International Journal of Transdisciplinary Research and Perspectives
Volume 2, Issue 5, May 2026
www.ijtrp.com | E-ISSN: 3107-7935 | RESAIM Publishing | www.resaim.com

Impact of Childhood Trauma on Adult Sexual Functioning: A Review of Psychological and Therapeutic Perspectives

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***Abstract*: Childhood trauma is more widespread than many people realise, and one consequence that rarely gets the attention it deserves is how it affects sexuality in later life. Physical abuse, sexual abuse, emotional abuse, neglect, and witnessing violence at home can all leave lasting marks on how a person relates to their own body and to intimate partners in adulthood. This paper reviews existing research on the psychological effects of childhood trauma on adult sexual functioning, and looks at what kinds of therapy have been found to help. The review draws on attachment theory, trauma theory, neurobiological research, and cognitive models to understand why early adversity so often disrupts adult sexuality and intimacy. In terms of treatment, the paper covers trauma-informed care, Trauma-Focused Cognitive Behavioural Therapy (TF-CBT), Eye Movement Desensitisation and Reprocessing (EMDR), somatic approaches, sex therapy, and couple therapy. Given that both authors are based in India, the paper also addresses how cultural factors such as stigma, silence around abuse, and limited access to trained clinicians shape this issue in the Indian context. Childhood trauma affects adult sexuality through several different pathways, and no single intervention is enough on its own. Effective clinical work in this area needs to be trauma-informed, integrated across psychological and somatic domains, and sensitive to the relational and cultural context each client brings.**

***Keywords*: Adverse childhood experiences, attachment theory, PTSD, sexual dysfunction, sex therapy, trauma-informed therapy.**

1. Introduction

When people think about the long-term effects of childhood trauma, they usually think about depression, anxiety, and trust issues. What comes up far less often is how trauma affects adult sexuality. Yet anyone who works clinically with trauma survivors will know that sexual difficulties are incredibly common in this population, and the research backs this up consistently [1]. What is less clear, at least in mainstream clinical training, is why this happens and what can be done about it. That gap is what this paper tries to address.

Childhood trauma is a broad term covering experiences that overwhelm a child's ability to cope and disrupt their development. One of the most useful frameworks for thinking about this is the Adverse Childhood Experiences (ACEs) model, developed from the landmark study by Felitti et al. [1]. ACEs cover three categories: abuse (physical, sexual, and emotional), neglect (physical and emotional), and household dysfunction, which includes witnessing domestic violence, living with a parent with a substance use problem, or having a family member imprisoned. What the ACE study demonstrated so powerfully was a dose-response relationship between the number of adverse experiences and the severity of health problems across the lifespan. More trauma, more damage.

Sexual functioning covers desire, arousal, the physical capacity for sexual response, and the ability to experience pleasure - as well as the emotional dimension of intimacy with a partner. Problems in any of these areas, collectively called sexual dysfunction, are more common than is usually acknowledged. Among trauma survivors, they are considerably more prevalent [4]. Yet the intersection between trauma and sexuality is still relatively neglected in research, and many mental health practitioners receive very little training in it.

The reasons why childhood trauma leads to adult sexual difficulties are not simple. They involve how early experiences shape the nervous system, how they disrupt attachment, what kinds of beliefs they generate about sex and relationships, and how trauma gets stored in the body in ways that persist long after the original events [3]. Understanding these different pathways matters for clinical practice because it shapes what kind of help is actually useful.

For those of us training and practicing in India, there is also a cultural dimension that cannot be ignored. Sexuality is not something discussed openly in most Indian households or medical settings, and abuse tends to be hidden. Survivors often carry their experiences in silence for years without ever connecting what happened to them as children with the difficulties they face now. This review tries to take that context seriously rather than simply applying frameworks developed in Western settings [31].

The paper is structured as follows: theoretical frameworks explaining the trauma-sexuality link; specific sexual difficulties trauma survivors commonly experience; types of childhood trauma and their effects on intimacy; assessment approaches; therapeutic interventions; cultural considerations specific to India; and challenges and future directions.

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2. Theoretical Foundations

No single theory fully explains the relationship between childhood trauma and adult sexual functioning. What helps most is drawing on several frameworks together, each illuminating a different piece of the picture. This section covers four: attachment theory, trauma theory, neurobiological models, and cognitive approaches.

A. Attachment Theory

Attachment theory was originally developed by Bowlby [5] and built on empirically by Ainsworth and colleagues [6]. The core idea is that children have a biological drive to seek closeness to caregivers when scared or stressed. Over time, repeated interactions with caregivers build internal working models: mental blueprints for how relationships work, whether others can be relied on, and whether intimacy is safe or dangerous.

