INFLUENCE OF SEXUAL ABUSE ON THE PSYCHOLOGICAL HEALTH AND EMOTIONAL REGULATION OF ADOLESCENTS

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Abstract

Sexual abuse is a major psychosocial and public health issue that disrupts adolescents' emotional, cognitive, and social development. This study investigated its influence on adolescents' psychological health and emotional regulation. A quantitative design was employed using a structured questionnaire administered to 530 respondents comprising 234 males (44.2%) and 296 females (55.8%), aged 10–19 years, with a mean age of 14.05 ± 2.44 years. Data were analysed using descriptive statistics, ANOVA, and t-test procedures to assess the effects of sexual abuse on health, psychological well-being, and coping mechanisms. Results showed that sexual abuse significantly affected adolescents' physical and mental health, manifesting in depression, anxiety, and psychosomatic symptoms. Survivors also reported social withdrawal, stigma, and difficulty forming relationships. Those who adopted adaptive coping strategies such as counselling, therapy, and social support displayed better emotional regulation than those using avoidance or self-blame. The study concludes that sexual abuse exerts a multidimensional impact on adolescent well-being. It recommends trauma-informed education, accessible counselling, and stronger child-protection policies to promote resilience and recovery among survivors.

Keywords: sexual abuse, adolescents, psychological health, emotional regulation,

Introduction

Adolescence is a pivotal stage of human development characterized by rapid biological, cognitive, and socio-emotional transformations. During this period, young people establish personal identity, autonomy, and emotional competence, all of which are foundational to psychological adjustment (Steinberg, 2014; Casey, 2015). Emotion regulation is the ability to monitor, evaluate, and modify emotional reactions emerges as a critical developmental task that supports mental health, social adaptation, and academic success (Gross, 2015). However, exposure to early adverse experiences, particularly childhood sexual abuse (CSA), can derail these

developmental processes and lead to enduring emotional and psychological difficulties (McLaughlin et al., 2015).

Childhood sexual abuse, defined as the involvement of a child in sexual activity that he or she does not fully comprehend, cannot consent to, or that contravenes social or legal norms, is recognised as one of the most serious violations of child rights (World Health Organisation, 2020). Global estimates show that sexual abuse is alarmingly prevalent: meta-analytic reviews suggest that about 18 % of girls and 7 % of boys experience some form of sexual abuse before age 18 (Stoltenborgh et al., 2011; Barth et al., 2013). Such exposure is consistently associated with heightened risks of depression, anxiety, post-traumatic stress disorder (PTSD), substance use, and suicidal behaviour across adolescence and adulthood (Chen et al., 2010; Lo Iacono et al., 2021).

Emotion-regulation difficulties are increasingly recognised as a central mechanism linking CSA to adverse mental-health outcomes. Survivors often display maladaptive strategies such as suppression, avoidance, and rumination, which may initially dampen distress but ultimately sustain or exacerbate psychopathology (Gratz & Roemer, 2004; Aldao et al., 2010). Among female adolescent survivors, poor emotion-regulation capacity has been shown to predict both depressive and PTSD symptoms, with depressive symptoms partially mediating this relationship (Chang et al., 2018).

Neurobiological evidence reinforces these findings. Childhood maltreatment is associated with atypical functioning of the amygdala–prefrontal circuitry, which underlies the ability to modulate emotional responses to threat and stress (McLaughlin et al., 2015). Using experience-sampling methods, Ion et al. (2023) demonstrated that individuals with a history of childhood maltreatment report more intense negative effects and less effective use of adaptive emotion-regulation strategies in everyday contexts. At the behavioural level, Uzun et al. (2023) observed that sexually abused adolescents exhibit greater emotional dysregulation, lower self-esteem, and more aggression than non-abused peers, highlighting regulation deficits as a key transdiagnostic vulnerability.

Gender variations have also been documented, with adolescent females typically reporting higher levels of internalising symptoms, while males exhibit more externalising or behavioural difficulties following sexual trauma (Zheng et al., 2024). Furthermore, the severity and chronicity of abuse, often described as the trauma dose, have been linked to escalating emotion-regulation problems and psychological impairment (Chang et al., 2018). Addressing these developmental and contextual factors is crucial because effective emotion regulation not only mediates the psychological consequences of trauma but also serves as a foundation for resilience and recovery. Strengthening adolescents' regulatory skills through trauma-informed and evidence-based interventions, therefore, remains an essential focus for mental-health research and practice.

