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The association between childhood sexual abuse and adult female sexual difficulties

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Childhood sexual abuse (CSA) has been associated with a number of long-term negative consequences, including depression, anxiety and psychosomatic symptomology. Sexual trauma has also been linked to problematic sexual functioning and sexual behaviour in adulthood. This paper critically evaluates the current literature on CSA and adult sexuality and identifies the main sexual difficulties experienced by women with a history of CSA. The authors also present a preliminary theoretical model of the association between CSA and problematic sexual outcome. This model takes into consideration literature that directly critiques previous models of association and identifies important factors that have not adequately been accounted for in the reviewed literature.

Keywords: sexual abuse; sexual dysfunction; sex therapy; coping strategies; sexuality

Introduction

This paper provides an overview of the contemporary literature exploring the association between childhood sexual abuse (CSA) and adult female sexual outcome. Through critical evaluation of the current literature and theoretical conceptualisations, the authors identify overarching issues in the research and put forth a new model of association between CSA and adult female sexual difficulties. Although the expression ''sexual dysfunction'' is used throughout the literature, the authors have opted to use the term ''sexual difficulty'' in reference to sexual disorders listed in DSM-IV-TR and to a range of other sexual experiences. The authors argue that ''sexual dysfunction'' is focused largely on sexual functioning rather than sexual behaviours and also indicates that a specific diagnosis has been identified (Heiman & Heard-Davison, 2004). In this paper, the term ''sexual difficulty'' encompasses difficulties with sexual functioning, sexual satisfaction, sexual cognitions and sexual behaviour. These criticisms of prevailing nomenclature have been documented for over a decade (for example, Tiefer, Hall, & Travis, 2002). Other terminology used in this paper includes, ''sexual behaviour'', which refers to sexual activities, and ''sexual functioning'', which refers to the experiences of sexual desire, sexual responsiveness or genital pain (Heiman & Heard-Davison, 2004). ''Sexual outcome'' is used as a

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collective term encompassing the multi-faceted nature of sexuality, including sexual behaviour, sexual functioning and sexually-relevant cognitions.

Although incidents of CSA are often under-reported and undisclosed (Hall, 2007), prevalence studies indicate that between one fifth and one third of women report a history of childhood sexual abuse (Fanslow, Robinson, Crengle, & Perese, 2007; Felitti et al., 1998; Finkelhor, Hotaling, Lewis, & Smith, 1989; Najman, Dunne, Purdie, Boyle, & Coxeter, 2005; Ullman, 2007). Women are more likely to report a history of CSA than men (Moore et al., 2010; Najman et al., 2005; Pereda, Guilera, Forns, & Gomez-Benito, 2009) and are also more likely to report penetrative abuse (Maikovich-Fong & Jaffee, 2010; Najman et al., 2005) and to be abused by a family member (Finkelhor et al., 1989; Najman et al., 2005; Rind & Tromovitch, 1997).

Given the the heterogenic nature of the abuse experience, there is currently no standardised definition for CSA (Fergusson & Mullen, 1999). Most commonly, CSA is defined as any sexual contact by an adult with a child, including inappropriate touching, oral-genital stimulation and coitus (Crooks & Baur, 2008). This definition does not however, acknowledge the capacity of children to be coercive and exploitative of other children, in the form of peer and sibling sexual abuse. Using more explicit criteria, CSA can be defined as occurring in incidents when the age difference between perpetrator and child is more than five years or when the age difference is less than five years but the contact is coercive or is not desired (Wyatt & Newcomb, 1990; Wyatt & Peters, 1986). Non-contact-type experiences such as exposure to exhibitionists and pornography are typically excluded in the literature, although that is not to say that non-contact experiences may not be associated with adverse consequences (Lesserman, 2005). There is also some variation in the upper age cut-off in defining a ''child'', however the most frequently used age limits range from 15 to 17 years (Pereda et al., 2009).

Research has indicated that CSA is associated with numerous long-term intrapersonal outcomes, including cognitive, affective and physical consequences (Drauker, 2000; Felitti et al., 1998), as well as interpersonal and intimate relationship difficulties (Colman & Widom, 2004; Davis & Petretic-Jackson, 2000; Finkelhor et al., 1989). Women with a history of CSA have higher incidence of gynaecological and psychosomatic problems (Lesserman, 2005), anxiety and depression (Boudewyn & Liem, 1995; Fergusson, Boden, & Horwood, 2008; Meston, Rellini, & Heiman, 2006; Spataro, Mullen, Burgess, Well, & Moss, 2004), Post Traumatic Stress Disorder (PTSD) (Connor & Higgins, 2008; Gwandure, 2007), suicidality and self-harming (Briere & Runtz, 1986; Cameron, 2000), eating disorders (Felitti et al., 1998; Wonderlich et al., 1997), substance abuse (Felitti et al.,1998; Harrison, Fulkerson, & Beebe, 1997) and behavioural problems (Siegel & Williams, 2003; Swanston et al., 2003). Some of the interpersonal difficulties associated with a history of CSA include difficulties with emotional and sexual communication, issues with trust (DiLillo & Long, 1999; Pistorello & Follette, 1998) and an increased likelihood of revictimisation, including physical abuse or rape by a partner (Filipas & Ullman, 2006; Walsh, Blaustein, Knight, Spinazzola, & van der Kolk, 2007).

