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Sexual health in women reporting a history of child sexual abuse

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ABSTRACT

Objective: The present study examined the association between child sexual abuse (CSA) and sexual health outcomes in young adult women. Maladaptive coping strategies and optimism were investigated as possible mediators and moderators of this relationship.
Method: Data regarding sexual abuse, coping, optimism and various sexual health outcomes were collected using self-report and computerized questionnaires with a sample of 889 young adult women from the province of Quebec aged 20–23 years old.
Results: A total of 31% of adult women reported a history of CSA. Women reporting a severe CSA were more likely to report more adverse sexual health outcomes including suffering from sexual problems and engaging in more high-risk sexual behaviors. CSA survivors involving touching only were at greater risk of reporting more negative sexual self-concept such as experiencing negative feelings during sex than were non-abused participants. Results indicated that emotion-oriented coping mediated outcomes related to negative sexual self-concept while optimism mediated outcomes related to both, negative sexual self-concept and high-risk sexual behaviors. No support was found for any of the proposed moderation models.
Conclusions: Survivors of more severe CSA are more likely to engage in high-risk sexual behaviors that are potentially harmful to their health as well as to experience more sexual problems than women without a history of sexual victimization. Personal factors, namely emotion-oriented coping and optimism, mediated some sexual health outcomes in sexually abused women. The results suggest that maladaptive coping strategies and optimism regarding the future may be important targets for interventions optimizing sexual health and sexual well-being in CSA survivors.

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While the exact prevalence of childhood sexual abuse (CSA) remains difficult to establish because of the different definitions of CSA and methodologies used in empirical reports (Senn, Carey, & Vanable, 2008), current studies suggest that between 15% and 30% of North American women experienced childhood sexual victimization (Pereda, Guilera, Forns, & Gómez-Benito,

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2009). Several studies have indicated that exposure to CSA is associated with a variety of short- and long-term negative outcomes including depression, anxiety, low self-esteem, suicidality, substance abuse, and sexual revictimization (Barnes, Noll, Putnam, & Trickett, 2009; Briere & Elliott, 2003; Filipas & Ullman, 2006). The experience of CSA has also been linked to adverse physical health including greater health risk behaviors such as substance abuse (Rodgers et al., 2004). More recently, authors have suggested that CSA survivors may also face important issues related to their sexual health (Lemieux & Byers, 2008; Senn et al., 2008). According to Hansen, Mann, McMahon, and Wong (2004), sexual health is not merely the absence of disease but represents a core and essential part of being human. The concept of sexual health thus refers to numerous aspects of human sexuality including sexual functioning, satisfaction, and behavior that go beyond the mere absence of diseases such as sexually transmitted infections (STIs) or sexual dysfunctions (Coker, 2007; Lemieux & Byers, 2008; van Roode, Dickson, Herbison, & Paul, 2009). In order to fully grasp the extent to which CSA may compromise women's sexual health, attention must therefore be given to various indicators of women's sexual health as well as to possible adverse effects on women's sexual well-being.

Problems regarding sexual health are generally operationalized as high-risk sexual behaviors such as: younger age at first consensual intercourse, large number of both lifetime and recent sexual partners, high frequency of unprotected sex, use of drug or alcohol during sexual activities and a greater likelihood of contracting a STI (Lemieux & Byers, 2008; Senn et al., 2008). Data from several studies seem to indicate that women with a history of CSA are more likely to engage in high-risk sexual behaviors than women without such history (for reviews see: Arriola, Louden, Doldren, & Fortenberry, 2005; Senn et al., 2008). Furthermore, research indicates that CSA survivors may also experience difficulties in sexual functioning including a greater risk of experiencing sexual dysfunctions, sexual anxiety, and fear of sexual activities (Luo, Parish, & Laumann, 2008; Meston, Rellini, & Heiman, 2006; Najman, Dunne, Purdie, Boyle, & Coxeter, 2005; Noll, Horowitz, Bonanno, Trickett, & Putnam, 2003; Noll, Trickett, & Putnam, 2003; Schloredt & Heiman, 2003; Zwickl & Merriman, 2011).