Sexual abuse during adolescence represents a serious violation of personal security that can disrupt developmental stability. Its effects often continue into adulthood, influencing emotional, cognitive, and social functioning. Evidence links exposure to sexual abuse with greater vulnerability to depression, anxiety, post-traumatic stress disorder (PTSD), and reduced self-esteem (Campbell, Dworkin, & Cabral, 2009; Ehring & Quack, 2010; Uzun, Sezgin, 3akır, & Şirin, 2023). These outcomes arise not only from the assault itself but also from secondary processes such as shame, stigma, and lack of social support (Campbell et al., 2009).

Research shows that survivors often experience internalising symptoms and psychosomatic complaints more frequently than non-abused peers (Ehring & Quack, 2010). Depression, intrusive memories, and emotional numbing are common and can interfere with academic performance and peer relationships. The persistence of distress varies, but both prolonged and single-episode abuse can be associated with lasting psychological effects (Trickett, Noll, & Putnam, 2011). Comorbidity between PTSD and depression is common, suggesting that trauma may affect overlapping emotional and cognitive mechanisms (O'Leary, Coohey, & Easton, 2010).

Emotion regulation refers to the processes by which individuals monitor and modify their emotional reactions in line with personal goals and situational demands (Gross & John, 2003). Effective regulation typically involves awareness of emotions, acceptance, and adaptive coping strategies such as cognitive reappraisal (Gratz & Roemer, 2004). Traumatic experiences can impair these processes, leading to difficulty recognising emotions, tolerating distress, and maintaining control under stress (Ehring & Quack, 2010; Cloitre, Garvert, Weiss, Carlson, & Bryant, 2014).

Adolescents exposed to sexual abuse often report heightened emotional reactivity and greater use of maladaptive strategies such as avoidance and rumination (Uzun et al., 2023). These difficulties are consistent with broader findings showing that maladaptive regulation is linked to higher levels of anxiety and depression, while adaptive strategies correspond to better outcomes (Aldao, Nolen-Hoeksema, & Schweizer, 2010). Neurobiological research indicates that childhood maltreatment can alter brain systems involved in emotional control, particularly connectivity between the prefrontal cortex and amygdala (McLaughlin, Peverill, Gold, Alves, & Sheridan, 2015). Such findings provide a biological context for observed problems in emotion management among adolescent survivors.

Integrating emotional regulation with psychological distress provides a clearer understanding of trauma adjustment. Regulation difficulties can intensify depressive and anxiety symptoms by restricting access to effective coping, while intense negative affect can undermine regulation, forming a cyclical pattern (Schдfer, Naumann, Holmes, Tuschen-Caffier, & Samson, 2017). During adolescence, when neural systems for emotional control are still developing, this interaction may increase vulnerability to persistent stress responses (McLaughlin et al., 2015). Neuroscientific reviews show that exposure to early abuse is associated with enduring structural and functional changes in brain regions supporting emotion processing and stress regulation (Teicher & Samson, 2016). Consequently, interventions that integrate cognitive restructuring with emotion-management skills are recommended to mitigate long-term effects (Cloitre et al., 2014).

Gaps and rationale for current research

Despite growing evidence, important gaps remain. Much existing research focuses on adults or clinical populations, leaving community-based adolescents less represented. Few studies simultaneously assess psychological well-being and emotion regulation, limiting understanding of their interaction in younger survivors. Gender differences are also underexplored, though adolescent females often show higher internalising symptoms following trauma (Ullman, Peter-Hagene, & Relyea, 2014). Furthermore, abuse severity and chronicity are inconsistently examined, despite evidence that more severe or prolonged abuse predicts poorer adjustment (Teicher & Samson, 2016). Addressing these gaps can improve prevention and intervention strategies that strengthen emotion-regulation skills

and foster resilience among adolescent survivors.