It has been documented for over 50 years that CSA is a risk factor for problematic adult sexual outcome (Bartoi & Kinder, 1998; Becker, Skinner, Abel, & Treacy, 1982; Fergusson, Horwood, & Lynskey, 1997; Meston, Heiman, & Trapnell, 1999; Najman et al., 2005). The effects of CSA are highly variable and there is no single disorder that emerges from the experience of sexual trauma (Rathus, Nevid, & Fichner-Rathus, 2008). Sexual correlates of CSA can be divided into two main

categories: sexual functioning and sexual risk behaviours (Schloredt & Heiman, 2003). Low sexual desire, decreased sexual arousal and decreased orgasm are the most prevalent sexual functioning difficulties in women with a history CSA (Becker et al., 1982; Tsai, Feldman-Summers, & Edgar, 1979) and many women also experience decreased sexual satisfaction, without meeting the DSM-IV-TR criteria for sexual dysfunction (Bartoi & Kinder, 1998; Finkelhor et al., 1989). Sexual avoidance, sexual distress and sexual guilt are also associated with CSA (Becker et al., 1982; Pistorello & Follette, 1998). Studies have also shown that as a group, women with a history of CSA are younger at the age of first voluntary intercourse (Ferguson, Horwood, & Lynskey, 1997; Noll, Trickett, & Putman, 2003), endorse lower birth control efficacy (Meston et al., 1999), have a greater preoccupation with sex (Noll et al., 2003), more liberal sexual attitudes (Meston et al., 1999) and have a greater likelihood of engaging in unrestricted and risky sexual behaviour (Bartoi & Kinder, 1998; Colman & Widom, 2004; Ferguson et al., 1997; Parillo, Freeman, Collier, & Young, 2001; Senn, Carey, Vanable, Coury-Doniger, & Urban, 2006).

It is the premise of the authors that many sexual difficulties in adulthood are psycho-emotional in nature, founded in a history of CSA. According to Maltz (2001), a history of CSA can have long-term consequences on numerous facets of sexuality, including how a woman feels about her body and sex organs, how she thinks about sex, how she expresses herself sexually and how she experiences physical pleasure and intimacy with others. It has been suggested that women with a history of CSA may process and react to the world differently, particularly in regard to attentional biases, interpretation, storage and retrieval of sexual and relationship information (Meston & Heiman, 2000; Rellini & Meston, 2007). Women with a history of CSA also experience more negative affect during sexual arousal (Meston et al., 2006; Schloredt & Heiman, 2003), are more inclined to perceive their sexual feelings as reduced or inhibited (Bartoi & Kinder, 1998; Becker et al., 1982; Schloredt & Heiman, 2003) and may associate cues of the sexual arousal response with negative sexual schema and/or the automatic physiological responses experienced during the abuse (Wenninger & Heiman, 1998).

While there is a considerable body of literature that supports an association between CSA and adult sexual difficulties, there is some research to suggest that there are no significant differences in sexual functioning and behaviour between women who have a history of CSA and those who do not (for example, Fromuth, 1986; Rellini & Meston, 2007; Rind & Tromovitch, 1997). Inconsistencies in findings may, to some extent, be attributable to issues related to definitional criteria, sampling and measurement. It is difficult to compare results when there is no standard definition of CSA, sexual function and sexual dysfunction and it has been argued that studies using particular definitional criteria should not infer to CSA experiences characterised by different definitional criteria (Leonard & Follette, 2002; Rind & Tromovitch, 2007). Inconsistencies in the findings across studies may also be attributable to issues in measurement and the ability of the measures to capture the complex and multi-faceted phenomenon of sexuality. For example, it has been suggested that a subjective perception of "no effect" may not be supported by empirical measurement (Tsai et al., 1979) and there is also evidence to support the phenomenon of delayed symptomology and PTSD (Andrews, Brewin, Philpott, & Stewart, 2007; Cameron, 2000; Soloman, & Mikulincer, 2006).

Sampling may also impact on findings, with college samples often reporting fewer associations between CSA and adult sexual difficulties than clinical or

population-based samples. It can be argued that college samples have limited generalisability based on the assumption that they potentially exclude most persons who are deeply troubled and thus those most negatively affected by childhood sexual trauma (Meston et al., 1999). This argument does not imply that there are no college students who have suffered CSA, or if they have that some of them are not deeply troubled by such. Population and community samples typically have greater generalisability and have generally been more consistent in the finding of significant associations between a history of CSA and sexual difficulties (for example Fergusson et al., 1997; Finkelhor et al., 1989; Najman et al., 2005). For example, the Australian study by Najman et al. (2005) using a random probability sample indicates that CSA is "significantly associated with the frequency of sexual dysfunction symptoms" (p. 522) and that women with a history of CSA have more sexual partners over a lifetime. In a similar line, Stein, Golding, Siegel, Burnam and Sorension (1988, as cited in Leonard & Follette, 2002) examined a random probability sample of 3132 men and women in the Los Angeles area. The lifetime prevalence of sexual difficulties for women with a history of CSA included 35% reporting a fear of sex, 32% reporting less sexual interest and 36% reporting less sexual pleasure. The population-based study by Laumann, Gagnon, Michael and Michaels (1994, as cited in Leonard & Follette, 2002) indicated that over half of women with a history of CSA report emotional problems that interfere with sex.

It is also important to note that CSA is not a contained event and that many women who report a history of CSA also report experiencing childhood physical, psychological and emotional abuse and neglect (Feliti et al., 1998; Gibb, Chelminski, & Zimmerman, 2007; Higgins & McCabe, 2001; Meston et al., 1999). These other forms of childhood maltreatment have also been associated with long-term adverse outcomes, including sexual difficulties (Feliti et al., 1998; Johnson et al., 2002; Meston et al., 1999; Scholerdt & Heiman, 2003). For example, Scholerdt and Heiman (2003) compared women who reported childhood physical and sexual abuse, sexual abuse only and no abuse history on measures of sexual functioning and behaviour. Negative affect during sexual arousal and number of sexual partners differentiated the physical and sexual abuse group from the control group, but did not differentiate the sexual abuse group from the other two groups. This may suggest that CSA alone is not as strong a predictor of sexual difficulties as is combined forms of abuse, or that physical abuse is a stronger predictor of sexual difficulties than CSA. Other research indicates however, that sexual abuse is associated with an increased likelihood of a range of sexual difficulties, independent of the effects of other forms of childhood maltreatment (Briere & Runtz, 1990; Meston et al., 1999). For example, Meston et al. (1999) found that after controlling for the effects of other forms of childhood maltreatment, significant correlations remained between CSA and unrestricted sexual attitudes, fantasies and behaviours, frequency of masturbation and intercourse, variety of sexual experience and sexual fantasy and liberal sexual attitudes.

