Risk Factors of Post Traumatic Stress Disorder in Child Sexual Abuse Victims

Hera Wahyuni
Lecturer at the Faculty of Psychology,
Universitas Trunojoyo
Madura East Java, Indonesia
Doctoral student in Psychology, Faculty of
Universitas Airlangga
Surabaya East Java, Indonesia
herapsi@yahoo.co.id

Hamidah
Lecturer at the Faculty of Psychology,
Universitas Airlangga
Surabaya East Java, Indonesia
hamidah@psikologi.unair.ac.id

Nurul Hartini
Lecturer at the Faculty of Psychology,
Universitas Airlangga
Surabaya East Java,Indonesia
nurul.hartini@psikologi.unair.ac.id

Suryanto
Lecturer at the Faculty of Psychology,
Universitas Airlangga
Surabaya East Java, Indonesia
suryanto@psikologi.unair.ac.id

Abstract

This research aims to explore the risk factors of post-traumatic stress disorder in child sexual abuse victims in Indonesia. Sexual abuse is a lifelong crime in which the victim experiences a prolonged trauma commonly known as post traumatic stress disorder (PTSD). We used qualitative methods to collect case studies, namely through in-depth interviews and participant observations. The research was conducted on children aged 11 – 12 years of age who are victims of sexual and experienced PTSD. Our findings reveal that PTSD in victims of child sexual abuse are associated with two risk factors: 1) Internal factors or vulnerabilities in children (i.e., low intelligence, shyness, introvert, and pessimistic personality), 2) Environmental factors (i.e., lack of support from parents, teachers, friends and people around the victim which triggered the development of PTSD).

Keywords: *Post Traumatic Stress Disorder* (PTSD), risk factors, child sexual abuse

Received 9 March 2018/Accepted 27 July 2018

Introduction

Indonesia's Witness and Victim Protection Agency reveals that child sexual abuse (CSA) is the highest reported case by citizens, amounting to 46% of 21,000 reports. The sexual violence includes molestation, rape and sexual harassment. Data from the agency reported that there were 37 reports of crimes against children during January 2015 to June 2015 (5

months), with 24 of them being child sexual abuse. It comprises of 11 sexual intercourse cases, 9 molestation cases, 2 rape cases and 2 sexual harassment cases (Wisnugroho, 2016).

CSA is becoming more frequent and widespread in many countries. The CSA cases are increasing over time, not only in quantity (i.e., the number of cases) but also quality. Ironically, perpetrators often come from children's immediate surrounding, such as home, school, educational institution and social environment. This phenomenon needs immediate action because the level of sexual violence against children in Indonesia keeps increasing every year. Therefore, Indonesia launches an emergency CSA program because the problem could significantly affect the growth of those children.

Several studies found that CSA results in physical damages in the sexual organ and brain as well as increasing the likelihood of contracting life-long sexually transmitted diseases. These damages are revealed by Anderson, et al. (2004) who stated that CSA can cause internal injuries and bleeding. In severe cases, internal organ damage may lead to death. Some studies also found that CSA has destructive impact on brain development. Szalavitz, et al. (2006) found that traumatic stress on sexually abused children causes significant changes in brain function and development. Ito et al. (1998) found that "the size of the left and right brain becomes asymmetric. The left brain is larger on sexually abused subject."

CSA cause not only physical damage, but creates psychological disorder such as PTSD. Brown (2000) pointed out that there is a causal relationship between sexually abused children and adult psychopathologies, such as suicidal tendency, anti-social behavior, PTSD symptoms, anxiety and alcoholism. CSA also leads to eating disorders, inferiority, personal identity disorder, anxiety and general psychological disorder such as somatization and nerve pain (Arnow et al, 2006).

The study above suggests that PTSD is a result of CSA. Therefore, studies focusing on this case needs to be conducted. PTSD is a mental disorder that develops after a person is exposed to a traumatic event, such as sexual abuse, war, traffic accidents, or other threats to a person's life.

Besides sexual abuse, PTSD can also be caused by exposures to natural disasters, accidents, and wars. However, the impact of traumatic exposure will have different effects depending on how severe or threatening the exposure to the individual was, as described by the following studies: 1). Natural disasters usually have a lower PTSD impact compared to other traumatic events (Earls et al., 1988; Hanford et al., 1986); 2). Zoladz et al, (2013) suggested that people with interpersonal trauma (e.g., rape or child abuse) are more likely to develop PTSD, compared to people experiencing non-violence trauma (e.g., accidents and natural disasters); 3). Bisson et al. (2015) revealed that 50% of rape victims will develop PTSD; 4). Kiser et al. (1988) found that CSA victims may develop symptoms under the PTSD's DSM-III-R classification.