This study adopted a descriptive survey research design to examine the influence of sexual abuse on the psychological health and emotional regulation of adolescents. The design was appropriate because it allows systematic data collection and quantitative analysis of naturally occurring variables without manipulation (Creswell & Creswell, 2018). Descriptive surveys are particularly suitable for exploring sensitive experiences such as trauma and abuse, where experimental control is neither feasible nor ethical (Bryman, 2016). Moreover, surveys ensure respondent anonymity, which is crucial when addressing emotionally charged topics among adolescents (Babbie, 2021). This design made it possible to gather broad, reliable data and identify patterns between sexual abuse, psychological health, and emotional regulation.

The study population comprised adolescents enrolled in secondary schools within the study area. A total of 530 respondents participated, consisting of 234 males (44.2%) and 296 females (55.8%). The ages ranged from 10 to 19 years, with a mean age of 14.05 ± 2.44 years, representing the middle to late adolescent period characterised by emotional and social changes.

A multi-stage sampling technique was used. First, schools with functional counselling units were purposively selected to ensure accessibility to students receiving psychosocial support. Next, stratified sampling was applied to capture diversity in terms of gender and age, followed by the random selection of participants within each stratum. This approach ensured proportional representation of adolescents across the selected schools.

Data were gathered using three structured instruments that assessed demographic characteristics, psychological health, and emotional regulation. The demographic section captured essential background information—such as age, gender, school type, and duration of residence in the study area—to provide contextual understanding and support subgroup analyses.

Psychological health was measured using an adapted tool based on the work of Campbell, Dworkin, and Cabral (2009) and Ehring and Quack (2010). The modified scale included 20 items assessing depression, anxiety, self-esteem, and trauma-related symptoms, rated on a four-point Likert scale from Strongly Agree to Strongly Disagree. Higher scores indicated greater psychological distress. Items were simplified to suit adolescent comprehension, and the content and constructs were validated by three psychology experts. A pilot test involving 40 adolescents produced a Cronbach's alpha of 0.87, demonstrating strong reliability (Tavakol & Dennick, 2011) and confirming the instrument's suitability for measuring psychological well-being among adolescents exposed to abuse.

Emotional regulation was assessed using the Emotion Regulation Questionnaire (ERQ) by Gross and John (2003). The ERQ consists of 10 items, rated on a seven-point Likert scale, and evaluates two strategies: Cognitive Reappraisal (six items) and Expressive Suppression (four items). Higher reappraisal scores indicate more adaptive emotional management, whereas higher suppression scores suggest restricted expression. The ERQ has established construct validity and internal consistency, with Cronbach's alpha values of 0.79 and 0.73 (Balzarotti, John, & Gross, 2010), making it suitable for use with adolescents.

Ethical approval was obtained from the relevant educational authorities. Parental consent and participant assent were secured before data collection. Trained

research assistants administered the questionnaires in classroom settings under the supervision of school counsellors to maintain confidentiality and emotional safety. Participation was voluntary and anonymous. Each session lasted approximately 40 minutes, and questionnaires were collected immediately to minimise missing responses. All procedures followed ethical guidelines for research with minors outlined by Israel and Hay (2006).

Data were coded and analysed using the Statistical Package for the Social Sciences (SPSS, version 26). Descriptive statistics such as frequency counts, percentages, means, and standard deviations were used to summarise demographic data and responses on psychological health and emotional regulation. Inferential statistics, including independent t-tests and one-way Analysis of Variance (ANOVA), were conducted to test the study's hypotheses at a significance level of 0.05. These tests were appropriate for identifying significant differences and relationships among naturally occurring variables in non-experimental settings (Pallant, 2020). The results provided empirical insight into how sexual abuse influences adolescents' psychological and emotional outcomes.

Ethical Considerations (Streamlined – 100 words)

The study complied with institutional and professional ethical standards. Ethical clearance was obtained, and official approval was granted by participating schools. Informed consent from parents and assent from students were secured before participation. Respondents were informed of their rights to withdraw at any point, and confidentiality was strictly maintained. Emotional support was available through school counsellors for participants showing distress. The study adhered to the ethical guidelines for social research outlined by Israel and Hay (2006) and the American Psychological Association (2020), ensuring the protection, respect, and psychological safety of participants.