The female sexual response cycle

In order to conceptualise the association between sexual trauma and sexual difficulties, the multidimensional nature of female sexual response should be explored. Traditional models of female sexual response have depicted a progression from desire through increasing arousal to orgasm. Updated models have sought to include the mediating roles of cognition and affect through expectancies,

attributions, apprehension, anxiety and mood (Rellini, 2006). Basson (2000, 2002) identifies a number of aspects of female sexuality that incorporate many of the criticisms of earlier models. These include the notion that women's motivations to have a sexual experience may stem from rewards that are not strictly sexual (e.g. emotional closeness, acceptance, love) and women's sexual arousal is a subjective mental excitement that may or may not be accompanied by awareness of physical manifestations of arousal.

Based on the model of female sexual response proposed by Basson (2000), it is hypothesised that the distress associated with sexuality observed in some women with a history of CSA may be linked to the non-sexual gains that women seek from sexual experience. These non-sexual rewards, characteristic of emotional intimacy, are often not experienced, or experienced with difficulty, in women with a history of CSA. It is therefore argued that if women with a history of CSA are unable to achieve these non-sexual rewards through sexual experience, then they are more likely to consider the sexual experience unsatisfying. It is also probable that they will not experience the sexual desire that goes with these non-sexual rewards and, ultimately, not have a satisfying or sexually functional experience (Leonard & Follette, 2002). This hypothesis would account for decreased sexual desire, decreased sexual arousal and decreased sexual satisfaction reported in women with a history of CSA (Bartoi & Kinder, 1998; Becker et al., 1982; Tsai et al., 1979).

Theoretical models of CSA and sexual function

Theoretical conceptualisations of the association between CSA and adult sexual functioning can be divided into two groups: those that posit a direct effect of CSA on adult sexual outcome and those that assume moderating factors such as patterns of coping (Hall, 2007). The trauma-based models, such as that put forth by Finkelhor and Browne (1985) posit a direct link between different aspects of sexual abuse and different traumatic reactions. In terms of sexual functioning this is a straightforward trajectory from traumatic sexualisation to sexual problems in adulthood. There is some research to support the influence of particular CSA variables on long-term outcome. These variables include duration of the abuse (Steel, Sanna, Hammond, Whipple, & Cross, 2004), the use of physical force (Rind & Tromovitch, 1997), number of perpetrators (Steel et al., 2004) and CSA involving oral-genital contact or anal or vaginal penetration (Becker et al., 1982; Fergusson et al., 1997; Najman et al., 2005; Steel et al., 2004).

The major drawback of trauma models of the association between CSA and adult sexual functioning is the failure to locate the sexual abuse within an unfolding life course (Browning & Laumann, 1997). That is to say, such models fail to take into account subsequent life events that may impact upon adult sexual outcome and fail to predict what the problems may be. Furthermore, despite the empirically established association between specific CSA variables and an increased likelihood of adverse outcome, there is still considerable variability in outcome that cannot be adequately account for by these variables alone (Hall, 2007).

An alternative to trauma models that assume a direct link between CSA and adult sexual outcome, are developmental theories. The theory put forth by Browning and Laumann (1997) assumes that moderating variables explain the long-term outcomes of CSA. Browning and Laumann argue a life course perspective, whereby sexual trajectories such as patterns of sexual activity established after CSA account

for differences in sexual outcome seen in women with a history of CSA. In support of this view there is considerable empirical evidence for the impact of moderating variables on sexual outcome, thus refuting the concept of a straightforward trajectory from traumatic sexualisation to sexual difficulties in adulthood. Variables that have been identified as having a moderating effect include family environment (Elliot & Carnes, 2001; Hyman, 2001), other forms of childhood maltreatment (Felitti et al., 1998; Schloredt & Heiman, 2003), reactions and support following disclosure (Elliot & Carnes, 2001; Gold, 1986; Jonzon & Lindblad, 2006) and sexual re-victimisation (Hyman, 2001; Mackey et al., 1991). There is also a growing body of evidence that suggests that the coping strategies implemented during and after CSA are a significant moderating variable in determining long-term general and sexual outcome (Bal, van Oost, de Bourdeaudhuij, & Crombez, 2003; Herman-Stahl, Stemmler, & Petersen, 1995; Leipold, & Greve, 2009; Merrill, Guimond, Thomsen, & Milner, 2003; Runtz & Schalllow, 1997).

Coping strategies are the cognitive and behavioural strategies used in the management of internal and/or external stress, such as that surrounding a CSA experience (Lazarus, 1993; Proulx, Koverola, Federowicz, & Kral, 1995). Various measures of coping have been proposed, however, the most enduring is that which categorises cognitions, emotions and behaviours as either orientated toward or away from the CSA experience and associated stimuli (Herman-Stahl et al., 1995; Lazarus, 1993). Approach strategies have been described as problem-focused coping strategies as they attempt to manage or change the stressor, whereas avoidance strategies are described as emotion-focused as they serve to regulate the emotional pain associated with abuse, largely through functionally avoidant cognitions and behaviours (Wright, Crawford, & Sebastian, 2007). The most commonly identified patterns of coping in women with a history of CSA are those that avoid rather than approach stimuli associated with the abuse (Leitenberg, Gibson, & Novy, 2004; Sigmon, Greene, Rohan, & Nichols, 1996). This avoidant style coping can be further divided into self-destructive coping strategies and avoidance coping strategies, both of which are associated with particular patterns of sexual functioning and behaviour (Merrill et al., 2003).

The authors acknowledge that the labelling of a coping strategy and associated patterned functioning and behaviour as ''self-destructive'' may be seen as stigmatising. This label is, however, one commonly used in contemporary literature (for example, Boudewyn & Liem, 1995; Merrill et al., 2003; Rodriguez-Srednicki, 2001) and will also be used in this paper in reference to a range of potentially damaging and risky behaviours, including alcohol and drug abuse, self-harming behaviours and sexual risk-taking. Researchers such as Brown, Comtois and Linehan (2002), Klonsky (2007) and Osuch, Noll and Putnam (1999) note that it is extremely important to put the behaviour in context of what the person gains as a function of the self-injurious and self-destructive behaviours. The function of these behaviour may be associated with affect regulation, disassociation from the painful memories of CSA and attempts to destroy the self-identity attached to being a *victim* of CSA.