Based on the explanation above, it can be inferred that PTSD is a psychological impact of sexual abuse. However, several studies reveal that CSA does not always lead to PTSD. In some cases, trauma will gradually disappear, depending on the degree of risk and protective factors against PTSD that those victims have.

Chou (2007) pointed out that some people can overcome their trauma over time, while others do not. It was found that the prevalence of PTSD decreases from 8.3% at six months to 4.2% at three years after the traumatic event. Chou's finding is consistent with a previous study conducted by Kaijun et al. (2015), who found that post-traumatic events will result in two different things: PTSD and post-traumatic growth (PTG). These syndromes will determine whether the individuals could deal with their trauma positively or negatively. If they face their traumatic event negatively, it will cause behavioral changes, including anxiety that manifest in sleep disturbances, disturbed thoughts, nightmares, trauma avoidance-related disorders, and eventually PTSD.

Risk factors are "early predictors" of an undesirable event that make people more vulnerable to undesirable situations (Kaplan, et al., 2010). The disclosure of risk factors is expected to describe PTSD's psychological dynamics on CSA victims. There are a few PTSD studies revealing risk factors directly after a traumatic event because most focuses on long-term factors. A study conducted by Kaplow et al. (2005) was the first research to develop PTSD's analytic model on children immediately after sexual abuse. This model seeks to

reveal risk factors, such as demographic factors of sex and age. However, the study has not yet been integrative to reveal complete risk factors, such as individual susceptibility factors and environmental factors.

Hence, we aim to explore more about these risk factors to reveal further psychological processes of PTSD in CSA victims. PTSD study needs to be conducted immediately, because prolonged PTSD will affect children while growing up, including: low educational functioning (Scott et al., 2014; Carmen et al., 2014; David et al., 2012), impaired social functioning (David et al., 2012), increased addiction to liquor/alcohol (Cynthia et al, 2004; Henrietta H., F. & Sarah E., U., 2006) and reduced level of marital satisfaction (Adam et al., 2013). Moreover, children will assume greater burden than adults as a result of their sexual abuse experience. They will face moral challenges with the people around them, particularly peers, thereby affecting their moral development.

Studies focusing on PTSD are quite developed in Indonesia although the majority still comes from Western countries. PTSD studies in Indonesia mostly focus on trauma after natural disasters (e.g., tsunami and mountain eruption). Some of the studies include: "Tsunami and Post Trauma Stress" in Children by Hartini (2009); a study conducted by Agustini et al. (2011) which measured demographic factors (e.g., gender and parental support) in adolescents experiencing PTSD in Aceh where the tsunami took place; "Social Support and PTSD in Adolescent Survivors of Mount Merapi" by Tentama (2014). Only one study have looked specifically on victims of abuse, namely Sholichah (2009) who studied three adult female rape victims. That particular study tested the effectiveness of a module designed for reducing PTSD symptoms.

The above studies indicate that PTSD research on CSA victims in Indonesia are still lacking. In addition, the studies have not been integrated with the Indonesian culture to provide insight into PTSD's risk factors within our specific background. Therefore, the lack of research conducted in Indonesia has an impact on limited psychological-oriented preventive efforts. This study on risk factors of PTSD of CSA victims is expected to provide benefits in modeling the prevention of PTSD on the victims.

Additionally, a developed PTSD concept in Western countries cannot be applied in Indonesia due to cultural differences. Jobson and O'karney (2008) emphasized that cultural factor also contribute to individual trauma, especially regarding memory, information management and self-concept. The findings are consistent with a study conducted by Scott et al. (2014), who found that PTSD studies cannot be generalized to other population (regarding demography sample). This finding reveals that PTSD's theoretical assumption requires cultural factor to reformulate the theory. Thus, we are interested in conducting a research on the PTSD risk factors of CSA victims in Indonesia.