Results

Hypothesis 1: There is no significant effect of sexual abuse on health among survivors

Table 1: ANOVA showing the significant effect of sexual abuse on health among survivors

Health	Sum of Square	df.	Mean Square	F	p.(Sig)
Between Groups	4009.572	15	267.305	51.795	0.000 significant
Within Groups	2652.647	514	5.161		
Total	6662.219	529			

The result of the one-way Analysis of Variance (ANOVA) in Table 1 shows a between-group mean square of 267.305 and a within-group mean square of 5.161, yielding an F-value of 51.795 with a p-value of 0.000, which is less than the 0.05 significance level. This indicates a statistically significant effect of sexual abuse on the health of survivors. Therefore, the null hypothesis, which stated that there is no significant effect of sexual abuse on health among survivors, is rejected. The result implies that variations in health status among adolescents are significantly influenced by their experience of sexual abuse. Adolescents exposed to sexual abuse are more likely to exhibit poor physical and psychological health outcomes compared to their non-abused counterparts.

Hypothesis 2: There is no significant effect of sexual abuse on psychological well-being among survivors

Table 2: ANOVA showing the significant effect of sexual abuse on psychological well-being among survivors

Psychological well-being	Sum of Squares	df.	Mean Square	F	p.(Sig)
Between Groups	5756.890	15	383.793	63.892	0.000 significant
Within Groups	3087.563	514	6.007		
Total	8844.453	529			

The result of the one-way Analysis of Variance (ANOVA) in Table 2 reveals a between-group mean square of 383.793 and a within-group mean square of 6.007, producing an F-value of 63.892 with a p-value of 0.000, which is less than the 0.05 level of significance. This indicates a statistically significant effect of sexual abuse on the psychological well-being of survivors. Consequently, the null hypothesis, which stated that there is no significant effect of sexual abuse on psychological well-being among survivors, is rejected.

This finding implies that the psychological well-being of adolescents varies significantly based on their experiences of sexual abuse. Survivors are more likely to exhibit symptoms such as depression, anxiety, fear, and low self-esteem, reflecting emotional distress associated with trauma. The significant F-ratio suggests that sexual abuse has a profound negative impact on adolescents' mental and emotional stability.

Hypothesis 3: There is no significant effect of sexual abuse on social well-being among survivors

Table 3: ANOVA showing the significant effect of sexual abuse on social well-being among survivors

Social well-being	Sum of Squares	df.	Mean Square	F	p.(Sig)
Between Groups	4916.137	15	327.742	48.266	0.000 significant
Within Groups	3490.243	514	6.790		
Total	8406.379	529			

The result of the one-way Analysis of Variance (ANOVA) in Table 3 shows a between-group mean square of 327.742 and a within-group mean square of 6.790, yielding an F-value of 48.266 with a p-value of 0.000, which is below the 0.05 level of significance. This indicates a statistically significant effect of sexual abuse on the social well-being of survivors. Therefore, the null hypothesis, which stated that there is no significant effect of sexual abuse on social well-being among survivors, is rejected.

This result implies that sexual abuse significantly influences the social functioning and relationships of adolescents. Survivors tend to experience greater social withdrawal, trust difficulties, stigma, and isolation compared to non-abused peers. The

significant F-ratio demonstrates that the degree of abuse exposure is associated with differing levels of social adjustment, indicating that sexual abuse disrupts interpersonal relationships and impairs victims' ability to engage confidently in social interactions.

Hypothesis 4: There is no significant difference between adaptive and maladaptive coping mechanisms among survivors

Table 4: T-test of the difference between adaptive and maladaptive coping mechanisms among survivors

Test	N	Mean	SD	df.	r	t-Cal	t-Crit	P value
Adaptive	530	16.48	2.28	99	.782**	2.998	1.960	0.003 ($p<0.05$) It Significant
Maladaptive coping mechanisms	530	16.13	19.42					

The result of the independent t-test in Table 4 shows a calculated t-value (t-cal) of 2.998, which is greater than the critical t-value (t-crit) of 1.960, with a p-value of 0.003 that is less than the 0.05 level of significance. This indicates a significant difference between adaptive and maladaptive coping mechanisms among survivors. Consequently, the null hypothesis, which stated that there is no significant difference between adaptive and maladaptive coping mechanisms, is rejected.

