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As we move into the 21st century, information about sex is widespread and more accessible to the general public than ever before. This interest in sex also increases the focus on symptoms and patterns associated with sexual problems. However, the etiology of sexual dysfunction is multifaceted and poorly understood. One factor that has received growing attention is the role that early sexual abuse plays in sexual development and later sexual functioning, and how these associations differ between males and females. Despite high prevalence rates of child sexual abuse (CSA), which occurs to approximately 1 in 3 females and 1 in 10 males under the age of 18, we do not completely understand the complexities of how and to what extent CSA affects sexual functioning. Nonetheless, the research highlights the need to recognize the potentially powerful influence that abusive childhood experiences contribute to sexual health, performance, and satisfaction. We review research on the relationship between CSA and adolescent and adult sexual functioning. We use a developmental framework to guide our understanding of the effects of CSA, as well as gender and ethnic differences, on the sexual functioning of male and female survivors.

Key words: adolescents, child sexual abuse (CSA), sexual dysfunction, sexual functioning.

As we move into the 21st century, information about sex is more accessible to the general public than ever before. Barriers to sexual knowledge have been reduced, due, in part, to explicit television programming and the accessibility of computer-driven information. As a consequence, access to information about diverse sexual experiences is more readily available. There is also a growing awareness and acceptance of a myriad of lifestyle choices, including same-sex unions. Sexual functioning today is increasingly defined by sexual response and dysfunction, including sexual arousal, satisfaction, and ability to reach orgasm (Berman, Berman, Bruck, Pawar, & Goldstein, 2001). Interest

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in sexual performance also increases the focus on the symptoms and patterns associated with factors that contribute to problems in achieving sexual pleasure. However, the etiology of sexual dysfunction is multifaceted and often poorly understood. One factor that has received growing attention in the United States during the last 25 years is the role that early sexual abuse plays in sexual development and later sexual functioning, and how these effects differ for females and males.

Significant associations have recently been documented between CSA and HIV-risk behaviors (Bensley, Van Eenwyk, & Simmons, 2000; Wyatt, Vargas-Carmona, Loeb, Ayala, & Chin, 2002). Some researchers have suggested that a "continuum of victimization" exists, with early abuse experiences being associated with greater sexual risks, including revictimization (Wyatt, Vargas-Carmona, et al., 2002). More research is needed to understand these associations and to construct culturally congruent primary and secondary prevention messages tailored to children at risk for disruptions in sexual development. Programs are also needed to ameliorate the disruptions in sexual development that are associated with child sexual abuse (CSA; Wyatt, Vargas-Carmona, et al., 2002). A thorough review of the associations between CSA and adolescent and adult sexual functioning is needed to develop effective and appropriate interventions.

Based on developmental theory (Hughes, 2000; Tharinger, 1990; Tharinger & Lambert 1999), we can assume that adolescent and adult sexual functioning are greatly affected by prior sexual development. Both risk and protective factors affect this development (Hughes, 2000). We use a developmental framework to guide our understanding of the effects of CSA, as well as gender and ethnic differences, on the sexual functioning of female and male survivors.

The preparation of this manuscript involved conducting literature searches from the PsychInfo, Medline, and Social Science databases. We included all studies written in English that were conducted during the past 2 decades. This is the period that has produced the greatest proliferation of research conducted on CSA and during which CSA and its relationship to sexuality has received the most attention. These literature searches included the following key words: child sexual abuse and long-term effects, adolescent development, adolescent pregnancy, pubertal timing, puberty, sexually transmitted diseases, sexuality, sexual development, sexual functioning, early onset sexual activity, sexual risk-taking behaviors, revictimization, psychobiological development, psychoneuroimmunology, male sexual abuse, sexual dysfunction, vaginismus, dyspareunia, painful intercourse, orgasm dysfunction, and HIV. We also searched by various authors known to us in the CSA literature.

Background on Child Sexual Abuse

Although the association between CSA and psychological and behavioral problems among children has been well documented, consensus has yet to be established regarding the effects of CSA on children's sexuality (Tharinger, 1990). Researchers (e.g., Friedrich, 1988; Friedrich, Urquiza, & Beilke, 1986) have reported that abuse incidents do not affect all children uniformly; rather, the child's age, severity and frequency of abuse, relationship of the perpetrator to the child, and number of perpetrators are some of the factors that influence the child's reaction to the abuse. Symptoms displayed by sexually abused children include varying degrees of inappropriate sexual knowledge and sexually aggressive behaviors, increased sex play with peers, and excessive masturbation (Adams, McClellann, Douglass, McCurry, & Stork, 1995; Carrey & Adams, 1992; Cosentino, Meyer-Bahlburg, Alpert, Weinberg, & Gaines, 1995; Friedrich, 1988; Kohan, Pothier, & Norbeck, 1987; Mills, Rieker, & Carmen, 1984; Zeanah & Hamilton, 1998). These symptoms present extra burdens for children as they struggle to meet normal sexual developmental challenges.

Reaching consensus regarding the effects of CSA on sexual development is also made more difficult by methodological variations across studies, including sample characteristics, sampling techniques, and data collection methods (Wyatt & Peters, 1986b). Most research on the effects of CSA has been conducted with small, clinical samples (Siegel, Sorenson, Golding, Burnam, & Stein, 1987). However, in several large, community-based samples, the long-term associations between CSA and women's health, and psychological, interpersonal, and sexual functioning have been documented (Russell, 1984; Siegel et al., 1987; Wyatt, 1985; Wyatt, Loeb, Romero, Solis, & Vargas-Carmona 1999; Wyatt, Vargas-Carmona, et al., 2002). Despite a focus on the long-term effects of CSA on adult females, little is known about how CSA impacts the development of sexuality among adolescent females and males, and adult males (McCarthy, 1998). In this article, we will review the extant literature examining associations among CSA and adolescent and adult sexual functioning.

The Definition of Child Sexual Abuse

Definitions of CSA vary according to the types of sexual behavior included in the definition, the upper limit placed on the victim's age at the time the abuse occurred, and the criteria used to define the incident as abusive (Wyatt & Peters, 1986a). Wyatt (1985), in her examination of the prevalence of CSA in a random community sample of women in Los

Angeles County, initially defined CSA as sexual body contact prior to age 18 by someone of any age and relationship to the victim. More recently, two additional exclusion criteria were used to distinguish CSA from exploratory sexual experimentation before age 12 or consensual sexual activity with peers (Wyatt et al., 1999; Wyatt & Newcomb, 1990). Incidents were considered sexual abuse if (a) the age difference between the alleged perpetrator and victim was more than 5 years; or (b) the age difference was less than 5 years, but the contact was not desired or was coercive. For a more thorough discussion of issues in the definition of CSA see Wyatt and Peters (1986a).

The Types and Prevalence of Child Sexual Abuse Incidents

Child sexual abuse is a widespread and underreported problem (Summit, 1983). Researchers have confirmed that many more children are sexually abused than are reported to authorities (Green, 1996; Siegel et al., 1987). Wyatt et al. (1999) reported contact abuse incidents ranging in severity from those that were less severe (fondling and frottage) to very severe (digital penetration and attempted or completed oral sex, anal sex, or rape). A commonly reported estimate of the prevalence of CSA in the United States is approximately 33% in community samples of females under the age of 18 (Finkelhor, 1994a; Wyatt, Guthrie, & Notgrass, 1992; Wyatt et al., 1999) and approximately 5%-10% in males under 18 years of age (Finkelhor, 1994a). Research has been conducted examining the stability of prevalence rates, with some results suggesting that the prevalence of CSA among females has remained stable over time (Wyatt et al., 1999).