However, other studies have failed to find any association between CSA and a variety of high-risk sexual behavior (Bartoi & Kinder, 1998; Medrano, Desmond, Zule, & Hatch, 1999) and sexual problems (Merrill, Guimond, Thomsen, & Milner, 2003; Meston, Heiman, & Trapnell, 1999; Miner, Flitter, & Robinson, 2006). These inconsistent findings may be due to methodological issues such as a lack of consensus on the definition and measurement of CSA, and the diversity of both sampling and assessment measures used across studies (Senn et al., 2008). Studies may have relied on different operational definitions of CSA; some may include a spectrum of CSA experiences, whereas others may focus only on the most severe forms of CSA (e.g., involving penetration). This renders the task of comparing results across studies difficult and challenging (Senn et al., 2008). Furthermore, the majority of studies have been conducted with clinical samples and high-risk populations; such results may overestimate the link between CSA and adverse sexual outcomes (NIMH Multisite HIV Prevention Trial Group, 2001; Parillo, Freeman, Collier, & Young, 2001; Senn, Carey, Vanable, Coury-Doniger, & Urban, 2006). The current literature clearly lacks documentation of the sexual health outcomes in CSA survivors within large community samples (Coker, 2007).

Numerous conceptual models exist to explain CSA, however the concept of traumatic sexualization proposed in Finkelhor and Browne's (1985) traumagenic dynamics model seems particularly relevant (Lemieux & Byers, 2008) in understanding sexual health consequences associated with CSA. Traumatic sexualization refers to the development of precocious and negative feelings and attitudes about sexuality that result from a child being rewarded for engaging in sexual activity and sexual behaviors that are inappropriate in regards to his or her developmental level (Finkelhor & Browne, 1985). Clinical and empirical data suggest that CSA may be associated with opposing sexual health outcomes through the process of traumatic sexualization (Merrill et al., 2003; Simon & Feiring, 2008). Women who have experienced CSA may come to view sex as necessary for affection, and thus engage in high-risk sexual activity with one or many partners resulting in an "oversexualization" of their relationships (Senn et al., 2008; Simon & Feiring, 2008), whereas some CSA survivors may also have been conditioned to associate sex with negative feelings, leading to problems of diminished sexuality as well as sexual dysfunctions (Merrill et al., 2003; Simon & Feiring, 2008). Thus, CSA survivors may experience sexual problems related to both heightened and diminished sexuality, which can in turn increase these women's risk of reporting sexual health problems (Briere, 2000; Simon & Feiring, 2008). Studies therefore need to document various indicators of women's sexual health in order to fully understand the impact of CSA (Lemieux & Byers, 2008).

While past studies have provided strong evidence of a relationship between CSA and later sexual health outcomes, little is known about the process through which CSA survivors may experience later adverse outcomes (Merrill, Thomsen, Sinclair, & Milner, 2001). Researchers have proposed models that include coping as a potential mediator of associations between CSA and long-term outcomes (Briere, 2002; Spaccarelli, 1994; Walsh, Fortier, & DiLillo, 2010). Findings from these studies have provided evidence that coping strategies may in fact be among the key mediators by which CSA may influence long-term adjustment (Briere, 2002; Spaccarelli, 1994; Walsh et al., 2010). More specifically, the experience of CSA may promote particular maladaptive coping strategies that may, in turn, be related to various outcomes (Walsh et al., 2010). Previous research has also identified the use of maladaptive coping strategies including both avoidant (e.g., avoidance, denial, distancing, disengagement) and emotion-oriented coping strategies (strategies aimed at managing negative emotional responses) to be associated with more adverse outcomes in adults sexually abused as children (Long & Jackson, 1993; Merrill et al., 2003). Nevertheless, some authors have recently stated that coping strategies may serve both a mediating or moderating role (Walsh et al., 2010). Specifically, CSA may lead to the use of a certain type of coping, which in turn, may influence long-term outcomes (mediator model), and the long-term impact of CSA may vary depending on the type of coping strategies employed by CSA survivors (moderator model) (Banyard & Williams, 2007; Banyard, Williams, Saunders, & Fitzgerald, 2008; Walsh et al., 2010; Wright, Crawford, & Sebastian, 2007). Thus, coping strategies may in fact serve both functions, which