The result implies that survivors differ considerably in how they manage the emotional aftermath of sexual abuse. Those employing adaptive coping strategies such as seeking therapy, relying on social support, and engaging in positive self-reflection reported better emotional adjustment, as reflected by a higher mean score ($M = 16.48$) compared to those using maladaptive strategies such as avoidance, self-harm, or substance use, who had a lower mean score ($M = 16.13$).

The positive correlation ($r = 0.782$) further suggests a strong relationship between coping style and emotional outcomes, indicating that adaptive strategies are associated with improved psychological recovery and resilience among adolescent survivors of sexual abuse.

Discussion of Findings

The findings of this study demonstrate that sexual abuse significantly influences the overall well-being of adolescents across four major dimensions—health, psychological stability, social functioning, and coping capacity. The results collectively indicate that exposure to sexual abuse during adolescence produces lasting disruptions in emotional and behavioural development. These outcomes are consistent with extensive research establishing sexual trauma as a multidimensional stressor that impairs physical, emotional, and social domains of functioning (Afifi et al., 2017; Fergusson et al., 2013).

The study revealed that adolescents who experienced sexual abuse exhibited poorer health outcomes than those who had not. Survivors reported experiences of physical pain, injuries, and medical complications, alongside psychosomatic symptoms such as loss of appetite and sleep disturbances. These manifestations suggest that the physiological stress

associated with trauma may weaken the immune system and alter neuroendocrine functioning, leading to prolonged physical vulnerability.

This finding aligns with the conclusions of Anda et al. (2006), who found that childhood trauma increases susceptibility to chronic diseases and psychosomatic complaints in later life. Similarly, Paras et al. (2009) reported that survivors of sexual abuse are at a higher risk of developing long-term health issues, including fatigue and reproductive complications. The overlap between emotional distress and physical symptoms implies that the health effects of sexual abuse extend beyond immediate injuries to include systemic and enduring biological impacts. These results underscore the necessity of integrating physical and mental health interventions for adolescent survivors.

The study further established that sexual abuse has a profound negative effect on the psychological well-being of adolescents. Survivors displayed symptoms of depression, anxiety, emotional numbness, and self-blame. These findings reinforce the body of evidence indicating that sexual trauma disrupts cognitive and affective processes, leading to long-term emotional dysregulation.

Briere and Elliott (2014) observed that trauma exposure in childhood or adolescence alters emotion processing and memory consolidation, heightening vulnerability to post-traumatic stress disorder (PTSD). Similarly, Campbell et al. (2009) argued that the psychological consequences of abuse are shaped not only by the event itself but also by survivors' access to emotional support and societal responses to disclosure. Adolescents are particularly at risk because they are still developing the emotional competencies necessary for managing distress. When abuse occurs during this critical period, it may hinder the development of self-esteem, self-regulation, and adaptive coping.

These findings emphasise the importance of early trauma-focused psychological interventions, including counselling, cognitive-behavioural therapy, and emotional skills training, to help survivors rebuild resilience and prevent the internalisation of trauma-related distress.

The study also revealed that sexual abuse significantly affects the social functioning of adolescent survivors. Many respondents reported social withdrawal, difficulty trusting others, and feelings of stigma and rejection. These social consequences often arise because trauma alters how individuals perceive relationships and safety in social contexts.

This aligns with Mason et al. (2017), who found that interpersonal trauma leads to isolation and avoidance of social contact due to fear of judgment or re-traumatisation. Likewise, Collin-Vĭzina et al. (2015) noted that survivors frequently experience strained interpersonal relationships, partly due to disrupted attachment and negative self-concept. Adolescents, being at a stage where affiliation peer is essential for identity development, may experience profound emotional setbacks when social engagement becomes fraught with fear or shame.

Therefore, beyond psychological treatment, survivors require structured opportunities for social reintegration, such as peer-support groups, community education programs, and family-based therapy aimed at restoring interpersonal trust and social confidence.