The Relationship of Ethnicity and Culture to CSA

Few studies have focused on ethnic differences in CSA (Behl, Crouch, May, & Valente, 2001; Lindholm & Willey, 1986). In fact, a content analysis of over 1,000 articles in child abuse journals revealed only "modest" improvement in attention to ethnicity issues over a 20-year span, with fewer than seven percent addressing the issue of ethnicity (Behl et al., 2001). Researchers often fail to report the ethnicity of their samples (Hornberger et al., 1995; Mennen, 1995). Although race and ethnicity have not received adequate attention in the area of CSA (Lindholm & Willey, 1986; Mennen, 1995), they are important issues to address because the sociocultural context in which CSA occurs influences definitions of sexual abuse, initial reactions to the abuse, the meaning the abuse has to the victim, the effects of disclosure, and associated symptomatology (Mennen, 1992; Wyatt, 1990, 1992). Epidemiological studies with female CSA survivors have been primarily limited

to European American women (Mennen, 1995). Similarly, the focus of research with male CSA survivors has also been on men of European American origin (Hall, Matthews, & Pearch, 1998; Sarwer, Crawford, & Durlak, 1997).

Researchers generally suggest that few differences exist in prevalence rates among African American, Latina, and European American women with histories of CSA (Mennen, 1994; Romero, Wyatt Loeb, Vargas-Carmona, & Solis, 1999; Roosa, Reinholtz, & Angelini 1999; Russell, 1984). Wyatt (1985) reported similar prevalence rates of CSA across African American, Mexican American, Native American, and non-Hispanic White women. Similarities in prevalence rates suggest that ethnic background is not a risk factor for CSA. However, the circumstances surrounding abuse incidents and how they are processed by individuals and their families have been hypothesized to differ by ethnicity (Romero et al., 1999). Longitudinal studies (specifically, with ethnic minority males and females who vary on a variety of demographic characteristics) are needed to understand how CSA relates to and affects the psychological and sexual health of ethnic minority women (Romero et al., 1999).

Despite being the fastest growing ethnic group in the United States, Latinas have received little attention, and differences between Latina and European American women's rates of CSA have been contradictory (Romero et al., 1999). In some studies, no differences in prevalence rates for Latinas have been documented (Mennen, 1994; Romero et al., 1999; Russell, 1984), whereas, in others, lower rates have been obtained (Urquiza & Goodlin-Jones, 1994).

Despite similarities in prevalence rates, differences in the circumstances of abuse incidents have also been documented (Wyatt et al., 1999). In community samples of African American, Latina, and European American women in Los Angeles County, differences have been noted in type of sexual abuse, with European American women significantly more likely than African American women to report being raped in childhood (Wyatt et al., 1999). Some researchers have documented conflicting results regarding ethnic differences in the age of the victim at the time the abuse occurred (DeJong, Hervada, & Emmett, 1982; Wyatt, 1985); however, no differences were noted in a more recent community sample (Wyatt et al., 1999). These discrepancies may be due to differences in sampling and age classification between studies (Wyatt et al., 1999). Ethnic group comparisons in this study, however, were limited to African American, Latina, and European American women in Los Angeles County. Confirmation of these findings regarding the circumstances of abuse using representative community samples of CSA

survivors is needed. The inclusion of a more comprehensive sampling of ethnic minority women, including Asian, Pacific Islander and Native American women, is also necessary to understand issues pertaining to possible ethnic differences in CSA.

Association of CSA and Adolescent Female Sexual Functioning

Sexual abuse research has been focused primarily on females, children and adults; less attention has been given to adolescents. For female adolescents, normative development includes sexual development, sexual decision-making, and forming satisfying romantic relationships. Early sexual abuse may compromise this developmental trajectory in complicated ways that researchers are just beginning to address. Sexual abuse may also interfere with the psychological and biological processes of pubertal development, and it may add increased stress and difficulty to this phase of development (Trickett & Putnam, 1993).

Physiological Effects of CSA

In the last decade, researchers have examined the impact of chronic sexual abuse and other trauma on physiological functioning. It appears that there may be biochemical abnormalities associated with early chronic sexual abuse, including the dysregulation of physiological stress response systems and increased urinary catecholamine excretion (DeBellis, Burke, Trickett, & Putnam, 1996; DeBellis, Lefter, Trickett, & Putnam, 1994). In their sample of 8- to 15-year-old girls from a prospective, longitudinal study, DeBellis and colleagues compared 12 sexually abused girls to 9 matched controls. When controlling for height, the abused girls had significantly higher homovanillic acid excretion. Overall, results indicate higher catecholamine functional activity among sexually abused girls compared to controls. Further, Herman-Giddens, Sandler, and Friedman (1988) speculated that there may be an association between sexual abuse and an early onset of puberty based on 7 out of 105 sexually abused girls under 10 years developing secondary sexual characteristics before the age of 8.

Trickett and Putnam (1993) conceptualize chronic sexual abuse as a repetitive stressful event that can activate the hormonal markers of the stress response, including elevated cortisol, androstenedione, and dehydroepiandrosterone levels, and decreased levels of luteinizing and testosterone levels. They hypothesized that female victims of sexual abuse may have hormonal levels that may be associated with increased sexual behaviors. These possible physiological and biochemical associations, including earlier puberty and differences in hormonal levels, are of particular relevance for female sexuality given that early puberty and increased

sexual behaviors are also associated with early sexual intercourse (Miller, Benson, & Galbraith, 2001) and coercive sexual experiences (Vicary, Klingaman, & Harkness, 1995) in adolescence. However, more empirical data are needed to validate these hypothesized associations.

In medical settings, common physical complaints of sexually abused female children and adolescents include genital abnormalities (e.g., discharge, bleeding, pruritis, skin lesions, and trauma), genital infections or sexually transmitted infections (STIs), recurrent urinary tract infections, abdominal pain, and pregnancy (Jenny, 1996). These physical symptoms represent a host of problems that sexually abused adolescents are forced to address at an earlier age than otherwise expected. Having to confront these difficulties may exacerbate the normal difficulties of adolescent development involving sexual maturation, the development of secondary sex characteristics, and the challenges inherent in grappling with a changing body and body image (Sroufe, Cooper, & DeHart, 1992; Trickett & Putnam, 1993).

Along with physiological associations and physical symptoms, various theorists have suggested that sexual victimization may have an impact on female sexuality by impairing sexual decision-making, sexual behaviors, and risk taking. Yates (1987) explained that victims of chronic sexual abuse may become hyperaroused due to the frequency of sexual contact. Further, Finkelhor and Browne (1986) asserted that sexual abuse may lead to traumatic sexualization whereby the victim learns to behave in sexually inappropriate ways, either through positive or negative reinforcement.

High-Risk Sexual Behaviors

High-risk sexual behaviors, which may result in negative sexual outcomes, such as pregnancy and STD/HIV infection, have been associated with sexual victimization. For example, engaging in consensual sexual activity at an earlier age has been reported among female adolescents who were victims of sexual abuse (Mason, Zimmerman, & Evans, 1998; Taylor-Seehafer & Rew, 2000). Engaging in early consensual sexual activity may result from the physiological disruptions and hyperarousal described above. Psychological factors, including attempts to regain self-esteem, attention, power and control, and/or an impaired ability to resist a sexual request have also been noted (Lee, 1995). Along with early sexual initiation, researchers have also reported that adolescent females with histories of sexual abuse are less likely to use contraception, compared to nonabused counterparts (Mason et al., 1998) and are more likely to engage in HIV-risk behaviors (Elze, Auslander, McMillen, Edmond, & Thompson, 2001; Lodico & DiClemente, 1994).

An important negative sexual outcome that may result from CSA and the behaviors described above is pregnancy (Chandy, Blum, & Resnick, 1996). Elders and Albert (1998) suggested that teen pregnancy may be an indicator of chronic sexual abuse and ongoing coercive sexual experiences among adolescent females. In a study by Silverman, Raj, Lorelei, and Hathaway (2001), adolescent relationships involving violence were also found to predict various negative outcomes, including sexual risk behaviors and pregnancy. In a community sample of adolescent mothers, over half reported sexual abuse (Butler & Burton, 1990). Similarly, in a longitudinal study of 520 females from a New Zealand birth cohort, Fergusson, Horwood, and Lynskey (1997) found that by the age of 18 years, women with histories of sexual abuse had engaged in earlier sexual intercourse; had higher pregnancy rates, more sexual partners, and more STDs; and were more likely to have engaged in unprotected sex and to have experienced sexual revictimization.