Literature Review

Definition of Child Sexual Abuse

CSA occurs when a person uses a child to gain pleasure or sexual satisfaction. This act is not limited to sex but also actions that lead to sexual activity: touching the child sexually, whether the child is wearing clothes or not; all forms of sexual penetration, including penetration into the child's mouth using any objects or limbs; making or forcing children to engage in sexual activity; deliberately doing sexual activity in the presence of children, or not protecting and preventing the child from witnessing the sexual activity of another person; creating, distributing and displaying images or films containing children's scenes in indecent pose or acts; showing images, photographs or films that feature sexual activity (www.parenting.co.id). This is in line with O'Barnett et al. (Matlin, 2008) who stated that CSA is any form of sexual activity towards children that usually involve psychological or physical pressure resulting in negative consequences to the child.

In line with Lyness (Maslihah, 2006) sexual violence against children includes the act of touching or kissing the child's sexual organs, sexual acts or rape on children, showing media/porn objects, and showing genitals in children.

Symptoms of PTSD in Children

PTSD is a condition that occurs after a person experienced traumatic or adverse events in their life (Sadocket, al., 2007). PTSD is considered as a part of anxiety disorder. People with PTSD tends to remember the traumatic incident and continuously try to avoid things which would remind them of the incident.

Diagnostic criteria for PTSD includes a history of exposure to traumatic events that meet specific stipulations and symptoms from each symptom clusters: stressor, intrusion, avoidance, negative alterations in cognition and mood, and alterations in arousal and reactivity. The sixth criterion is concern about the duration of symptoms; the seventh assesses functioning; and, the eighth clarifies symptoms as not attributable to a substance or co-occurring medical condition.

Two specifications are noted, including delayed expression and a dissociative subtype of PTSD, the latter of which is new to DSM-V (APA, 2013). In both specifications, the full diagnostic criteria for PTSD must be met for an application to be warranted: 1). Criterion A: stressor. The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, 2). Criterion B: intrusion symptoms. The traumatic event is persistently re-experienced, 3).Criterion C: avoidance. Avoidance of trauma-related stimuli after the trauma, 4). Criterion D: negative alterations in cognitions and mood. Negative thoughts or feelings that began or worsened after the trauma, 5).Criterion E: alterations in arousal and reactivity. Trauma-related alterations in arousal and reactivity that began or worsened after the trauma, 6).Criterion F: duration. Symptoms last for more than one month, 7). Criterion G: functional significance. Symptoms create distress or functional impairment (e.g., social, occupational), 8). Criterion H: exclusion. Symptoms are not due to medication, substance use, or other illness.

Specify if dissociative symptoms are present. In addition to meeting criteria for diagnosis, an individual experiences high levels of either depersonalization or de-realization in reaction to trauma-related stimuli. Depersonalization refers to the experience of being an outside observer of or detached from oneself (e.g., feeling as if "this is not happening to me" or one was in a dream). Meanwhile, de-realization refers to the experience of unreal, distance, or distortion (e.g., "things are not real").Specify if delayed expression was shown. Full diagnosis is not met until at least six months after the trauma(s), although onset of symptoms may occur immediately.

Risk Factors of PTSD in Victims of Child Sexual Abuse

Risk factors are those that are associated with the increase of a particular disease or disorder, some of which cannot be changed (e.g., age, gender) and others that can be changed like environmental conditions (e.g., family support). Breslau et al. (1998) informed that women are twice as likely to develop PTSD in their lives with more chronic disruption. This is reinforced by the National Collaborating Center for Mental Health (2005) which revealed that men are more likely to experience traumatic incidents, whereas women are more likely to experience the high impact of traumatic incidents that may cause PTSD, such as interpersonal and sexual violence.

Research shows that 100% of children who witnessed their parents' murder and sexual abuse experience PTSD, 90% of children who were sexually abused almost always experience PTSD, 77% were children who are affected by shootings and 35% are teenagers of urban areas experiencing community violence (Hamblen, 2016). From the above research, it is known that the age of children and adolescents have a greater risk of developing PTSD. In addition, having high intelligence seems to be a protective factor; probably because it is associated with better coping skills (Macklin et al,1998).

Personality is also regarded as a trigger for PTSD, specifically pessimistic and introverted personalities, self-blame, and denial (Schiraldi, 2000).This is in line with the study of personality studies in etiology and PTSD phrases by Miller (2003) which concluded that high negative emotions are a major risk factor for the development of PTSD. Sagatun (2015) revealed that PTSD is closely related to family pathology and lack of community support. Victims who experience acute stress have a need to have healthy relationships and support from the people around them. Thus, victims need significant support from their environment to recover from the trauma.