The study further revealed that survivors who adopted adaptive coping strategies—such as seeking therapy, confiding in trusted individuals, or relying on religious and social support—experienced better emotional adjustment than those who engaged in maladaptive behaviours such as

avoidance, denial, or substance use. The findings suggest that coping strategies mediate the relationship between trauma and recovery outcomes, shaping how survivors regulate emotions and rebuild their lives after abuse.

This is consistent with Compass et al. (2017) and Gross (2015), who emphasised that emotion regulation and coping play pivotal roles in mitigating the psychological effects of stress and trauma. Adaptive coping promotes emotional balance and cognitive reframing, while maladaptive coping reinforces distress and avoidance. In the context of sexual abuse, interventions that encourage problem-focused coping and emotional awareness are crucial to facilitate recovery and prevent retraumatization.
These findings affirm the value of trauma-informed interventions that incorporate resilience training, psychoeducation, and supportive counselling to help survivors transition from reactive to adaptive coping.

Taken together, the results highlight that sexual abuse exerts a multidimensional impact on adolescents' lives. The interconnections among physical health, psychological stability, social functioning, and capacity to cope demonstrate that trauma recovery requires a holistic approach. These findings align with trauma and stress models, suggesting that early exposure to abuse alters neurobiological systems responsible for emotional regulation and social engagement (Teicher & Samson, 2016).

Adolescents are vulnerable due to ongoing neurological and emotional development, and the effects of sexual abuse can therefore persist in adulthood if left unaddressed. Early intervention programs, school-based counselling, and community awareness initiatives are vital in mitigating the long-term harm associated with sexual trauma and fostering emotional recovery.

Conclusion, Recommendations, and Limitations

This study examined the influence of sexual abuse on the psychological health and emotional regulation of adolescents, revealing that such experiences have profound and far-reaching effects on multiple aspects of well-being. The findings show that sexual abuse compromises adolescents' physical health, increases psychological distress, weakens social functioning, and shapes both adaptive and maladaptive coping responses. Survivors often experience anxiety, depression, and withdrawal, while those who adopt adaptive coping strategies, such as counselling or social support, tend to recover more effectively. These outcomes emphasise that the effects of sexual trauma extend beyond immediate harm to influence long-term developmental, emotional, and social adjustment.

Overall, the study concludes that addressing the consequences of sexual abuse among adolescents requires a coordinated, trauma-informed approach that involves schools, health systems, families, and communities. The interconnection between physical, emotional, and social well-being underscores the need for interventions that treat survivors holistically rather than in isolation. Early detection, psychological care, and community reintegration support are crucial for helping survivors regain stability and confidence.

In practical terms, it is recommended that schools implement trauma-sensitive programs that equip teachers and counsellors to identify behavioural signs of distress and refer affected students for professional help. Counselling and psychological services should be made accessible in schools and community health centres, offering trauma-focused therapy and emotional support. Health professionals should integrate abuse screening into adolescent care to detect and manage physical and psychological

symptoms early. Families and community members must be educated to respond empathetically, reduce stigma, and foster supportive environments where adolescents feel safe to disclose abuse. At the policy level, governments should strengthen child protection frameworks, improve enforcement of existing laws, and promote awareness programs that encourage early reporting and access to justice.

Despite its contributions, the study has limitations. Data were collected through self-reported questionnaires, which may be influenced by recall bias or reluctance to disclose traumatic experiences. Additionally, the sample was restricted to adolescents within a specific locality, limiting the generalizability of findings to other cultural contexts. Future studies should employ mixed-method or longitudinal designs to explore long-term psychological and behavioural outcomes of sexual abuse, as well as cross-cultural variations in coping and recovery. Evaluating the impact of trauma-informed interventions and emotional skills programs would also enhance understanding of effective support strategies for survivors.

In conclusion, this study provides empirical evidence that sexual abuse profoundly disrupts adolescents' mental, emotional, and social functioning. Recovery depends not only on therapeutic interventions but also on the presence of understanding families, responsive institutions, and enabling communities. A coordinated, compassionate, and evidence-based response is therefore essential to help survivors rebuild resilience, restore trust, and achieve psychological healing.

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