When caregiving is warm and consistent, children tend to develop secure attachment, supporting trust and the capacity for genuine intimacy. When caregiving is unpredictable, cold, or frightening, children develop insecure patterns: anxious, avoidant, or disorganised [7]. Disorganised attachment, developing when the caregiver is the source of fear, is strongly linked to dissociation and serious difficulties in adult relationships [8]. It is not hard to see how this kind of early relational experience would continue to shape someone's sexual and intimate life years later.

B. Trauma Theory

Herman's [2] foundational work described three core trauma responses: hyperarousal, where the nervous system stays on high alert; intrusion, where trauma forces itself back into consciousness through flashbacks or triggers; and constriction, where the system shuts down as self-protection. All three have direct relevance to sexual functioning. Hyperarousal can make intimacy feel threatening; intrusions can be triggered by touch or closeness; emotional numbing can kill desire and the capacity for pleasure.

Herman [2] also described Complex PTSD, now recognised in the ICD-11, which describes the more pervasive consequences of prolonged, repeated interpersonal trauma in childhood. Beyond core PTSD symptoms, it involves chronic difficulties regulating emotions, a deeply damaged sense of self, and profound relational difficulties. Dissociation during sex is particularly significant: many survivors describe feeling detached from their body during sexual activity, a response that makes complete psychological sense when the body was the site of violation, but which severely disrupts the capacity for pleasure and relational presence in adulthood [16].

C. Neurobiological Perspectives

The hypothalamic-pituitary-adrenal (HPA) axis - the body's main stress-response system - is significantly altered by chronic early adversity, leading to dysregulated cortisol levels and heightened reactivity to perceived threats. These physiological changes affect mood, the capacity for pleasure, and the ability to regulate arousal [3]. Porges' polyvagal theory [9] proposes a hierarchy of autonomic states: the ventral vagal system supports social engagement and pleasurable connection; the sympathetic system drives fight-or-flight; and the dorsal vagal system produces shutdown or freeze. Trauma survivors frequently get stuck in sympathetic or dorsal states, making the sense of safety necessary for sexual connection very difficult to access.

Kearney and Lanius [10] describe a 'brain-body disconnect' in trauma, where signals from the body are poorly integrated with conscious experience. For sexuality, this is particularly significant because sexual pleasure is an embodied experience it requires presence in the body, not disconnection from it.

D. Cognitive Models

Cognitive approaches highlight the beliefs that trauma generates. Survivors of childhood abuse commonly develop beliefs like 'my body does not belong to me,' 'sex is dangerous,' 'I am broken,' or 'I do not deserve to feel good' [11]. These beliefs persist into adulthood and shape how a person experiences their sexuality and relationships. Shame is arguably the most clinically significant response, particularly in cases of childhood sexual abuse. Perpetrators frequently cultivate self-blame, and families and social systems often reinforce it through silence. Research has found that self-criticism mediates the relationship between childhood maltreatment and adult sexual dysfunction, pointing toward self-compassion-focused work as particularly important in treatment [12].

3. Impact of Childhood Trauma on Adult Sexual Functioning

Childhood trauma can affect virtually every aspect of adult sexual functioning. This section looks at the main areas: sexual desire, arousal, orgasm, sexual pain, patterns of sexual behaviour, and the capacity for emotional intimacy.

A. Sexual Desire

Reduced sexual desire also called hypoactive sexual desire is among the most commonly reported difficulties among trauma survivors. Many describe feeling little interest in sex, or actively avoiding it, reflecting the nervous system's attempt to protect against re-experiencing trauma in an intimate context, neurobiological changes that make pleasure harder to access, or shame-based beliefs that make desire itself feel threatening [4]. Not all survivors show reduced desire, however. Gewirtz-Meydan [13] found distinct profiles among adult survivors, including profiles characterised by compulsive or high-risk sexual engagement rather than avoidance, associated with different abuse histories and PTSD levels. This variability is an important reminder that trauma does not produce a single predictable outcome.

B. Arousal Difficulties

Problems with physiological arousal occur at elevated rates among trauma survivors. Chronic sympathetic nervous system activation tends to inhibit parasympathetically-driven arousal processes. Daily stress has been shown to mediate the relationship between childhood sexual abuse and arousal function in women, suggesting that it is not only the historical

trauma but its ongoing effects on stress reactivity that cause current difficulties [14]. There is also the phenomenon of arousal non-concordance, where physiological genital response occurs without subjective desire or pleasure, which is more common in trauma survivors and reflects the broader dissociation from bodily experience that trauma produces [15].

