implications for health care clinicians. *J Am Med Womens Assoc*. 2001;56(2):79–85.