A history of CSA has been associated with two seemingly opposite patterns of sexual functioning and behaviour; ''oversexualisation'' (also termed hypersexuality) and ''undersexualisation'' (hyposexuality) (Najman et al., 2005; Rellini, 2008). ''Oversexualisation'' is a term that encompasses an increase in a range of sexual behaviours and cognitions associated with a history of CSA, including a higher prevalence of sexual risk-taking behaviours, multiple and transient sexual relationships and more liberal sexual attitudes (Colman & Widom, 2004; Merril et al., 2003;

Meston et al., 1999). The term ''undersexualisation'' refers to sexual avoidance and distress, emotional difficulties related to sex and sexual functioning difficulties (Becker et al., 1982; Pistorello & Follette, 1998; Tsai et al., 1979). The use of self-destructive coping strategies has been associated ''oversexualisation'', whereas avoidant coping strategies have been associated with ''undersexualisation'' (Merrill et al., 2003).

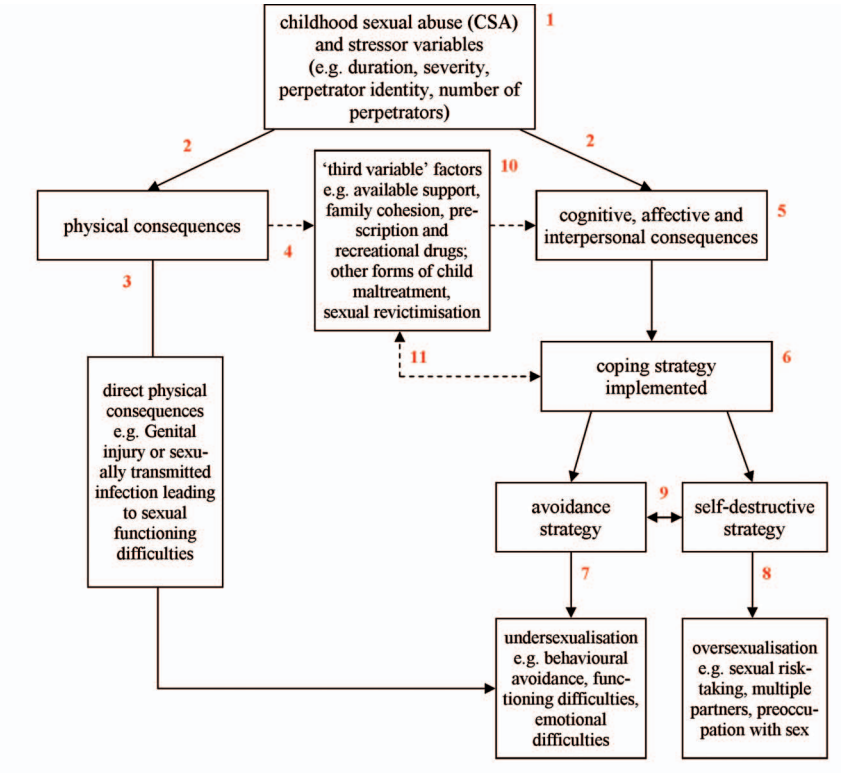
The authors argue that both self-destructive and avoidance coping strategies can be interpreted as functionally avoidant behaviours. This functionality can be conceptualised through an experiential avoidance model, based on the principle that behaviour is understood in terms of function rather than topography and that context must be examined in order to understand the function of the behaviour (Leonard & Follette, 2002). The context, within which a behaviour occurs includes both distal variables such as early sexual experiences and proximal variables such as current stressors and relationships. From this theoretical perspective, both coping strategies and associated patterns of sexual difficulties can be understood as behaviours to avoid or alter the experience of unpleasant internal events, including painful thoughts, feelings and memories (Leonard & Follette, 2002). Avoidance coping strategies and associated ''undersexualisation'' can be understood as functioning to avoid stimuli, particularly sexual stimuli associated with the abuse. Self-destructive coping strategies and associated ''oversexualisation'' can also be understood as functionally avoidant when the motivations and perceptions of sex are considered. For example, multiple and transient sexual relationships have been associated with attempts to regain self-esteem, attention, power and control, to counteract a sense of isolation and using physical sensations to distract from emotional pain (Davis & Petretic-Jackson, 2000; Lee, 1995, as cited in Loeb et al., 2002, p. 313).

A new model of association

Based on a critical review of the CSA literature, the authors suggest a preliminary theoretical model for an association between CSA and adult sexual difficulties. This model is adapted from a number of earlier models, in accordance with noted criticism of previous research and with the addition of factors that the authors believe have not previously been placed within a CSA/adult sexual outcome model. As depicted in Figure 1, the authors propose a number of associations between CSA and female adult sexual difficulties. It must noted, however, that in depicting such theorised associations, the authors in no way imply that these are the only possible outcomes of CSA. In focusing on problematic sexual outcomes, the authors have not included within the model other alternative outcomes of abuse, such as the implementation of positive coping strategies and associated sexual outcome.

Firstly, CSA is a stressor with high traumatic potential. It does not exist as a contained event and has been associated with a range of immediate and longer-term intrapersonal and interpersonal difficulties (Davis & Petretic-Jackson, 2000; Felitti et al., 1998; Gold, 1986; Lesserman, 2005; Pistorello & Follette, 1998). The actual CSA can be regarded as the primary stressor and the subsequent intrapersonal and interpersonal difficulties as the secondary stressors.