Impact of PTSD on Children as Victims of Sexual Violence

Untreated PTSD will affect the functioning of the child of his or her entire life. A study by Carmen et al. (2014) showed that the severity of PTSD symptoms are significantly associated with lower social competence. In line with the above research, Herbert et al. (2016) concluded that more than half (60%) of CSA victims were reported to be disturbed,

51% had verbal disorders and a third (35%) experienced physical abuse from their school colleagues.

Henrietta, H., F and Sarah E., Ulman (2006) stated that the average number individuals who experience child and adult sexual does exhibit PTSD symptoms. Thus, they tend to use drugs or alcohol to overcome their anxiety, withdraw from people or the environment, and seek therapeutic services to reduce and eliminate the trauma. In addition, this group also tends to blame themselves more. In line with Najdowski and Ulman (2009) CSA is associated with greater PTSD symptoms and later drinking problems. Schaefera, et al. (2013) stated that the experience of CSA contributes to a unique variant in the symptoms of PTSD severity due to combat exposure and has a direct negative relationship with marriage satisfaction. Howgegoet, al. (2005) further generalizes that PTSD also causes a decrease in the value of living their lives.

Based on the above studies, it can be concluded that prolonged PTSD in children as victims of sexual violence has an impact on the quality and function of life until adulthood such as alcohol and drugs problems, possible engagement in risky sex, low marital satisfaction, and tendency to withdraw from the social environment.

Method

This research used a qualitative method with case study approach. The case study approach aims to explain and express the case comprehensively as a whole. Qualitative research can understand the cases in detail and in-depth, exploring the personal experiences that underlie their cause of PTSD symptoms. It emphasizes the uniqueness of how CSA victims perceive, interpret, and understand their experiences and attempt to generate common themes that appear within the group samples (Smith & Osborn, 2003) which may not be visible through a quantitative approach.

Subjects in this research are two CSA victims aged 11 years and 12 years who experienced post traumatic stress disorder. Data collection was done by interview and observation. The collected data was analyzed using Miles and Huberman (1992) technique, with three activity

paths: data reduction, data presentation, and conclusion/verification. Data validity technique used triangulation technique. This is done by utilizing something else outside the data for checking or as a comparison of other data outside that data. Creswell (2013) describes triangulation techniques that can be used to include: a) triangulation of data, b) triangulation of researchers, c) methodological triangulation, d) theoretical triangulation.

Result

Risk Factors of PTSD in Child Sexual Abuse Victims

PTSD is a psychological impact of traumatic exposure to sexual violence. Only a few studies reveal that sexual violence experienced by children does not always persist in PTSD. In some cases, as time goes by, the disorder will gradually disappear depending on how much risk and protective factors the victims have against PTSD. Several studies and research reveal this. Chou (2007) stated that traumatic experiences do not always continue in the form of PTSD; for some people, trauma can be overcome over time, but others do not. The prevalence of PTSD decreased from 8.3% at six months to 4.2% at three years after the traumatic incident. After the data was collected, we conducted data analysis and discussion, as follows:

Internal Factors (Individual Vulnerability)

Risk factors becomes "early predictors" of unwanted things or that make people more vulnerable to undesirable things (Kaplan et al., 2010). The disclosure of risk factors is expected to provide a picture of the psychological dynamics of PTSD development in children who are victims of sexual violence.

Personality is regarded as a trigger for PTSD, such as pessimistic and introverted personality, self-blame, and denial (Schiraldi, 2000).This is in line with Miller (2003) who concluded that high negative emotions is a major risk factor for the development of PTSD, as experienced by the subject below:

> *I am basically a shy person. People say I'm a closed person who doesn't talk much. So after this incident my shyness increased, I was embarrassed about going to*

school, getting out of the house made me feel ashamed. I ended up crying and getting angry.) (S1).

I wanted to share something at one point, but I was too afraid of getting scolded. I never used to say anything, many people say I'm a quiet person. I'm scared that if I say something then people will start to talk negatively about me…that it was because of my mistake and stupidity that this happened. (S2).

In addition to personality factors, low intelligence level is also a risk factor for PTSD for CSA victims. This is related to the selection of appropriate strategies. Macklin et al. (1998) revealed that having high intelligence seems to be a protective factor, perhaps because it is associated with better coping skills. Two respondents have a reasonably high Intelligence based on the interview result:

When it was exam time, out of 15 numbers, I only got one correct. They asked me to repeat the exam, but still, it was terrible. I was confused because the materials seem too complicated for me and I couldn't understand. I often ask for help from friends because it is embarrassing to ask from teachers, but my friends often tease me. (S1).