The health of a pregnant adolescent may also be compromised by a sexual abuse history. Stevens-Simon and McAnarney (1994) found that among a sample of 127 (42 abused and 85 nonabused) poor African American adolescents, those with abuse histories reported more stress, depression, substance use during pregnancy, and less social support than their nonabused pregnant peers. These results may account for the additional finding that these abused pregnant teens had significantly smaller, less mature babies, compared to their nonabused pregnant peers. For example, the average birth weight for babies from the abused adolescent was 2904 kg and the average gestational age was 38 weeks, versus an average weight of 3198 kg for babies from the nonabused cohort and an average gestational age of 39.1 weeks. However, given the limited sample used in this study, more studies are needed using larger samples with diverse ethnic and demographic backgrounds in order to better understand the relationship between histories of sexual abuse and risks for early pregnancy.

Sexual abuse can also result in sexually transmitted infections (STI), which can be transmitted either directly from the perpetrator or indirectly from the impact that sexual abuse has on adolescent sexuality and sexual behaviors. Tyler, Whitbeck, Hoyt, and Yoder (2000) reported that early sexual abuse was associated with STIs and risky sexual behaviors among a group of homeless and runaway female adolescents. In another study of homeless adolescents, Noell, Rohde, Seeley, and Ochs (2001) reported a cycle of compromised sexual development in which early sexual abuse was associated with greater sexual coercion, which was associated with more partners and higher rates of STIs. Although these findings have yet to be replicated among more representative samples,

the results demonstrate how sexual abuse victimization might propel adolescent females into patterns resulting in negative sexual outcomes.

Researchers investigating precursors to prostitution have focused primarily on retrospective reports of adults. However, in some studies that included adolescent prostitutes, sexual abuse has been described as a contributing factor (Simons & Whitbeck, 1991). When comparing a group of prostitutes and nonprostitutes, Earls and David (1990) found that male and female prostitutes were more likely to have a significant history of CSA. Although researchers have documented an association between CSA and increased sexual behaviors in adolescence, they have also noted other effects, including social isolation and sexual aversion (Downs, 1993). In addition, feelings of shame and self-blame may result in sexually abused adolescents experiencing difficulties in forming satisfying friendships and romantic relationships (Feirling, Rosenthal, & Taska, 2000). Finkelhor and Browne's (1986) model of traumagenic dynamics of sexual abuse, particularly being stigmatized as a victim, may account for these problems with interpersonal functioning. Adolescents who feel like "damaged goods" may be more likely to isolate themselves from peers they perceive as nonvictims. Further, adolescent girls who engage in romantic relationships may begin to experience symptoms of Post Traumatic Stress Disorder (PTSD), including flashbacks and intrusive thoughts during intimacy and sexual interactions. Thus, the effects of past experiences can reemerge as adolescents progress through normal phases of sexual and social development. However, the degree to which the effects of these experiences can have lasting effects depends on many environmental, family, and personal factors.

Abuse Survivors as Perpetrators

Female victims of sexual abuse may also perpetrate on other children (Gil & Johnson, 1993) and demonstrate greater sexual aggression (Kisiel & Lyons, 2001). Sexual perpetration by children or adolescents is distinct from age-appropriate sexual exploration that is normal according to their developmental stage. Perpetration of sexual abuse is defined by sexual activity that involves coercion; inappropriate sexual behaviors, such as anal or vaginal penetration; and/or sexual activity between children with a significant age discrepancy. Other factors that distinguish inappropriate from age-appropriate sexual play include disparity in physical size, status differences (i.e., an older child designated as a babysitter), and the use of threats, force, and dominance (Gil, 1993).

There are significantly fewer female adolescent sexual abuse perpetrators than males (Blues, Moffatt, & Telford, 1999), and unlike the case

for males, researchers have found that almost all (100%) of female perpetrators report a history of sexual abuse (Becker, 1998; Johnson, 1993). Such perpetration by survivors of sexual abuse may be a reaction to their earlier trauma through sexually abusive and aggressive means (Cunningham & MacFarlane, 1991). Another possible interpretation of these findings is that survivors are attempting to master the traumatic experience by identifying with the dominant perpetrator rather than the victim (Van der Kolk, 1989). Although there are many similarities between male and female perpetrating adolescents in the manner in which they abuse (Blues et al., 1999), Johnson (1993) reported that female perpetration is associated with a more severe history of sexual abuse (e.g., chronic abuse, sexual penetration, intrusion, and interfamilial ties) compared to males.

Association of CSA and Adult Female Sexual Functioning

It is important to examine sexuality in the context of interpersonal functioning and to understand the relationship between CSA and both individual and relationship adjustment. Researchers examining the association of CSA with women's sexual functioning describe conflicting findings. In some studies, more pervasive and diverse effects on sexual functioning have been documented (e.g., Elliott & Briere, 1992; Kinzl, Trawager, & Bieble, 1995; Laumann, Paik, & Rosen, 1999; Sarwer & Durlak, 1996). In other studies more modest effects have been reported (see Rind, Tromovitch, & Bauserman, 1998), and in still other, no effects were reported (Greenwald, Leitenberg, Cado, & Tarran, 1990). In their review of the long-term correlates of CSA, Polusny and Follette (1995) reported that CSA was associated with a greater prevalence of sexual disorders in adulthood. Elliott and Briere (1992), studying a sample of professional women, found that women with a history of CSA reported more sexual problems, particularly if the abuse involved parental incest and was experienced frequently. In a study of couples seeking sex therapy, reports of sexual dysfunction (such as sexual desire disorder and inhibited female orgasm) were higher for women who had experienced CSA, particularly if the abuse involved sexual penetration and force (Sarwer & Durlak, 1996). Kinzl, Traweger, and Biebl (1995) also noted that university women with a history of CSA were more likely to report sexual desire, arousal, and orgasm disorders, particularly if they had experienced multiple incidents of CSA. Further, college women with a history of CSA also reported more negative attitudes about sexuality (Johnsen & Harlow, 1996). Much of the research on female sexual dysfunction focuses on measures of sexual performance, examining symptoms, including low sexual desire or arousal, orgasmic dysfunction, and

vaginismus. However, a focus on symptoms alone, without an examination of their context and etiology, reveals little valuable information about the possible effects of sexual abuse on sexual functioning. More specific details about what aspects of sexual functioning may be affected should be most useful to the sex therapist whose clients may disclose sexual problems.

An examination of CSA proved particularly relevant in a study conducted by Berman et al. (2001). Berman et al. examined the efficacy of sildenafil (Viagra), a drug used to treat arousal disorders in men, for women with and without a history of CSA who sought treatment for sexual dysfunction. This drug was effective in increasing sexual arousal (including lubrication, genital sensation, satisfaction with intercourse, and orgasm) for women who had no history of CSA, but not for women with CSA histories. These findings illustrate the importance of taking sexual histories into consideration when treating female sexual dysfunction. When sexual dysfunction has its roots in childhood trauma, a pharmacological intervention may prove ineffective in resolving sexual symptoms; a more extensive exploration and confrontation of the psychological, emotional, and relational issues that impact women's sexuality is needed.

In a study examining factors associated with sexual dysfunction for a random probability sample of sexually active women and men, Laumann et al. (1999) documented associations between sexual dysfunction and prior negative sexual experiences, including CSA. Women's sexual victimization in childhood was associated with arousal disorder and lubrication difficulties. For men, CSA was related to sexual dysfunctions such as erectile dysfunction, premature ejaculation, and low sexual desire. Indeed, the relationship between gender and the severity of sexual dysfunction is receiving more attention. In their meta-analysis of association of CSA with adjustment, Rind et al., (1998) found that the relation between CSA and adjustment problems was stronger for women than for men. However, because adjustment problems in this meta-analysis were operationalized as a composite of 18 measures of psychological adjustment that have been investigated in the literature (i.e. alcohol problems, anxiety, depression, dissociation, eating disorders, hostility, sexual adjustment, phobias, self-esteem, social adjustment, psychotic symptoms, etc.), it is impossible to ascertain gender differences in the relationship of CSA with any specific areas of adjustment. Although sexual adjustment (which includes sexual self-esteem, sexual functioning, and sexual arousability) was included in this meta-analysis as one of 18 measures of psychological adjustment, gender differences were not examined for the association of CSA with sexual

adjustment. When pooling together studies including men and women, CSA had a modest but significant association with sexual adjustment. As already noted, however, this index of sexual adjustment included diverse aspects of sexuality, such as sexual self-esteem, sexual arousability, and other measures of sexual functioning. Strong associations of CSA with one aspect of sexual functioning could be diluted by weaker associations of CSA with other aspects of sexual functioning. A review examining the relationship of CSA to specific problems in sexual functioning of women and men separately would better inform how CSA may influence sexual functioning. Other limitations included the use of student samples and inattention to ethnic diversity.