There is also considerable variability across CSA experiences and a number of abuse characteristics have been associated with greater likelihood of adverse outcome. These ''stressor variables'' include duration of the abuse and number of perpetrators (Steel et al., 2004) the use of physical force (Rind & Tromovitch, 1997) and CSA that involves oral-genital contact or anal or vaginal penetration (Becker et al., 1982;



1. CSA as primary stressor and stressor variables.
2. CSA leads to intrapersonal (physical, cognitive and affective) and interpersonal difficulties, which in themselves are also a source of stress (secondary stressors).
3. Direct physical consequences (i.e. no moderating variables) of CSA on sexual outcome leading to sexual functioning difficulties.
4. Indirect physical consequences of CSA by way of cognitive/affective difficulties. May be affected by moderating variables.
5. Cognitive, affective and interpersonal consequences of CSA.
6. A functionally avoidant coping strategy is implemented to manage the stress associated with the CSA and subsequent intrapersonal and interpersonal difficulties.
7. An avoidance coping strategy is associated with undersexualisation which encompasses sexual avoidance, sexual functioning difficulties and cognitive and emotional sexual difficulties.
8. A self-destructive coping strategy is associated with oversexualisation which encompasses sexual risk-taking behaviours, multiple transient relationships and preoccupation with sex.
9. The two coping strategies are not fixed, can change over time and contexts an can co-occur.
10. 'Third variable' factors may account for variability in outcome and across time by way of influence on the cognitive, affective and interpersonal consequences of the CSA and on the coping strategy that is implemented.
11. The utilised coping strategies can impact on the 'third variables' and cognitive, affective and interpersonal consequences component by way of a feedback component.

Figure 1. The association between childhood sexual abuse and adult female sexual difficulties.

Fergusson et al., 1997; Najman et al., 2005; Steel et al., 2004). In addition, abuse severity has also been associated with the increased likelihood of implementing functionally avoidant coping strategies (Coffey, Leitenberg, Henning, Turner, & Bennett, 1996; Filipas & Ullman, 2006; Fortier et al., 2009; Leitenberg et al., 2004).

Childhood sexual abuse may result in physical consequences that have a direct impact on sexual outcome (i.e. no moderating variables). For example, CSA may result in genital injury and/or sexually transmitted infections (STIs) leading to sexual functioning difficulties such as arousal, orgasm and sexual pain difficulties (Christian et al., 2000; Heppenstall-Heger et al., 2003; Johnson, 2004). Physical consequences of CSA can also have an indirect impact on sexual outcome by way of cognitive, affective and interpersonal difficulties founded in physiological consequences (Johnson, 2004).This component of the model may be affected by moderating variables, for example, support from others may reduce the likelihood of cognitive, affective and interpersonal difficulties (Gold, 1986; Jonzon & Lindblad, 2006).

In addition to physical consequences, elements of the CSA experience may be so difficult to integrate into the concept of self and the world, that distortions of cognition and affect occur (Spacarelli, 1994). Potential cognitive and affective consequences of CSA include low self-esteem and self-worth (Diehl & Prout, 2002; Gold, 1986; Gwandure, 2007), shame and self-blame (Feiring & Taska, 2005), emotions such as anger, fear, despair and confusion and emotional detachment (Burnam et al., 1988; Gold, 1986; Steel et al., 2004). These cognitive and affective consequences are associated with a wide array of interpersonal outcomes, including issues with trust and difficulties with emotional and sexual communication (DiLillo & Long, 1999; Pistorello & Follette, 1998).

In order to manage the internal and external stress surrounding the CSA experience and associated immediate and long-term consequences, a coping strategy of functionally avoidant, patterned cognitions and behaviours may be implemented (Lazarus, 1993; Leitenberg et al., 2004; Proulx et al., 2005; Sigmon et al., 1996). Numerous studies suggest that the coping strategies implemented in response to the CSA are the significant moderating variable between the abuse and adult adjustment (Bal et al., 2003; Herman-Stahl et al., 1995; Merril, Thomsen, Sinclair, Gold, & Milner, 2001; Runtz & Schalllow, 1997). The two main categories of coping in women with a history of CSA are self-destructive strategies and avoidance strategies. Each coping strategy is associated with a specific sexual outcome of patterned sexual behaviour, sexual functioning and sexuality-relevant cognitions (Merrill et al., 2003).

Self-destructive strategies are associated with ''oversexualisation'', a pattern of sexual behaviour and functioning that encompasses indiscriminate and risky sexual behaviour, transient sexual relationships and more liberal sexual attitudes (Merrill et al., 2003). Avoidance coping strategies are associated with the sexual outcome of ''undersexualisation'', characterised by sexual avoidance, sexual distress and sexual functioning difficulties (Merrill et al., 2003).These two coping strategies are not fixed, can change over time and in accordance with the greater context in which they occur and are strongly and positively correlated, indicating that many women use both types of avoidant coping strategies (Hall, 2007; Leipold & Greve, 2009; Merrill et al., 2003). The sexual distress of some women with a history of CSA has been linked to the coexistence or experience in quick succession of ''oversexualisation'' and ''undersexualisation'' (Rellini, 2008).

Childhood sexual abuse is not a contained event – it occurs within the context of a range of external and individual factors. In accordance with a life course perspective, ''third variables'' may impact on the sexual outcome at any stage of the sexual trajectory. Empirical evidence supports the notion that moderating variables may account for at least some of the variability in sexual outcome seen between

individuals and across time and context. These variables include family environment (Elliot & Carnes, 2001; Hyman, 2001), other forms of child maltreatment (Felitti et al., 1998; Schloredt & Heiman, 2003), family and peer reactions following disclosure and social support (Elliot & Carnes, 2001; Gold, 1986; Jonzon, & Lindblad, 2006) and sexual revictimisation (Hyman, 2001; Mackey et al., 1991). For example, disclosure of CSA may be met by positive responses, negative responses or indifference. Positive responses and support following disclosure have been associated with more adaptive outcomes (Fillipas & Ullman, 2001; Murthi, & Espelage, 2005), whereas negative responses have been associated with more adverse outcomes (Brand & Alexander, 2003). Similarly, sexual revictimisation in adolescence or adulthood has been shown to compound the difficulty in resolving sexual trauma and has been associated with more sexual difficulties (Mackey et al., 1991). This variable is of importance given that women with a history of CSA are significantly more likely than non-abused women to experience sexual revictimisation (Filipas & Ullman, 2006; Fromuth, 1986; Walsh et al., 2007).