I am the oldest in the classroom because I keep failing in class (two times of not moving to higher class). My brain is different from the others, maybe the teachers gave me a pass because they were bored of me since my scores never met the standard. (S2).

The results above correspond to the findings from the teacher interviews teacher. Based on our interview, we found that S1 finds it challenging to understand the lesson. Thus, instruction needs to be repeated several times until S1 can understand. S1's scores are not good either, often scoring 10 to 50. He or she once received 90 but it was because cheating was involved. Our data analysis reveals that low intelligence factor is a risk factor of PTSD for CSA victims.

External Factors (Lack of Support from the Environment)

In addition to individual vulnerability, the lack of environmental support also contributes to the development of PTSD. It is experienced by the S1 who informed that after the trauma incident most of his friends treat him differently. Often he experiences both verbal and physical bullying. With such treatment of friends, he is reluctant to join her peer community and prefer to stay away at home.

> *My friends knew that I got sodomy, Sir. So they kept mocking on me… I was told that I am not virgin anymore, but I am actually a boy. If some friends get closed to me, the others will say "don't be closed to S1, or you will get raped." I really wanted to hit them because I was annoyed. … Sometimes they pushed me from chair and it made my pants tore down. Now, it is so lazy to meet those people, I prefer staying at home. (S1).*

This is in line with Martine et al. (2016) who revealed that more than half (60%) of CSA victims were reported to be harassed by their friends, 51% had verbal disorders and a third (35%) experienced physical abuse from their peers at school. This allows the victim to experience up to threefold for the clinical level of dissociation and symptoms of PTSD. Another similar study by McFarlane. et al. (2001) stated that the symptoms of PTSD greatly disrupt the attachment and intimate behavior, leading to a widespread of negative effects on interpersonal relationships that will ultimately influence a decline in social functioning.

Family support was not found, particularly in the case of S1. After his case was uncovered and handled by the police, his mother began to get sick and soon died. According to his siblings, the mother of S1 died as a result of their brother's problems. Thus, there is a sense of disappointment and blame from his siblings regarding his mother's death. After his mother died, he felt that he no longer had any psychological nor financial support. He decided to leave school and stayed home more often. In line with the above data Sagatun (2015) revealed that PTSD is closely related to family pathology and lack of community support. Victims who experience acute stress need to have healthy relationships and support from the people around them to recover from the trauma.

Contrary to S1, S2 received enough support from the family, but the school environment and community tend to corner him, the teachers at school blamed him and asked harsh questions such as:

> *Why don't you fight back? You should have run away. It means that you enjoyed it too. How could you stay silent when it happened repeatedly? Why don't you report it? Why have you only reported it now after two years? This is all your fault… (S2).*

These questions made S2 feel cornered, guilty, dirty and worthless. Negative attitudes and beliefs experienced by the subject are caused by cognitive distortions, negative interpretations of accepted experiences, negative evaluations of self and negative expectations of the future. The source of the problem can come from the early development as well as the psychoanalytic view (Beck, 2010).

Discussion

CSA victims often experience psychological problem called PTSD, characterized by feelings of intense fear, anxiety, and emotional disturbance after a traumatic incident. Zoladz (2013) disclosed that individuals who experience interpersonal trauma (e.g., rape or child abuse) are more likely to develop PTSD, compared to people who are traumatized by on non-violence event (e.g., accidents and natural disasters).

Not all trauma survivors develop PTSD, some people can be detached from the trauma over time. Many individuals, particularly children, cannot separate from their trauma and become susceptible to PTSD. This is because of their internal and external risk factors. Risk factors are those that are associated with the increase of a particular disease or disorder, some of which cannot be changed (e.g., age, gender) and others that can be changed like environmental conditions (e.g., family support). Based on our findings, it is concluded that PTSD risk factors can be divided into two; 1). risk factors from within (individual), commonly referred to as individual vulnerability factors, such as intelligence level and personality; 2). External risk factors (environmental) such as lack of family support from

parents, siblings, extended family, as well as outside of family environment such as friends, school teachers, neighbors, or people around the victim.