C. Orgasmic Difficulties

Difficulty reaching orgasm is frequently reported among survivors. Orgasm involves a degree of surrender and loss of control that can feel genuinely threatening for someone whose survival depended on staying vigilant. Shame-based cognitions generate anxiety that interrupts the physiological process, while somatic dissociation makes it hard to experience the escalating arousal that leads to orgasm [16].

D. Sexual Pain Disorders

Vaginismus and dyspareunia are both associated with trauma histories, particularly histories of sexual abuse. Vaginismus can be understood as a conditioned defensive response, where the body learned to protect itself from penetration associated with harm. Research has found links between trauma history, insecure attachment, and somatisation in women presenting with dyspareunia, suggesting the body's encoding of traumatic experience manifests in physical ways directly relevant to sexual functioning [17].

E. Risky and Compulsive Sexual Behaviour

Some survivors engage in sexual behaviour that feels out of control or risky in ways that cause distress. Steil et al. [18] describe how specific trauma-related beliefs drive these patterns - for example, the belief that one is obligated to provide sex in order to receive care, or that one's worth is essentially sexual. These behaviours may also serve an affect-regulation function or represent an unconscious repetition of early relational dynamics.

F. Emotional Intimacy

Perhaps the most pervasive impact of childhood trauma is on emotional intimacy itself. Many survivors find it genuinely difficult to feel safe being vulnerable with a partner, to trust, or to stay emotionally present when closeness increases. Research has found that trauma survivors consistently report lower sexual satisfaction and higher relational distress than non-survivors, findings partly explained by attachment insecurity and self-criticism [12], [17].

4. Types of Childhood Trauma and Their Effects on Intimacy

While all forms of childhood trauma carry risk for adult sexual and relational difficulties, different types tend to produce somewhat different patterns of impact.

A. Childhood Sexual Abuse

Childhood sexual abuse (CSA) is the most direct pathway to adult sexual dysfunction because it involves a violation of bodily and sexual integrity specifically. CSA covers a wide range from non-contact abuse to penetration, with intra-familial abuse tending to produce more severe and longer-lasting effects due to betrayal by a trusted person. The mechanisms include direct association between sexual experience and fear or coercion, disruption of healthy sexual self-concept, intense shame, and conditioned bodily responses like vaginismus or dissociation during sex that remain long after the abuse ends [16]. The developmental stage at which abuse began, its duration, the relationship to the perpetrator, and whether supportive adults were available all moderate the severity of long-term impact [4].

B. Physical Abuse

Physical abuse produces PTSD, difficulties regulating emotions, and insecure attachment, all of which carry consequences for sexual and relational functioning. Survivors may develop hypervigilance around physical contact, difficulty tolerating closeness, or conditioned fear responses to touch. In India, the national child abuse study found physical abuse to be the most common form of maltreatment, with the majority of abused children identifying a parent as the perpetrator [31], underlining its clinical significance in the Indian context.

C. Emotional Abuse and Neglect

Emotional abuse and neglect are often less visible than other forms of maltreatment but are no less damaging. Their impact operates primarily through disrupted attachment and a damaged sense of self-worth. Adults with these histories frequently carry chronic shame, fear of rejection, and a deep-seated belief that they are undeserving of care or pleasure, all of which affect sexual self-esteem and the capacity for intimacy [19].

D. Exposure to Domestic Violence

Children who grow up watching intimate partner violence between caregivers absorb powerful lessons about what close relationships look like. Even without being directly abused, they learn that love and danger can coexist, and that intimacy is unpredictable. These early relational templates shape adult partnerships, sometimes through fear and avoidance of closeness, and sometimes through an unconscious tendency to repeat familiar patterns [34].

5. Assessment in Trauma-Informed Sex Therapy

Good assessment is not just about gathering information. In trauma work, how assessment is conducted matters as much as what is covered. The goal is to create conditions where clients feel safe enough to share, while gathering what is needed to understand the clinical picture.

A. The Clinical Interview

A trauma-informed approach to interviewing puts safety first: being clear about confidentiality, moving at the client's pace, normalising what the client shares, and making sure they know they are in control of how much they disclose and when [20]. Clinicians need to routinely ask about trauma history and take a careful sexual history covering development, current and past functioning, relational context, and how the client understands what is happening for them. Asking about sexual concerns reduces shame rather than increasing it - when a

clinician brings something out of silence into the therapeutic space, it signals that the subject can be discussed without judgment.