Survivors of CSA often find indirect ways to register the effects of these incidents. For example, CSA has also been associated with somatic complaints (see Polusny & Follette, 1995, for a review). Kinzl et al. (1995) found that repeated or severe CSA (intercourse) was associated with somatization disorder, specifically lower abdominal pain and painful menstruation. These findings are consistent with Walker et al.'s (1992) study of women scheduled for diagnostic laparoscopy (half for chronic pain and half for tubal ligation or infertility evaluation). They found that women with severe CSA (incest, rape, oral contact, or repeated fondling) were more likely to have unexplained medical symptoms, particularly chronic pelvic pain. In another study, Farley and Keaney (1997) found that the number of perpetrators, rather than the type or frequency of CSA, was related to physical symptoms. Somatization was also associated with dissociation for women with histories of CSA compared to women without CSA histories, suggesting that dissociation may play a role in translating traumatic memories into bodily symptoms. Participants in this study, however, were a sample of women requesting treatment at an outpatient psychiatry clinic. Additional research using more representative nonclinical samples is needed to examine the association of CSA with somatization, and the role of dissociation in somatic symptoms following CSA.

CSA can have lasting effects in the area of adult sexual relationships. In their review, Polusny and Follette (1995) reported that compared to women without a CSA history, CSA survivors face greater difficulties in interpersonal relationships, including less relationship satisfaction, greater sexual dissatisfaction, more high-risk sexual behavior, and greater likelihood of revictimization in adulthood, including adult sexual assault and partner violence. In addition, university women who reported a history of CSA also described less satisfaction with the quality of their past relationships (Bartoi & Kinder, 1998; Davis, Petretic-Jackson, & Ting, 2001) and increased trauma symptomology, including

sexual concerns, intrusive thoughts, and defensiveness (Davis et al., 2001) than women without CSA histories. Experiencing both sexual and physical abuse in childhood is also associated with more relationship problems and sexual difficulties (Davis et al., 2001; Mullen, Martin, Anderson, Romans, & Herbison, 1996); women who reported multiple types of childhood abuse described greater fears of intimacy, dysfunctional sexual behavior, and intrusive experiences than those who experienced no abuse and those who experienced either physical or sexual abuse alone (Davis et al., 2001).

CSA and Sexual Health

A history of CSA may also affect women's abilities to protect and to preserve their sexual health (Wyatt, Vargas-Carmona, et al., 2002). Women with CSA histories have higher utilization rates for general medical care, including more hospital admissions, emergency room visits, and surgical procedures than those with no history of sexual abuse (Kirkengen, Schei, & Steine, 1993; Salmon, & Calderbank, 1996; Smith & Smith, 1999; Toomey, Seville, Mann, & Abashian, 1995). Furthermore, a history of CSA is associated with significantly higher annual health care costs (Walker et al., 1999).

Researchers have reported that CSA survivors are more likely than a nonabused cohort to underutilize gynecological services and are less likely to seek routine gynecological care (Robohm & Bittenheim, 1996; Smith & Smith, 1999). They have also reported feelings of shame and vulnerability during gynecological visits (Robohm & Bittenheim, 1996). These negative feelings, combined with high levels of anxiety during routine exams and an inability to recognize important body symptoms and signals (Briere, 1992), may lead CSA survivors to delay receiving standard gynecological care on a preventive basis.

CSA and Sexual Risk Taking

Child sexual abuse appears to be associated with subsequent sexual risk-taking behaviors. For example, investigators have found that female survivors of CSA reported lower condom self-efficacy, and less frequent and more inconsistent use of condoms (Brown, Lourie, Zlotnick, & Cohn, 2000). Further, individuals with histories of CSA are more likely to have an earlier onset of sexual activity (Browne & Finkelhor, 1986; Donalson, Whalen, & Anastas, 1989; Riggs, Alario, & McHorney, 1990), to have more partners and sexual encounters (Wyatt, Loeb, Ganz, & Desmond, 2002), to be more likely to engage in prostitution (Widom & Kuhns, 1996), and to be less able to refuse unwanted sex and to make decisions about contraception (Heise, Moore, & Toubia, 1995; Johnsen & Harlow,

1996). Markers of greater sexual risk among CSA survivors include higher rates of unintended pregnancy, sexually transmitted diseases (STDs), and greater likelihood of becoming HIV positive (Carmona et al., 2002; Heise et al., 1995; Johnsen & Harlow, 1996; Wyatt et al., 1997).

In a recent study by Bensley and colleagues, women who had experienced early and chronic sexual abuse were seven times more likely to engage in certain HIV-risk behaviors and to have particular markers of risk, including intravenous drug use, sexually transmitted diseases (STDs), and anal sex without condoms (Bensley et al., 2000). Furthermore, experiencing both sexual and physical abuse in childhood appear to influence subsequent substance use, as well as sexual risk taking. Combined sexual and physical abuse was associated with sexual risk behavior and heavy drinking among women, whereas physical abuse alone was not associated with either outcome. A different pattern was noted in men, for whom physical abuse predicted both sexual risk and alcohol abuse. The gender differences speak to the unique and profound trauma of sexual abuse for women, and suggest a uniquely disrupted path of sexual development.

The results of ethnographic studies suggest that sexual and drug risks can reciprocally influence one another. For example, women with drug dependence problems may trade sex for drugs, which may further impair their judgments about sex and high risk-taking practices (Ratner, 1993). Women who are drug-addicted or dependent may also rely on drugs to cope with the emotional effects of CSA, thus hindering their chances of learning more effective coping skills.

CSA and Family Background

The context in which sexual abuse occurs is an important dimension that deserves more attention. Child sexual abuse perpetrated by a family member is often associated with having a dysfunctional and disrupted family background (Briere & Elliott, 1993; Kinzl et al., 1995; Mullen et al., 1996). Multiple types of abuse (sexual, physical, psychological) are often reported in the same family and may have a cumulative effect on the difficulties that survivors face (cf. Mullen et al., 1996). Some associations with CSA are similar to those of other types of child abuse, although unique effects have also been reported. In their study of a community sample of women, Mullen et al. (1996) found that a history of physical, sexual, or emotional abuse in childhood was associated with sexual difficulties, interpersonal problems, psychopathology, and low self-esteem, suggesting similarities in the effects of different types of abuse. Women reporting multiple types of abuse in childhood were especially likely to suffer negative mental health outcomes. Sexual abuse was also strongly associated with sexual

difficulties, as well as interpersonal problems, early pregnancy, low self-esteem, and poor mental health, even when controlling for associated family background factors (e.g., violence in the family). Sexual abuse was associated with sexual problems, physical abuse with marital breakdown, and emotional abuse with low self-esteem. These results are consistent with the findings of Briere and Runtz's (1990) study of the association of CSA with maladaptive sexual behavior, physical abuse with aggression, and emotional abuse with low self-esteem.