This study finds two risk factors causing PTSD in child sexual abuse victims. First, the internal factor is a factor within the victim, including personality (e.g., introvert, pessimistic and shy) which can lead to PTSD. Extrovert individuals are more resilient than introverts because they are more communicative in expressing their anxiety after experiencing sexual abuse. Acocella and Calhoun (1990) stated that self-disclosure could help cope with emotions of being blamed and anxiety for individuals experiencing the traumatic situation. Calhoun and Acocella's finding is consistent with a study conducted by Schiraldi (2000), which found pessimistic, introvert, self-blaming and denial individuals. Internal factor also refers to pre-traumatic factor since these factors are within the individuals. We expect future studies to examine other traumatic situations. Also, history gram model is required to reveal pre-traumatic factor in details.

Second, external factor involves environmental factors outside the victims, for example, lack of family support after experiencing traumatic sexual abuse. Instead of supporting each other, the family members tend to blame them. Their surrounding avoids them. It is also followed by underestimated questions, such as, "Why did you not run away during the incident? Why could it happen many times?" The victim is often considered enjoying the sexual abuse. After a traumatic exposure, the victims prefer to avoid their friends because they get bullied. External factors are also commonly called post-traumatic factors due to the lack of support received by the victim after the traumatic exposure.

In addition to internal and external factors, there are pre-trauma factors. These factors measure how severe the traumatic exposure experienced by victims. The two participants are sexual abuse victims, with incidence occurring more than one year. These findings are consistent with a study conducted by Weems et al. (2007), who found: 1). Severity and closeness of the trauma. The more severe the trauma experienced and the closer one's position with an event, the more it increases the risk of a person to experience PTSD; 2). Duration and amount of trauma. The longer or more chronic the trauma, the more at risk the person is of developing PTSD. Multiple traumas can lead to PTSD.

The limitation of this study is that we did not include an intelligence measurement tool to test the intellectual capacity of the victims properly. Instead, we relied heavily on our interviews and observation. Future studies are advised to make use of appropriate measuring instruments.

Future Research

After getting an understanding of PTSD risk factors, we expect future researchers to provide a picture of the psychological dynamics of PTSD. This is to ensure that a prevention model can be build to handle CSA victims and environmental violence (especially family and school). Thus, we expect that future psychotherapy to eliminate PTSD that are appropriate for CSA victims will be designed.

Additionally, future research should take the cultural factors of each participant into account because it contributes to one's trauma and is key to the development of the traumatic impact on the child's identity.

References

Acocella, J. R., & Calhoun, J. F. (1990). *Psychology of adjustment human relationship (3th ed)*. New York: McGraw-Hill.

Adam, B., Miller, A., Karen, E., Schaefer,A., Keith, D., Renshawa., & Blais, R. K. (2013). PTSD and marital satisfaction in military service members: Examining the simultaneous roles of childhood sexual abuse and combat exposure. *Child Abuse & Neglect, 7 (In press)*.

Agustini, E. N., Asniar I., & Matsuo H. (2011). The prevalence of long-term post-traumatic stress symptoms among adolescents after the tsunami in Aceh. *J Psychiatr Ment Health Nurs.18*(6), 543-552.

American Psychiatric Association (APA). (2013). *Diagnostic and statistical manual of mental disorders (5th ed.)*. Washington, DC: American Psychiatric Publishing.

Anderson, J. M., & NancieL., A. (2004). Child sexual abuse: A public health issue. *The Justice Professional,17, 107-126*.

Arnow, B. A., Hunkeler, E. M., Blasey C. M., Lee, J., Constantino, M. J., Fireman, B., Kraemer, H. C., Dea, R., Robinson, R., & Hayward, C. (2006). Comorbid depression, chronic pain, and disability in primary care. *Psychosom Med*, 68(2), 262-270.

Beck, A. (2010).*Sexual victimization in prisons and jails reported by inmates, 2008-2009*. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics.

Bisson, J. I., Sarah, C., Catrin, L., & Neil, P. R. (2015). Post-traumatic stress disorder. *BMJ* 351, 6161-6175.

Breslau, N., Kessler, R. C., Chilcoat, H. D., Schultz, L. R., Davis, G. C., & Andreski, P. (1998). Trauma and posttraumatic stress disorder in the community: Detroit area survey of trauma. *Archives of General Psychiatry,* 55, 626–632.