B. Validated Assessment Tools

For trauma history, the Childhood Trauma Questionnaire Short Form (CTQ-SF) [19] provides a brief validated measure of five types of childhood maltreatment. The ACE Questionnaire [1] captures cumulative adverse childhood experiences. The PCL-5 is widely used for PTSD symptom measurement. For sexual functioning, the Female Sexual Function Index (FSFI) [35] covers desire, arousal, lubrication, orgasm, satisfaction, and pain in women, and the International Index of Erectile Function (IIEF) [36] provides parallel assessment for men. These tools should always be introduced carefully and embedded in the therapeutic relationship.

C. Relational Assessment

Where a client is in a relationship, understanding that relationship as part of the assessment is important. A partner who responds to sexual difficulties with frustration or pressure can significantly worsen a survivor's distress, while a supportive and patient partner can be one of the most important protective resources available. Understanding the quality of communication, how safe the client feels, and what the partner knows about the client's history will shape the treatment approach considerably.

6. Therapeutic Approaches

There is no single treatment that addresses all the ways in which childhood trauma disrupts adult sexual functioning. What the evidence points toward is an integrated, multi-level approach working across cognitive, emotional, somatic, relational, and cultural dimensions.

A. Trauma-Informed Care

Trauma-informed care (TIC) is not itself a technique but an overarching philosophy that should underpin all clinical work. SAMHSA [20] identifies six core principles: safety, trustworthiness and transparency, peer support, collaboration, empowerment and choice, and cultural sensitivity. Applied to sex therapy, this means never treating a client's sexual responses as pathological without first understanding them in the context of their history, and consistently framing difficulties as responses to what happened rather than as personal failings.

B. Trauma-Focused Cognitive Behavioural Therapy (TF-CBT)

TF-CBT is among the most researched trauma treatments and is recommended by the WHO and the UK's National Institute for Health and Care Excellence for PTSD across age groups. It combines cognitive restructuring, trauma narrative work, affect regulation skills, and behavioural components within a phased framework [21]. For trauma-related sexual difficulties, cognitive restructuring can directly target shame-based beliefs, beliefs about sexual danger, and self-blame schemas that maintain sexual difficulties. A randomised controlled trial comparing TF-CBT with EMDR in women who had experienced childhood sexual abuse found significant reductions in re-experiencing, avoidance, and emotional dysregulation, as well as improvements in overall quality of life [22].

C. Eye Movement Desensitisation and Reprocessing (EMDR)

EMDR, developed by Francine Shapiro [23], is a frontline treatment for PTSD recommended by both WHO and NICE. Its theoretical basis lies in the Adaptive Information Processing model, which proposes that traumatic memories stored in unprocessed, fragmented form are processed and integrated through bilateral stimulation, typically guided eye movements. If sexual contexts trigger fragmented traumatic memories or conditioned fear responses, processing those memories directly should reduce their capacity to intrude on present experience. EMDR has been adapted within an attachment-focused framework to address not just traumatic memories but relational disruptions shaping sexual functioning [24]. A recent clinical text has formalised EMDR protocols specifically for sexual dysfunction [25], and the randomised controlled trial by Molero-Zafra et al. [22] showed EMDR produced particular strengths in reducing dissociation and improving quality of life.

D. Somatic Therapies

Trauma is not only psychological - it is physiological. The nervous system learns defensive patterns, muscles hold chronic tension, and the capacity to be present in the body gets severely disrupted. Somatic approaches, including Somatic Experiencing [26] and Sensorimotor Psychotherapy [27], work directly with these bodily dimensions, helping clients gradually restore autonomic regulation. For survivors of sexual trauma specifically, somatic approaches offer a way back into the body as a place that feels safe rather than dangerous. Kearney and Lanius [10] argue that the brain-body disconnect in trauma requires somatic intervention, because talking about what happened is often not sufficient to restore embodied safety.

E. Sex Therapy Techniques

Sensate focus, developed by Masters and Johnson [28], involves structured exercises where couples explore physical touch progressively without pressure around performance or sexual outcome, aiming to reduce anxiety and rebuild safety in physical contact. Recent work has specifically examined how sensate focus can be adapted for sexual abuse survivors, emphasising gradual pacing, explicit consent at every step, and an approach that respects the survivor's window of tolerance. Mindfulness-based approaches have also shown promise: Brotto et al. [29] found improvements in arousal concordance following mindfulness-based sex therapy, suggesting mindfulness specifically addresses dissociative processes impairing embodied sexual experience.

F. Couple Therapy

Where a survivor is in a committed relationship, working with the couple together is often an important part of treatment. Emotionally Focused Couple Therapy (EFT) [30], grounded in attachment theory, focuses on identifying and shifting negative interactional cycles that maintain relational distress, building a

more secure emotional bond between partners. Research has found that childhood maltreatment is associated with poorer couple-level sexual outcomes, reinforcing the case for relational intervention as part of any comprehensive treatment plan [17].