Sexual Revictimization

Sexual abuse that occurs once is likely to occur again. Many women experience sexual abuse both as children and as adults. In fact, a history of CSA is associated with a greater likelihood of later adult sexual revictimization (Johnsen & Harlow, 1996; Wyatt et al., 1992). For instance, Wyatt et al. (1992) found that women with a history of CSA were 2.4 times more likely to experience sexual abuse as an adult, including rape, attempted rape, and unwanted observation. CSA is also associated with more severe negative reactions and sexual dysfunction following adult sexual abuse (ASA). In a sample of sexually assaulted women recruited through referrals and advertisements, those with CSA histories were found to have greater difficulties communicating with their partners, problems with intercourse, low sexual desire, emotional detachment, orgasmic dysfunction, and anxiety and guilt about sex than those who experienced ASA only (Mackey et al., 1991). Sexual revictimization can also influence high-risk sexual behavior. In a community sample of African American and White women, Wyatt et al. (1992) reported that CSA survivors who experienced revictimization as adults had more unintended pregnancies and abortions. Women who experienced multiple incidents of both CSA and ASA reported more high-risk sexual behaviors. In a prospective study of African American women with documented histories of CSA, those who experienced revictimization in adulthood reported more painful intercourse, vaginal infections, and STIs than those who experienced only CSA (West, Williams, & Siegel, 2000). Survivors of CSA who experienced revictimization in adulthood also reported more painful intercourse, vaginal infections, and STIs than those who experienced only CSA (West et al., 2000).

Interpretations of these findings vary. Some investigators have found that CSA and ASA similarly disrupt sexual functioning, whereas others have found that associations with CSA are different than those of ASA. Becker, Skinner, Abel, and Treacy (1982) noted that women who had experienced incest as children were likely to have orgasmic dysfunction, but this did not occur for women who experienced only adult sexual

assault. This finding suggests that early childhood assault may inhibit the development of orgasmic capability. However, the sample in this study consisted of women reporting adult sexual assault and/or incest, recruited through advertisements and referrals, and did not include a group of women without abuse. Additional research is needed with more representative samples.

In sum, the association of CSA with sexuality is influenced by aspects of the abuse, and by other stressors and contextual factors. The association of CSA with sexual dysfunction is more pronounced for women who experience severe abuse (i.e., penetration, force, incest, multiple incidents), report family dysfunction or other types of child abuse (i.e., physical abuse), or who experience revictimization in adulthood. In addition, other emotional problems or stressors can increase the probability of sexual dysfunction (Laumann et al., 1999). These findings highlight the importance of examining the context of a person's past and present experiences when examining the influence of CSA.

Association of CSA with Adolescent Male Sexual Functioning

Despite an increased focus on CSA and its relationship to psychological and sexual sequelae, the association between CSA and its effects in adolescent male victims has only recently received attention as a subspecialty within the CSA field (Cermak & Molidor, 1996; Froning & Mayman, 1990). Thus, the relationship between CSA and the sexual functioning of adolescent and adult males is a relatively new and controversial area of research.

Researchers have reported prevalence rates varying between 4% and 76%, depending on definitions used and populations examined (Holmes & Slap, 1998). A commonly cited estimate of the prevalence of abuse among boys under the age of 18 is approximately 5%-10% (Finkelhor, 1994a). The results of studies demonstrating gender differences in the associations with CSA indicate the value of studying male CSA as an independent area of research.

Adolescent males report more pronounced effects of CSA than do adolescent females, including greater problems with alcohol and drugs, aggressive behaviors and criminal problems, and higher rates of suicidal thoughts and attempts (Garenski & Arends, 1998). Researchers also have suggested that adolescent males are more likely to report CSA experiences that include frequent and repeated penetrative acts and oral sex, whereas females are more likely to report fondling and incest (Pierce & Pierce, 1985). In general, however, females are almost three times as likely as males to experience any type of abuse in childhood or

adolescence, and are significantly more likely than males to have been sexually abused (Silverman, Reinherz, & Giaconia, 1996).

Negative consequences of early sexual abuse on the development of male children and adolescents have been documented, including increased anxiety, depression with suicidal thoughts and/or attempts, PTSD, problems with self-esteem and social adjustment, including mistrust, aggression, criminal behaviors, and substance abuse (Brier & Runts, 1987; Garenski & Arends, 1998; Ruggiero, Mcleer, & Dixon, 2000; Silverman et al., 1996; Threlkeld & Thyer, 1992). In a 17-year longitudinal study, Silverman et al. (1996) examined the relationship between childhood and adolescent physical and sexual abuse prior to the age of 18 and psychosocial functioning in mid-adolescence (age 15) and early adulthood (age 21). The community sample included 375 participants, of which 188 were males. Over five percent of the male sample reported physical or sexual abuse incidents by age 18. Specifically, 5.3% reported physical abuse and 1.1% reported sexual abuse. Of those who reported either physical or sexual abuse, 80% met the criteria for at least one psychiatric disorder, as defined by DSM-III-R (American Psychiatric Association, 1987). Similar prevalence rates of psychiatric disorders among sexually abused adolescents have been reported using other nonclinical samples (Ruggiero, Mcleer, & Dixon, 2000; Tebbutt, Swanston, Oates, & O'Toole, 1997).

Adolescent males with histories of CSA have been found to demonstrate more sexual acting out, sexual identity confusion, and higher rates of sexually transmitted diseases, including HIV, compared to their nonabused peers (Bartholow et al., 1994; Chesney, Folkman & Chambers, 1996; Doll et al., 1992; Martin & Hetrick, 1988; Romano & De Luca, 2001). Researchers suggest that adolescent males may eroticize CSA experiences and, subsequently, act out sexually. These males may also engage in dangerous or self-injurious behaviors, including autoerotic asphyxia (Freidrich & Gerber, 1994). In studies using clinical outcomes that are not limited to self-report, increased rates of PTSD, aggressive behavior, and sex-related problems have been documented (Holmes & Slap, 1998). In addition, there is longitudinal evidence that some problems persist years after the alleged abuse has occurred (Tebbutt et al., 1997).

CSA and Sexual Functioning

Adolescent males may be vulnerable to long-term sequelae of early sexual abuse experiences, even if they do not perceive the experience as abusive (Weber, Gearing, Davis, & Conlon, 1992). Weber et al. (1992) reported that adolescent males who experienced sexual initiation before

age 11 or with a partner 2 or more years older than themselves were more likely to have greater numbers of sexual partners than adolescents who were older at the age of sexual initiation. Although these young boys did not consciously acknowledge or perceive themselves to be victimized, their initiation of early sexual activity was correlated with a greater risk for unrecognized abusive situations and increased number of sexual partners, along with the related social, psychological, and sexual health risks. Furthermore, in one study, 25% of adolescent males who were victimized described themselves as being "sexually dysfunctional" (Johnson & Shrier, 1987). Sexual dysfunction was defined as nonorganically based complaints of inhibition of libido, premature ejaculation, erectile difficulties, and failure to ejaculate. In addition, one half of the boys who had been molested by males subsequently identified themselves as homosexual and linked homosexuality to their sexual victimization.

CSA and Sexual Orientation

In one study of adolescent male CSA victims who were abused by men, 72% self-identified as homosexual (Johnson & Shrier, 1987). The prevalence rate of CSA among homosexual men is greater than that found among heterosexual men (Bell, Weinberg, & Hammersmith, 1981; Coleman, 1989; Harry, 1985, 1989). However, it is important to note that this is a correlational relationship that must be interpreted with caution. Several investigators documenting the association of sexual abuse and homosexual identity (Coleman, 1989; Harry, 1985, 1989) also reported effeminate behaviors, a lack of secondary sex characteristics, and lack of peer and familial support, especially a close relationship with a father, during the developmental stage of sexual identity formation. Sexually abused boys may express male gender identity confusion, sexual orientation ambiguity, and internalized homophobia, as well as disturbances with self-esteem and positive body image. Although these effects are greater than previously reported (e.g., Finkelhor, 1984) and are of limited generalizability due to small sample sizes, their implications are consistent with other studies (Dimock, 1988; Myers, 1989).

In contrast to those studies describing the harmful relationship of CSA to psychological and sexual functioning in males, there are several studies whose results suggest that adolescent boys with histories of sexual experiences with adult men are not harmed as a result of these experiences (Bauserman & Rind, 1997; Rind, 2001; Rind, Bauserman, & Tromovitch, 1999; Rind et al., 1998). Rind (2001) assessed a nonclinical sample of 129 college men aged 17-25, of which 26 reported having age-discrepant sexual relations (ADSRs) as adolescents between 12 and 17

years of age with adult males. Reactions to the ADSRs were predominantly positive, with the men who had ADSRs being as well-adjusted as controls, in terms of self-esteem and positive sexual identity. In addition, there was no evidence that ADSRs played a role in creating same-sex interest.