Brown, D. (2000). (Mis)representations of the long-term effects of childhood sexual abuse in the courts. *Journal of Child Sexual Abuse, 9 (3–4), 79–107.*

Carmen, P. M., & Edna, B. F. (2014). Prolonged exposure therapy for post-traumatic stress disorder: A review of evidence and dissemination. *Journal Expert review of neurotherapeutics,11*(8), 1151-1163.

Chou, F. H. (2007). *Post-traumatic stress disorders risk factors: Research in the area of post-traumatic stress disorders risk factors.* Atlanta: Mental Health Weekly Digest.

Creswell, J. W. (2013). *Research design: Pendekatan kualitatif, kuantitatif, dan mixed edisi ketiga*. (Research design: Qualitative and quantitative approach) Yogyakarta: Pustaka Pelajar.

Cynthia, Winn., Anthony J., & Urquiza (2004). *Treatment for abused and neglected children: Infancy To age 18 - user manual series.* Diane Pub Co.

David, T., Siddaway, A.P., Stedman, R.M., Serpell, L., & Field, A.P. (2012). A meta-analysis of risk factors for post-traumatic stress disorder in children and adolescents. *Clinical Psychology Review, 32, 122–138.*

Earls, C. M. (1988). Aberrant sexual arousal in sexual offenders, human sexual aggression: Current perspective. *Annals of the New York Academy of Sciences,4,* 41–48.

Hamblen, J. (2016). *PTSD in children and adolescents*: A national center for PTSD fact sheet. *http://www.ncptsd.va.gov/ncmain/ncdocs/fact_shts/fs_ children.html.*

Hanford, W. D., Burke, J. W., Fletcher, W. J., Hoskins, A. F. & Miller, T. A. (1982). *Farm accident survey report (Traumatic Injuries in Agriculture)*. Chicago, IL: National Safety Council. Available from: https://www.researchgate.net/publication /11369350_Traumatic_Injuries_in_Agriculture [accessed Mar 19 2017].

Hartini, N. (2009). Bencana tsunami dan stress pasca-trauma pada anak. *Jurnal Masyatakat Kebudayaan & Politik*, *3,* 259-264.

Henrietta. H., F., & Sarah., E. U. (2006). Child sexual abuse, coping responses, self-blame, posttraumatic stress disorder, and adult sexual revictimization. *Journal of Interpersonal Violence , 21(5), 652-672.*

Howgego, I. M., Owen, C., Meldrum, L., Yellowlees, P., Dark, F., & Parslow, R. (2005). Posttraumatic stress disorder: An exploratory study examining rates of trauma and PTSD and its effect on client outcomes in community mental health. *BMC Psychiatry*, *5*, 21–38.

Ito, Y.,Teicher, M. H., Glod, C. A., & Ackerman, E. (1998). Preliminary evidence for aberrant cortical development in abused children: a quantitative EEG study. *The Journal of Neuropsychiatry and Clinical Neurosciences*, *10*(3), 298–307.

Jobson, L., & O'karney, R. (2008). Cultural differences in personal identity in PTSD. *British Journal of Clinical Psychology, 47, 95-109.*

Kaijun, W, Yuqing, Z., Zhengkui L., Peiling, Z., & Chuguang, W. (2015). Coexistence and different determinants of posttraumatic stress disorder and posttraumatic growth among Chinese survivors after earthquake: role of resilience and rumination. *Front Psychol*, *6,* 1043-1056.

Kaplan H. I., Sadock B. J., & Grebb JA.(2010). *Sinopsis psikiatri ilmu pengetahuan perilaku psikiatri klinis.* Tangerang: Binarupa Aksara.

Kaplow, J. B., Dodge, K. A., Amaya-Jackson, L., & Saxe, G. N. (2005). Pathways to PTSD, part II: Sexually abused children. *American Journal of Psychiatry, 162*(7), 1305–1310.

Kiser, L. J., Ackerman, B. J., Brown, E., Edwards, N. B., McColgan, E. B., Pugh, R. L., & Pruitt, D.B. (1988). Post-traumatic stress disorder in young children: a reaction to purported sexual abuse. *J. Am. Acad. Child Adolesc. Psychiatry*, *5,* 645–649.

Macklin, M. L., Metzger L. J., Litz, B. T., McNally, R. J., Lasko, N. B., Orr, S. P., & Pitman, R. K. (1998). Lower precombat intelligence is a risk factor for posttraumatic stress disorder. *J Consult Clin Psychol*, *66*(2), 323-329.