In addition, cognitive and affective consequences of CSA may include mood and anxiety disorders (Boudewyn & Liem, 1995; Fergusson et al., 2008; Meston et al., 2006; Spataro et al., 2004) and PTSD (Connor & Higgins, 2008; Gwandure, 2007). These conditions have been associated with sexual difficulties (Baldwin, 2001; Montejo, Llorca, Izquierdo, & Rico-Villademoros, 2001; Schnurr et al., 2009) and antidepressant medications which are commonly used to treat these conditions have also been linked to sexual difficulties (Kennedy, Dickens, Eisfeld, & Bagby, 1999; Schweitzer, Maguire, & Ng, 2009). In the reviewed literature, no studies specifically examined the association between antidepressants and sexual difficulties in conjunction with a history of CSA. This association, may, in part, account for the higher prevalence of sexual difficulties reported in women with a history of CSA.

Lastly, there is also a feedback component, whereby, coping strategies may influence "third variable" factors and cognitive, affective and interpersonal consequences of CSA. For example, Research indicates that both self-destructive and avoidance coping strategies are associated with poorer adult adjustment and greater distress and general symptomotology (Filipas & Ullman, 2006; Frazier et al., 2005; Merrill et al., 2001).

Case example

Jenny is a 25-year-old, highly diligent secretary who is a survivor of CSA, which occurred from 8 to 12 years of age. The abuse was from Mike, a male, 40-year-old, family friend who would often take her to sport, where the majority of the non-violent, highly seductive, self-affirming, manipulative, sexual abuse would occur. The abuse stopped when Mike and his family moved away.

Jenny has never spoken to her family about the abuse. In her early teens at school she was shy, reclusive and studious at her school work but had few friends or socialised very much with peers. Towards the end of her high school dance event she was approached by one of the more attractive boys to dance with and then to go out behind the hall. After some kissing, she was pressured into and began giving oral sex to him. Three other boys were beckoned by him to also engage in the activities with Jenny. Though she physically resisted at first, pushing them away and shouting at them to stop, as one of them started to thrust into her she stopped resisting and actively engaged in the behaviours.

Jenny came for psycho-educational therapy at 23 due to contracting herpes from unprotected sex. Her medical officer referred her to counselling as she noted that she would never use condoms or other protective methods as she believed she would never catch anything. She believed that all men could be manipulated with sex to get her things, to achieve certain things and she certainly wasn't going to wear condoms and risk them viewing her as a slut. Since age 18 she averaged five sexual partners a month and was in a 12-month relationship with a male director associated with her work – which he assumed was monogamous.

Jenny's situation is not uncommon. During the behaviours involved with the childhood sexual abuse she gained some self-affirming views of herself, but these were developed from manipulated, seductive statements and behaviours in order to continue the abuse. Her teen years were characterised with avoidance behaviour, then in her early adult years she displayed and continues to behave in a manner that is self-destructive, non-trusting and self-focused. In many ways the ''third variables'' noted in the preliminary model continue to have a negative impact on Jenny's sexual world as there is no positive change in the third variables. If changes in the third variable resulted in her attempting to alter her ways of coping (for example, attempting to trust, to gain attention from other aspects rather than just sex) her behaviours and her concept of self may become less risky and more positive in both physical and psychological levels.

Implications for intervention approaches

The lack of a theoretical framework to explain the variations in sexual functioning and behaviour of women with a history of CSA has led to an eclectic and confusing conceptualisation of this phenomenon, with limited clinical relevance (Rellini, 2008). The theoretical model presented in this paper provides a clinically relevant and condensed conceptual understanding of the association between childhood sexual abuse and female adult sexual difficulties. Such a model has a two-fold benefit in terms of clinical interventions: it can assist the clinician in their understanding of CSA and adult sexual outcome and provide a framework for specific treatment intervention, such as targeted exploration of coping strategies. It may also benefit women with a history of CSA in providing a framework to understand their own processes. Hall (2007, p. 362) suggests that ''far more important than all the support and understanding provided by a therapist is giving clients a way of *thinking* about childhood sexual abuse experiences that makes sense of their feelings and their current sexual relationship''. Therefore, part of the therapeutic process is gaining an understanding of what happened and how it influenced the broad and specific aspects of sexuality. This process would be greatly assisted by a conceptual model such as that proposed in this paper.

Treatment for women with a history of CSA is typically unsystematic and long-term (Meston & Heiman, 2000). Although it has been argued that dealing with past abuse will result in alleviation of sexual symptomology, there is little empirical data to support this view and there is no agreement regarding what the resolution of sexual abuse issues would look like (Hall, 2007). Research has, however, consistently demonstrated that avoidance and self-destructive coping strategies are associated with poorer adult adjustment and greater symptomology (Filipas & Ullman, 2006; Frazier, Mortensen, & Steward, 2005; Merrill et al., 2001), whereas approach coping strategies (e.g. support seeking, discussing CSA and cognitive reframing) are

associated with higher levels of adjustment and reduced symptomology (Merrill et al., 2001; Runtz & Schallow, 1997; Tremblay, Hebert, & Piche, 1999). These associations indicate that women with a history of CSA may benefit from treatment interventions that include targeted exploration of coping strategies. There is also some initial evidence that a reduction of PTSD symptoms is associated with a decrease in sexual concerns (Schnurr et al., 2009). However, this study should be interpreted with caution, given that the sample consisted of female veterans and active duty personnel who had experienced some form of sexual trauma, but not necessarily CSA.