7. Cultural Considerations: The Indian Context

Culture shapes how trauma is experienced, how it is disclosed, and how it is treated. For clinicians in India, this is not a peripheral consideration - it sits at the centre of the work.

A. Stigma and Silence

In India, open discussion of sexuality remains largely absent from most social, familial, and medical contexts. This silence becomes even more pronounced in relation to sexual abuse. Families frequently choose concealment over addressing what has happened, and survivors, particularly girls and women, are often silenced through the shame that attaches to victimisation. Family honour, female purity, and social reputation are all implicated in ways that make disclosure extremely difficult [31].

Many survivors reach adulthood without having disclosed their abuse to anyone. When sexual difficulties emerge, they often have no framework for understanding why. Research on ACEs in India has demonstrated significant rates of childhood maltreatment across socioeconomic groups, with clear associations between adversity and risk behaviours in adolescence and young adulthood [31], [32], this is not a marginal clinical issue.

B. Gender and Power

The socialisation of girls and women into roles emphasising compliance and deference intensifies shame responses following abuse and reduces help-seeking. Within marriage, significant pressure can exist on women to remain sexually available regardless of their own distress or history - a dynamic that actively re-traumatises survivors. Male survivors face equally constraining cultural pressures: dominant constructions of masculinity in India render victimisation deeply incompatible with male identity, making it extraordinarily difficult for men to acknowledge abuse or seek help [31].

C. Clinical Capacity and Access

The infrastructure for trauma-informed sex therapy in India is still at an early stage. Sex therapy is not established as a distinct clinical specialty, and psychosexual concerns are frequently addressed by practitioners with limited training in either trauma or sexuality. As counselling psychology programmes grow in India, there is a real opportunity to build this capacity by deliberately integrating trauma-informed and sexuality-focused frameworks into curricula. The expansion of teletherapy platforms has also begun to extend access to psychological services, though privacy in shared living situations remains a practical concern [22].

8. Challenges and Future Directions

A. Research Gaps

Despite growth in research on trauma and sexual functioning, significant gaps remain. Most studies have focused on women and on childhood sexual abuse, leaving male survivors, LGBTQ+ survivors, and survivors of non-sexual forms of trauma less represented. Long-term longitudinal research tracking the developmental trajectory of trauma's effects on sexuality is rare. Perhaps most significantly for those working in India, there is very little research from non-Western contexts, meaning clinicians largely work with frameworks generated in settings that may not fully reflect the realities of their clients [31].

B. Training Needs

The shortage of clinicians trained in both trauma and sexuality is one of the most pressing practical challenges in this field. These are two specialist domains and training programmes rarely integrate them. Developing pathways that equip mental health professionals to work competently at this intersection, with cultural sensitivity, should be a professional priority - particularly in India, where even generalist trauma training is not yet universal.

C. Prevention and Public Awareness

Addressing the long-term effects of childhood trauma on sexuality also requires upstream work. Age-appropriate education about healthy relationships, bodily autonomy, and consent; public mental health campaigns that reduce stigma; and support for parents and caregivers around trauma-informed responses to children's distress all have a role to play. In India, where silence around abuse is so deeply entrenched, community-level engagement and advocacy are essential alongside individual clinical intervention [32].

9. Conclusion

Childhood trauma does not stay in the past. It travels with survivors into adulthood, shaping how they experience their own bodies, how they relate to partners, what pleasure feels like, and whether intimacy feels safe. This review has shown that the routes through which early adversity affects adult sexuality are multiple and interconnected: disrupted attachment, an altered nervous system, powerful beliefs about sex and the self, and the way trauma becomes encoded in the body long after the original experiences have ended.

What matters clinically is recognising that these difficulties are not signs of permanent damage or personal weakness. They are coherent responses to experiences that were genuinely harmful. And they are treatable. The range of evidence-based approaches now available - including TF-CBT [21], EMDR [22], [23], somatic therapies [26], [27], mindfulness-based sex therapy [29], and emotionally focused couple therapy [30] - gives clinicians a genuine toolkit for this work, provided those approaches are used within a framework that consistently prioritises safety, collaboration, and the gradual rebuilding of trust in one's own body and in other people.

For those training and practicing in India, building competence in trauma-informed sexual health work is not optional - it is part of what it means to offer genuine care to survivors. As Herman [2] wrote, the study of trauma is inseparable from the study of recovery. Understanding the profound ways that early harm disrupts adult intimacy and sexuality is a necessary foundation for the clinical work of helping people heal.

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