Rind et al.'s (1998) meta-analysis of 59 studies revealed that college students' family environment explained more adjustment variance than CSA, and CSA-adjustment relations were nonsignificant when family environment was controlled for. In addition, Rind et al. (1998) reported that boy-adult sex was not associated with symptoms when boys reported that they were willing participants. College men with histories of CSA also reported experiencing different types of CSA than their female cohorts. These men reported half the close family CSA experiences and encountered force about half as often as the female college students. However, as with much of the research reviewed here, these studies were based on stratified, mostly European American samples, retrospective data, and cross-sectional designs that do not allow for follow up of perceptions of effects at various time points. The age at which abuse occurs may also vary, which can also influence lasting effects. These studies demonstrate how little we understand about the sexual abuse of boys.

CSA and Ethnicity

Few investigators have examined ethnicity in their research on the effects of CSA in adolescent males. Among those who have, Weber et al. (1992) examined ethnic differences among 1,580 African American and European American adolescent males in a juvenile detention center. Two thirds (66.5%) of African Americans reported sex prior to the age of 11, and 50% of European Americans reported sexual intercourse prior to the age of 11. However, significantly more European American males reported engaging in early nonconsensual sex with older partners, compared to African Americans. In contrast, researchers documented that African American and Latino American men were more likely than European American men to report sexual contact as children with older and more powerful partners (Doll et al., 1992; Relf, 2001). These men were from a sample of 1,001 ethnically diverse men who have had sex with men recruited from STD clinics in three major cities: Chicago, San Francisco, and Denver. In contrast, DiIorio, Hartwell, and Hansen (2001) reported that Hispanic males were significantly more likely to experience unwanted or uninvited sexual activity, compared to African American males, prior to the age of 13. In addition, those who reported unwanted sexual activity during childhood (prior to age 13) were more

likely to report high-risk sexual behavior, including buying and selling sex for money, as well as abuse of drugs and alcohol and unwanted sexual activity after age 13.

Association of CSA with Adult Male Sexual Functioning

Little attention has been given to the role that CSA plays as a risk factor in the development of sexual dysfunction in men (Kinzl, Mangweth, Traweger, & Biebel, 1996). Findings regarding the effects of CSA are often based on case studies and descriptive clinical reports (Sarwer et al., 1997; Watkins & Bentovim, 1992), and are limited by small sample sizes and lack of ethnic diversity (Holmes, Offen, & Waller, 1997). CSA prevalence rates for men vary, with the results from large scale national studies ranging from 8% (Baker & Duncan, 1985), to 13% (Badgley et al., 1984), to 16% (Finkelhor, Hotaling, Lewis, & Smith, 1990), and others documenting rates varying between 4% to 76% (Bays & Chadwick, 1993; Black & Deblasseie, 1993; Carballo-Diguez & Dolezal, 1995; Conte, 1991; Ellerstein & Canavan, 1980; Ellsworth, Merguerian, & Copenig, 1995; Finkelhor, 1994b; Holmes & Slap, 1998; McCarty, Roberts, & Hendrickson, 1996; Watkins & Bentovim, 1992). Prevalence rates may differ in part due to difficulties inherent in assessing CSA among men. These challenges include denial of abuse because of shame and embarrassment, and unwillingness to disclose abuse due to feelings of being emasculated (Holmes et al., 1997).

Long-term effects of CSA in males include drug and alcohol problems, sexual difficulties and relationship problems, dissociation, shame, and gender shame (Bruckner & Johnson, 1987; Dimock, 1988; Hunter, 1990a, 1990b; Johaneck, 1988; Lew, 1990; Mendel, 1995; Morrell, Mendel, & Fischer, 2001; Schulte, Dinwiddle, Pribor, & Yutzy, 1995; Watkins & Bentovim, 1992). In one clinical sample of 124 male CSA survivors, all perceived CSA to be severely damaging to most aspects of their lives (Mendel, 1995). This finding is consistent with the findings of other studies (Nielsen, 1983) emphasizing that CSA is associated with negative outcomes for a majority of abuse victims. However, some of these studies did not include control groups. Further, specific information about the type of incidents that best predicted long-term effects is lacking.

Although many investigators have focused on the psychosocial consequences of CSA, others have addressed possible associations with male sexual functioning (McCarty et al., 1996). Urologic indicators associated with CSA include excessive surgeries and urogenital complaints, decreased sexual functioning (e.g., impotence and missing genitalia on examination), strong sexual impulses (e.g., compulsive masturbation), highly sexualized behavior in clinical settings (e.g., inappropriate sex-

ual language or behavior during interview/exam), and high-risk and harmful sexual behaviors (McCarty et al., 1996).

Men with histories of childhood sexual trauma may present a variety of physical complaints, which may result in frequent and excessive medical procedures (Beitchman et al., 1992; Courtois, 1993; Drossman, 1994; Goodwin, 1988; Loewenstein, 1990; McCarty et al., 1996; Van der Kolk, 1987). Adult male CSA survivors may have distorted perceptions of sensations and interpretations of their experiences (McCarty et al., 1996). Among these problems are genital and abdominal difficulties, as well as both higher and lower thresholds for pain (Courtois, 1993; Loewenstein, 1990; Lycaki, Josef, & Munetz, 1979; Scarinci, McDonald-Haile, Bradley, & Richter, 1994; Grumet, 1985). Further, male survivors also described eroticizing pain and incorporating painful sexual experiences into their sexual repertoire (Favazza, 1979; Grumet, 1985). In case studies, men who experienced early sexual and physical abuse were documented engaging in painful self-stimulation (Bryer, Nelson, Miller, & Krohl, 1987; Ellerstein & Canavan, 1980; Ellsworth et al., 1995; Friedrich & Gerber, 1994; Kaufman, Divasto, Jackson, Voohees, & Christy, 1980; Watkins & Bentovim, 1992). Friedrich and Gerber (1994) hypothesized that the pairing of sexual arousal and choking may lead men to engage in autoerotic asphyxia as a paraphilia to induce hypoxia for the purpose of heightened sexual euphoria (Cesnick & Coleman, 1989; Van Der Kolk, 1988; Wesselius & Bally, 1983).

Decreased sexual functioning, including erectile dysfunction (ED) and impaired or missing genitalia, are also problems that have been reported by male CSA victims (McCarty et al., 1996). Histories of ED related to multiple surgeries, including penile implants, inguinal hernia repairs, urethral dilations, orchiectomies, and transurethral resection of the prostate have also been documented (see McCarty et al., 1996). In addition, male victims have been reported to engage in self-injurious behaviors, including cutting off the penis or removing a testicle (McCarty et al., 1996). These behaviors are believed to be a result of significant distress from past abuse experiences, contributing to sexual identity confusion and sexual dysfunction (Beitchman et al., 1992; Courtois, 1993; Green, 1993). However, these studies lack control groups; clearly, more research on long-term effects is still needed.

Survivors of sexual trauma may also engage in seductive or provocative sexual behaviors with health care providers. Treating male patients with poor sexual boundaries may make providers uncomfortable and complicate the connection between current behaviors and sexual abuse making it more difficult to recognize (Courtois, 1993; McCarty et al., 1996). Although some men do not associate their abuse histories with

their adult sexual activity, others do. They realize that their current behavior can affect their personal, professional, and social lives. Male victims of CSA have also reported hypersexual behavior, including compulsive masturbation, unprotected sex with multiple partners, and high-risk sexual acts, such as autoerotic asphyxia or sadomasochistic behaviors (Black & Deblasse, 1993; Friedrich, 1988; Green, 1993; Grumet, 1985; McCarty et al., 1996; Watkins & Bentovim, 1992). Men reporting these behaviors often have urologic or medical complications from pain and skin excoriation, histories of sexually transmitted diseases, or psychiatric complaints. In addition, men with CSA histories also report poor impulse control, legal complications that result from poor impulse control, and a greater likelihood of perpetrating sexual and violent crimes (Black & Deblasse, 1993; Finkelhor, 1994b; Green, 1993; Holmes, Offen, & Waller, 1997; Watkins & Bentovim, 1992). Finally, associations have also been documented between a history of CSA and increased adult sexual risk taking, and higher risks for HIV infection (Carballo-Díquez & Dolezal, 1995; Jinich et al., 1998; Paul, 2001).