Conclusion and future direction

The preliminary model presented in this paper draws from a number of theoretical models, taking into consideration previous critiques and identifying important factors that have not adequately been accounted for in the reviewed literature. The authors argue that this association between CSA and adult sexual outcome is best conceptualised through exploration of the intrapersonal and interpersonal consequences of CSA, the implementation of coping strategies and the role of ''third variables'' in the manifestation of a sexual trajectory. This model provides a clinically relevant and accessible conceptualisation of the association between CSA and female adult sexual difficulties, which may benefit clinicians and women with a history of CSA in providing a framework for understanding processes and developing targeted treatment intervention.

On the basis of current research, no causal conclusions can be drawn in terms of a history of CSA and adult sexual difficulties. The authors recognise that not all women with a history of CSA will report adult sexual difficulties. However, we argue that there is considerable empirical evidence to suggest an association between CSA and problematic sexual functioning and behaviour. Contradictory findings do, however, stand to question such research, with a number of studies indicating no significant association between CSA and later sexual outcome. There a number of factors that may account for the differences in findings, including sampling, definitional criteria and measurement, and future studies need to address these issues. Based on the reviewed literature, there is a need for further exploration of the impact of coping strategies and other moderating variables on overall adjustment and sexual outcome in women with a history of CSA. In terms of the preliminary theoretical model presented in this paper, further research is needed to test the relevance and accuracy of this conceptualisation in intervention settings and in its ability to capture the complexities of this phenomenon.

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References

Andrews, B., Brewin, C.R., Philpott, R., & Stewart, L. (2007). Delayed-onset post-traumatic stress disorder: A systematic review of the evidence. *American Journal of Psychiatry*, *164*(9), 1319–1326.

Bal, S., van Oost, P., de Bourdeaudhuij, I., & Crombez, G. (2003). Avoidant coping as a mediator between self-reported sexual abuse and stress-related symptoms in adolescents. *Child Abuse & Neglect*, *27*(8), 883–897.

Baldwin, D.S. (2001). Depression and sexual dysfunction. *British Medical Bulletin*, *57*, 81–99.

Bartoi, M.G., & Kinder, B.N. (1998). Effects of child and adult sexual abuse on adult sexuality. *Journal of Sex & Marital Therapy*, *24*(2), 75–90.

Basson, R. (2000). The female sexual response: A different model. *Journal of Sex and Marital Therapy*, *26*, 51–65.

Basson, R. (2002). A model of women's sexual arousal. *Journal of Sex and Marital Therapy*, *28*, 1–10.

Becker, J.V., Skinner, L.J., Abel, G.G., & Treacy, E.C. (1982). Incidence and types of sexual dysfunctions in rape and incest victims. *Journal of Sex & Marital Therapy*, *8*(1), 65–74.

Boudewyn, A.C., & Liem, J.H. (1995). Childhood sexual abuse as a precursor to depression and self-destructive behavior in adulthood. *Journal of Traumatic Stress*, *8*(3), 445–459.

Brand, B.L., & Alexander, P.C. (2003). Coping with incest: The relationship between recollections of childhood coping and adult functioning in female survivors of incest. *Journal of Traumatic Stress*, *16*(3), 285–293.

Briere, J., & Runtz, M. (1986). Suicidal thoughts and behaviours in former sexual abuse victims. *Canadian Journal of Behavioural Science/Revue canadienne des sciences du comportement*, *18*(4), 413–423.

Briere, J., & Runtz, M. (1990). Differential adult symptomatology associated with three types of child abuse histories. *Child Abuse & Neglect*, *14*(3), 357–364.

Brown, M., Comtois, K.A., & Linehan, M.M. (2002). Reasons for suicide attempts and nonsuicidal self-injury in women with borderline personality disorder. *Journal of Abnormal Psychology*, *111*(1), 198–202.

Browning, C.R., & Laumann, E.O. (1997). Sexual contact between children and adults: A life course perspective. *American Sociological Review*, *62*(4), 540–560.

Burnam, M., Stein, J.A., Golding, J.M., Siegel, J.M., Sorenson, S.B., Forsythe, A.B., et al. (1988). Sexual assault and mental disorders in a community population. *Journal of Consulting and Clinical Psychology*, *56*(6), 843–850.

Cameron, C. (2000). *Resolving childhood trauma: The long-term study of abuse survivors*. Thousand Oaks, CA: SAGE.

Christian, C.W., Lavelle, J.M., De Jong, A.R., Loiselle, J., Brenner, L., & Joffe, M. (2000). Forensic evidence findings in prepubertal victims of sexual assault. *Pediatrics*, *106*(1), 100–104.

Coffey, P., Leitenberg, H., Henning, K., Turner, T., & Bennett, R.T. (1996). The relation between methods of coping during adulthood with a history of childhood sexual abuse and current psychological adjustment. *Journal of Consulting and Clinical Psychology*, *64*(5), 1090–1093.

Colman, R.A., & Widom, C.S. (2004). Childhood abuse and neglect and adult intimate relationships: A prospective study. *Child Abuse & Neglect*, *28*(11), 1133–1151.

Connor, P.L., & Higgins, D.J. (2008). The ''HEALTH'' model. Part 1: Treatment program guidelines for complex PTSD. *Sexual and Relationship Therapy*, *23*(4), 293–303.

Crooks, R., & Baur, K. (2008). *Our sexuality* (10th ed.). Belmont, CA: Thomson Wadsworth.

Davis, J.L., & Petretic-Jackson, P.A. (2000). The impact of child sexual abuse on adult interpersonal functioning: A review and synthesis of the empirical literature. *Aggression and Violent Behavior*, *5*(3), 291–328.

Diehl, A.S., & Prout, M.F. (2002). Effects of post-traumatic stress disorder and child sexual abuse on self-efficacy development. *American Journal of Orthopsychiatry*, *72*(2), 262–265.

DiLillo, D., & Long, P.J. (1999). Perceptions of couple functioning among female survivors of child sexual abuse. *Journal of Child Sexual Abuse: Research, Treatment, & Program Innovations for Victims, Survivors, & Offenders*, *7*(4), 59–76.

Drauker, C.B. (2000). *Counselling survivors of childhood sexual abuse* (2nd ed.). London: SAGE.