Martine H, Rachel, L., & Isabelle, D. (2016). The association between peer victimization, PTSD, and dissociation in child victims of sexual abuse. *Journal of Affective Disorders*, *193*, 227–232.

Maslihah, S. (2006).Kekerasan terhadap anak: Model transisional dan dampak jangka panjang. *Edukid: Jurnal Pendidikan Anak Usia Dini*, *1*(1), 25-33.

Matlin, M. W. (2008). *The psychology of woman. (6th ed.)*. United State of America: Thomson Wardsworth.

McFarlane, A. C., Creamer M., & Burgess P. (2001). Post-traumatic stress disorder: findings from the Australian National Survey of Mental Health and Well-being. *Psychol Med*, *31*(7),1237-1247.

Miles, B. Mathew dan Michael Huberman. (1992). *Analisis data kualitatif buku sumber tentang metode-metode baru*. Jakarta: UIP.

Miller E. A. (2003). Multiple cargo binding sites on the COPII subunit Sec24p ensure capture of diverse membrane proteins into transport vesicles. *Cell, 114*(4),497-509.

Najdowski, C.J., & Ullman, S.E.(2009). Prospective effects of sexual victimization on PTSD and problem drinking. *Addictive Behaviors, 34,* 965–968.

National Collaborating Centre for Mental Health (UK).(2005). *Post-traumatic stress disorder: The management of PTSD in adults and children in primary and secondary care*. *Editors National Collaborating Centre for Mental Health (UK)*. Leicester (UK): Gaskell.

Sadock, B. J., & Sadock, V. A. (2007). *Anxiety disorder in: Kaplan & Sadock's synopsis of psychiatry: Behavioral sciences/clinical psychiatry, 10th Edition*. New York: Lippincott Williams & Wilkin.

Sagatun, I. J .(2015). Post-Traumatic stress and attributions among incest family member. *The Journal of Sociology & Social Welfare, 11,* 4-7.

Schaefera. K. E., Keith D. R., & Rebecca K. B. (2013). PTSD and marital satisfaction in military service members: Examining the simultaneous roles of childhood sexual abuse and combat exposure. *J. Negl Child Abuse, 37*(11), 979-985.

Schiraldi, G. R. (2000). *The post traumatic stress disorder, sourcebook, guide to healing, recovery and growth*. Boston: Lowell House.

Scott, J. C., Matt, G. E., Wrocklage, K. M., Crnich, C., Jordan, J., Southwick, S. M., Krystal, J. H., & Schweinsburg, B. C. (2014). A quantitative meta-analysis of neurocognitive functioning in posttraumatic stress disorder. *Psychol Bull, 1,*105-140.

Sholichah, M. (2009). Pengaruh aplikasi metode feldenkrais pada perempuan korban pemerkosaan yang mengalami post-traumatic stress disorder. *Jurnal Anima, 24*(3), 201-300.

Smith, J. A., & Osborn, M. (2003). *Interpretative phenomenological analysis. Qualitative psychology: a practical guide to research methods*. London, UK: Sage Publications.

Szalavittz, M., & Perry, B. (2006). *The boy who was raised as a dog: and other stories from a child psychiatrist's notebook: what traumatized children can teach us about loss, love and healing*. New York: Basic Books.

Tentama, Fatwa. (2014). Dukungan sosial dan post traumatic stress disorder pada remaja penyintas gunung merapi. *Jurnal Psikologi Universitas Diponegoro*, *13*(2), 133-138.

Ullman, S.E., &Filipas, H.H. (2005). Gender differences in social reactions to abuse disclosures, post-abuse coping, and PTSD of child sexual abuse survivors. *Child Abuse Negl. 29(7),767-782.*

Weems, C. F., Costa, N. M., Watts, S. E., Taylor, L. K., & Cannon, M. F. (2007). Cognitive errors, anxiety sensitivity, and anxiety control beliefs. *Behavior Modification,31,*174–201.

Wisnugroho, A. (2016). Jawa Timur darurat kekerasan terhadap anak. Retieved November 20, 2016, from https://www.cnnindonesia.com/nasional/20161120214605-12-173984/jawa-timur-darurat-kekerasan-terhadap-anak.

Zoladz, P. R., Fleshner, M.,& Diamond D. M.(2013). Differential effectiveness of tianeptine, clonidine and amitriptyline in blocking traumatic memory expression, anxiety and hypertension in an animal model of PTSD. *Prog Neuropsycho pharmacol Biol Psychiatry, 11,* 259-281.