Disclosure of CSA

Compared to women, men are significantly less likely to report CSA (Finkelhor, 1984; Finkelhor et al., 1990; Roesler & McKenzie, 1994). In one study, only one of 25 male patients with CSA histories had disclosed the experience at the time the incident occurred (Dimock, 1988). Using a larger student sample in South Africa, Collings (1995) reported that none of the 82 men who had been abused in childhood reported the experience to another person at the time the incident occurred. Males were less likely to report incidents that were perpetrated by females, most likely due to negative feelings about being overpowered or controlled by a woman (Condy, Templer, Brown, & Veaco, 1987). Men may also be reluctant to disclose CSA or ASA because they fail to recognize that they, too, can be sexual victims, and their interpretation of the experience is not negative (Dimock, 1988; Finkelhor, 1984; Hunter, 1990a, 1990b; Merrill & Wolfe, 2000). Traditional male socialization, which defines men as sexually dominant and masculine beings, poses a barrier to disclosure (Mills, 1993). Experiencing rape or being sexually abused by another male carries with it feelings of shame, embarrassment, helplessness, and emasculation, and may result in fears of being labeled homosexual by others (Dimock, 1988; Evans, 1990; McMullen, 1990; Nasjleti, 1980). That is, the male victim may perceive that his masculinity has been called into question. Some men may even expect that a boy will have a sexual experience that will propel him into "man-

hood" (Bolton, Morris, & MacEchron, 1989). These gender roles and socialization experiences may shape perceptions of early CSA incidents as favorable (Fromuth & Burkhart, 1987), even if they are perpetrated by other men.

Males may also perceive incidents that do not include physical trauma as less harmful. Nondisclosure of CSA may result from a perpetrator's threats and the victim's fear of physical harm (Dimock, 1988; Nasjleti, 1980; Sebold, 1987). However, they may still exhibit significant symptomology (Evans, 1990). This discrepancy in definitions and effects of abuse poses a research validity question. Sexually abused boys tend to rate their abuse experiences as less negative when compared to sexually abused girls (Finkehor, 1990; Finkelhor et al., 1990). Even though male victims may not define the abuse as negative, psychological sequelae (including low self-esteem) are evident and can be even greater among boys than girls. More research is needed in order to examine the relationship between gender perceptions of abuse as positive and long-term effects on sexual and psychological functioning, as these associations do not address limitations inherent in the research, including the effects of confounding variables (Ruggiero et al., 2000).

CSA and Mental Health

Male survivors of CSA may be more likely to become involved in the criminal justice system than the mental health system. Adult male prisoners have reported high rates of CSA (Condy et al., 1987; Petrovich & Templer, 1984). Kaufman and Zigler (1987) suggested that male survivors of CSA may develop aggressive characteristics as adults in an attempt to define their masculinity. These aggressive behaviors may be manifested in violent and/or sexual offenses.

A male's history of CSA may go undetected in the health care system. Factors that contribute to this anonymity include clinician's lack of knowledge regarding how to take an appropriate sexual history and the relatively few services available to male CSA victims (Evans, 1990; Finkelhor, 1984; Holmes & Offen, 1996; Johanek, 1988; Mendel, 1995; Singer, 1989). When male victims do present, their chief complaints to health care practitioners may not stem directly from the CSA incident(s) but to related problems, including anxiety or depression (Johanek, 1988). In addition, clinician bias may also present barriers to the identification of CSA. That is, clinicians are more likely to suspect sexual abuse in females than in males (Holmes & Offen, 1996) and are more likely to disbelieve or to minimize the claims of abuse by males (Krug, 1989; Langsley, Schwartz, & Fairbairn, 1968; Lawson, 1993; Nasjleti, 1980).

Another fear expressed by male victims of CSA is the possibility of being viewed as potential perpetrators of abuse (Bruckner & Johnson, 1987; Mendel, 1995; Watkins & Bentovim, 1992). Holmes et al. (1997) noted that although there are high rates of CSA amongst perpetrators (ranging from 32% to 90%), it cannot be assumed that abused males will necessarily become perpetrators (Groth, 1979; Kasl, 1990). Although it has been reported that men abused as children do not inevitably become abusers, this myth exists (Briggs & Hawkins, 1996; Kaufman & Zigler, 1987).

How CSA Can Result in Sexual Dysfunction

In many studies in which the associations of CSA with sexual functioning were examined, theoretical conceptualizations of how CSA may influence sexual difficulties later in life were not examined. The correlational nature of research in this field makes it difficult to empirically test how CSA influences sexual functioning. Some researchers theorize that the trauma of CSA may result in psychosocial disturbances that affect sexual functioning (Browning & Laumann, 1997). Wyatt (1993) discussed how women who experience CSA may feel powerless over their sexuality as adults. Because they were not given the opportunity to make their own decisions about their sexuality as children or adolescents, they may feel powerless over their sexuality, sexual communication, and decision-making in adulthood. As a result, they may engage in more high-risk sexual behavior and report less sexual satisfaction in relationships. Feelings of powerlessness have also been posited as an explanation for the association of severe CSA with somatization (Walker et al., 1992). Reporting physical complaints may provide a safe way to describe distress for those who experienced unpredictable childhood environments over which they had little control.

Other researchers have hypothesized that CSA creates negative associations that have an impact on sexual functioning. Jehu, Gazan, and Klassen (1985) noted that, for CSA survivors, sex can become associated with pain and trauma, resulting in the conditioning of sex to feelings of anxiety and sexual dysfunction. Briere and Runtz (1987) suggested that sex becomes associated with negative emotions and pain, which can result in later conditioned anxiety and dysfunction during sexual activities, such as flashbacks or intrusive thoughts of sexual abuse.

Other perspectives of how CSA exerts its effects include Polusny and Follette's (1995) theoretical conceptualization. They suggested that those with CSA histories may employ coping efforts to avoid negative thoughts, emotions, and memories associated with the abuse. These strategies may involve suppression and denial, high-risk behavior (i.e.,

drug or sex risk behavior), somatization, avoidance of intimate relationships, emotional withdrawal from relationships, dissociation, or other emotionally avoidant behaviors. This results in a variety of long-term consequences, including difficulties in interpersonal and sexual functioning and feelings of isolation. Davis et al. (2001) similarly suggested that women who have experienced CSA may attempt to avoid the distress associated with thoughts about their abuse through emotional avoidance and dissociation. These emotional patterns may reduce immediate distress, but fears of intimacy may limit opportunities for experiencing healthy relationships.

Limitations of the Research

Researchers in this area face many challenges. Researchers need to use larger, more representative samples to facilitate the examination of the relationship of CSA experiences to sexual functioning and to allow for gender comparisons. Researchers also need to examine the effects of culture and ethnicity as they relate to CSA experiences.

Although CSA is linked to negative effects in many studies of sexuality and sexual behaviors, in other studies no differences between abuse victims and nonvictims were found (e.g., Rainey, Stevens-Simon, & Kaplan, 1995). Kendall-Tackett, Williams, and Finkelhor (1993) proposed that asymptomatic children may be less affected because they experience the least damaging sexual abuse (i.e., less severe and shorter). They further suggested that resilient children, who possess the most psychological, social, and treatment resources to cope with the sexual abuse experience, may also be less affected. On the other hand, Trickett and Putnam (1993) attributed the diversity of outcomes in studies to sampling problems, improper control of extraneous factors, and heterogeneity of the sexual abuse experience used in different studies. For instance, most of the samples of adolescent females consist of clinic populations, runaway and homeless youth, as well as incarcerated adolescents.

Increasingly, researchers are beginning to include community samples of adolescents (Boney-McCoy & Finkelhor, 1995; Munoz, Newcomb, & Carmona, 2002). However, sex research in community settings is difficult to conduct with children and adolescents. For example, when implementing surveys in school settings, questions that ask for sexually explicit information may be protested by parents or school staff (Munoz et al., 2002).

In spite of these limitations in how youth can be studied, research is needed to fully understand the impact of sexual abuse during this developmental period. Some of the effects not reported immediately

after abuse incidents do not emerge until years later. Individual and group treatment models must address these issues to enhance adolescent sexual health and to prevent sexual revictimization. Medical and mental health professionals must understand the importance of obtaining comprehensive sexual histories with adolescents in order to obtain information including a host of problematic sexual behaviors, negative sexual outcomes, and risk taking that they are sometimes reluctant to disclose (Lodico & DiClemente, 1994).

Little epidemiological data regarding the effects of CSA on adult male functioning exist (Kinzl et al., 1996). Early sexual abuse and the long-term effects reported in the literature have not been adequately demonstrated in males due to limitations inherent in case studies, as well as coexisting physical and emotional abuse (Briere & Runtz, 1990; Fromuth, 1986).

In much of the research, other factors that may account for some of the associations noted among CSA and various long-term effects have not been controlled for, including other types of childhood abuse, family environment, and level of social support (Conte & Schuerman, 1987; Fromuth, 1986; Kendall-Tacket et al., 1993; Rind, 2001). Indeed, in Sarwer et al.'s (1997) examination of 359 men seeking treatment for sexual difficulties, unemployment, rather than CSA, predicted sexual dysfunction. Further, documentation of long-term effects of CSA is limited by small, ungeneralizable samples and by a lack of formal diagnostic instruments to assess sexual functioning (Sarwer et al., 1997; Watkins & Bentovim, 1992).

Discussion

Despite the recent proliferation of CSA research, we still do not fully understand the complexities of how and to what extent CSA affects adolescent and adult sexual functioning. However, the research reviewed here highlights the need to recognize the powerful influence that abusive childhood sexual experiences contribute to the sexual health, performance, and satisfaction. In the future, researchers need to investigate the context in which the circumstances and effects of CSA occur. After all, devoid of context, sex is simply a series of behaviors. In order to develop prevention strategies, we need to understand more about environmental and family variables that increase the likelihood that CSA may occur. Risk factors (e.g., dysfunctional family characteristics) that may intensify its effects, and protective factors (e.g., social support) that can increase resilience and ameliorate potential negative effects of CSA also await further study. "Resilient" children, who have more psychological, social, and treatment resources than their less resilient counterparts, may be less vulnerable to the effects of CSA

(Kendall-Tacket et al., 1993). A supportive and functional family environment may also confer protective benefits. Characteristics of the CSA incidents, including severity and duration, may also provide information about specific associations with sexual functioning.

Associations between CSA and sexual risk taking suggest that prevention and treatment programs in the area of female reproductive health, including teen pregnancy, prenatal care, and STD and HIV clinics, need to address CSA and its correlates. An increased focus on the differences in symptomatology reported by male and female CSA victims will also assist the development of prevention and intervention programs that are gender-specific (Garnefski & Arends, 1998).

What We Need to Know

Most of what we know is based on descriptive studies of the effects of CSA on individuals. There is little information about the CSA history of couples and their sexual functioning. Although a history of CSA may contribute to problems in couple relationships, it is often not disclosed by partners to each other and, subsequently, is undetected by therapists (Mennen & Pearlmutter, 1993). Partners may report symptoms, including difficulty sustaining relationships and depression, that may have their roots in early abuse but are attributed to other stressors and therefore do not receive adequate attention or treatment. An increase in risky sexual practices, including unprotected sex, has been documented in heterosexual couples in which either the male or female partner has a history of CSA (Wyatt, 1999). Further, when both partners have CSA histories, they were twice as likely as couples with no CSA to report engaging in unprotected sex (Wyatt, 1999). Wyatt, Vargas-Carmona, et al. (2002) have called for research with couples in which one or both partners have histories of CSA in order to better understand these effects on their sexual and reproductive health.

Where Do We Go From Here? Implications for the Future

As a whole, the body of research in which the impact of CSA on the sexual functioning of females has been examined predates and is more developed than research with males. Researchers have documented that males and females may process and react to abuse experiences differently; these gender differences may mirror social norms and be influenced by biological factors (Rind et al., 1998). In future studies, large community samples of ethnically diverse males and females must be used to facilitate these gender comparisons.

The generalizability of findings from many of these studies has also been restricted due to small clinical samples that lack ethnic diversity.

Controversies over ethnicity as a risk factor for abuse or certain types of abuse need to be resolved to address the needs of particular populations. Current sampling methods must be expanded to incorporate interpersonal, familial, psychological, sociocultural, religious, and other demographic variables. Although links have been established between CSA and sexual risk taking, little is known about how CSA affects the sexual functioning and risk taking of homosexual, bisexual, and transsexual populations. Research with these populations is needed to comprehensively address how sexual functioning and satisfaction are associated with CSA experiences.

Medical and other health professionals need to be trained to take a comprehensive sexual history that would identify a variety of symptoms and complaints that are correlated with CSA (Lodico & DeClemente, 1994). A sexual history of consensual and nonconsensual experiences should also provide information about the impact of abuse histories on interpersonal relationships, psychological well-being, sexual satisfaction, and health. Religious and peer counselors, including alcohol, substance abuse, and HIV counselors who are likely to interact with CSA survivors should be trained to recognize these behavioral and psychological symptoms. With appropriate screening, referrals for treatment can be offered to further explore the patient's history and potentially risky behavior.

The training of health professionals should also emphasize the importance of striving for objectivity when identifying background factors that may be responsible for what may initially appear to be lasting effects of CSA. Although the associations between CSA and aspects of sexual functioning have been well documented, the impact of a CSA experience on any given individual may vary considerably. There may be a variety of explanations for the effects on sexual functioning that await further study. Some researchers contend that there is no given set of emotional effects or outcomes that result from CSA experiences (Rind et al., 1998). In their meta-analyses of CSA correlates among college students, Rind et al. discussed their finding that CSA was not experienced by men and women in the same manner, nor did they experience equivalent types of CSA.

Professionals should also look beyond CSA symptoms and inquire about other childhood experiences that may have been problematic. Child sexual abuse survivors are often forced to contend with the CSA experience(s), other types of abuse, and a dysfunctional family environment concurrently. A poor family environment may set the tone for abuse to occur and leave the survivor with little support to cope with the experience. Indeed, researchers have suggested that the direction of

causality may be from family environment to CSA (Rind et al., 1998). Future researchers need to more specifically document the unique effects of CSA, statistically controlling for other types of childhood abuse and family background factors as well.

Regardless of the limitations of the research, the most important message to convey is that sex is learned. Experiences that occur too early in life and against the will of a child or without their cognitive understanding of what is happening can have lasting effects on sexual functioning. Only research that is longitudinal and includes representative, community multiethnic samples of CSA survivors can be used to address concerns raised by what we know about the effects thus far. However, there are serious ethical dilemmas raised when child survivors of sexual abuse are followed in a natural history study without efforts to offer treatment to the victim and his/her family to forestall potential negative effects. Notwithstanding memory performance limitations, the retrospective accounts on which most of the CSA is based provide the best approach to understand how sexual abuse can affect adolescent and adult sexual functioning.

Although issues around the effects of CSA on sexual functioning may continue to be debated, CSA prevention programs are sorely needed now. Far too many children do not receive adequate protection and supervision which could prevent sexual victimization from occurring in the first place. Assumptions that sexual functioning will be minimally affected by CSA experiences or that every CSA victim will be invariably harmed are too simplistic. Child advocates, clinicians, researchers, and health providers need to work more effectively to ensure that healthy sexual functioning can be achieved, regardless of age, income, gender, ethnicity, and sexual orientation. Sexual development must unfold at a developmentally appropriate pace without fears of coercion or abuse affecting its trajectory.

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