Elliott, A.N., & Carnes, C.N. (2001). Reactions of non-offending parents to the sexual abuse of their child: A review of the literature. *Child Maltreatment*, *6*(4), 314–331.

Fanslow, J.L., Robinson, E.M., Crengle, S., & Perese, L. (2007). Prevalence of child sexual abuse reported by a cross-sectional sample of New Zealand women. *Child Abuse & Neglect*, *31*, 935–945.

Feiring, C., & Taska, L.S. (2005). The persistence of shame following sexual abuse: A longitudinal look at risk and recovery. *Child Maltreatment*, *10*(4), 337–349.
Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*, *14*(4), 245–258.
Fergusson, D.M., Boden, J.M., & Horwood, L. (2008). Exposure to childhood sexual and physical abuse and adjustment in early adulthood. *Child Abuse & Neglect*, *32*(6), 607–619.
Fergusson, D.M., Horwood, L., & Lynskey, M.T. (1997). Childhood sexual abuse, adolescent sexual behaviors and sexual revictimization. *Child Abuse & Neglect*, *21*(8), 789–803.
Fergusson, D.M., & Mullen, P.E. (1999). *Childhood sexual abuse: An evidence based perspective*. Thousand Oaks, CA: SAGE.
Filipas, H.H., & Ullman, S.E. (2001). Social reactions to sexual assault victims from various support sources. *Violence and Victims*, *16*(6), 673–692.
Filipas, H.H., & Ullman, S.E. (2006). Child sexual abuse, coping responses, self-blame, post-traumatic stress disorder and adult sexual revictimization. *Journal of Interpersonal Violence*, *21*(5), 652–672, 789–803.
Finkelhor, D., & Browne, A. (1985). The traumatic impact of child sexual abuse: A conceptualization, *American Journal of Orthopsychiatry*, *66*, 530–541.
Finkelhor, D., Hotaling, G.T., Lewis, I., & Smith, C. (1989). Sexual abuse and its relationship to later sexual satisfaction, marital status, religion and attitudes. *Journal of Interpersonal Violence*, *4*(4), 379–399.
Fortier, M.A., DiLillo, D., Messman-Moore, T.L., Peugh, J., DeNardi, K.A., & Gaffey, K.J. (2009). Severity of child sexual abuse and revictimization: The mediating role of coping and trauma symptoms. *Psychology of Women Quarterly*, *33*(3), 308–320.
Frazier, P.A., Mortensen, H., & Steward, J. (2005). Coping strategies as mediators of the relations among perceived control and distress in sexual assault survivors. *Journal of Counseling Psychology*, *52*(3), 267–278.
Fromuth, M.E. (1986). The relationship of childhood sexual abuse with later psychological and sexual adjustment in a sample of college women. *Child Abuse & Neglect*, *10*(1), 5–15.
Gibb, B.E., Chelminski, I., & Zimmerman, M. (2007). Childhood emotional, physical and sexual abuse and diagnoses of depressive and anxiety disorders in adult psychiatric outpatients. *Depression and Anxiety*, *24*(4), 256–263.
Gold, E.R. (1986). Long-term effects of sexual victimization in childhood: An attributional approach. *Journal of Consulting and Clinical Psychology*, *54*(4), 471–475.
Gwandure, C. (2007). Sexual assault in childhood: Risk HIV and AIDS behaviours in adulthood. *AIDS Care*, *19*(10), 1313–1315.
Hall, K. (2007). Sexual dysfunction and childhood sexual abuse: Gender differences and treatment implications. In S.R. Leiblum (Ed.), *Principles and practices of sex therapy* (4th ed., pp. 350–378). New York: The Guilford Press.
Harrison, P.A., Fulkerson, J.A., & Beebe, T.J. (1997). Mulitple substance use among adolescent physical and sexual abuse victims. *Child Abuse & Neglect*, *21*(6), 529–539.
Heiman, J.R., & Heard-Davison, A.R. (2004). Child sexual abuse and adult sexual relationships: Review and perspective. In L.J. Koenig, L.S. Doll, A. O'Leary, & W. Pequegnat (Eds.), *From child sexual abuse to adult sexual risk: Trauma, revictimisation and intervention* (pp. 13–47). Washington, DC: American Psychological Association.
Heppenstall-Heger, A., McConnell, G., Ticson, L., Guerra, L., Lister, J., & Zaragoza, T. (2003). Healing patterns in anogenital injuries: A longitudinal study of injuries associated with sexual abuse, accidental injuries, or genital surgery in the preadolescent child. *Pediatrics*, *112*, 829–837.
Herman-Stahl, M.A., Stemmler, M., & Petersen, A.C. (1995). Approach and avoidant coping: Implications for adolescent mental health. *Journal of Youth and Adolescence*, *24*(6), 649–665.
Higgins, D.J., & McCabe, M.P. (2001). Multiple forms of child abuse and neglect: Adult retrospective reports. *Aggression and Violent Behavior*, *6*(6), 547–578.
Hyman, B.W.L. (2001). Resilience among women survivors of child sexual abuse. *AFFILIA*, *16*(2), 198–219.
Johnson, C.F. (2004). Child sexual abuse. *Lancet*, *364*, 462–470.

Johnson, R.M., Kotch, J.B., Catellier, D.J., Winsor, J.R., Dufort, V., Hunter, W., et al. (2002). Adverse behavioral and emotional outcomes from child abuse and witnessed violence. *Child Maltreatment*, *7*(3), 179–186.

Jonzon, E., & Lindblad, F. (2006). Risk factors and protective factors in relation to subjective health among adult female victims of child sexual abuse. *Child Abuse & Neglect*, *30*(2), 127–143.

Kennedy, S.H., Dickens, S.E., Eisfeld, B.S., & Bagby, R. (1999). Sexual dysfunction before antidepressant therapy in major depression. *Journal of Affective Disorders*, *56*(2–3), 201–208.

Klonsky, E.D. (2007). The functions of deliberate self-injury: A review of the evidence. *Clinical Psychology Review*, *27*, 226–239.

Lazarus, R.S. (1993). Coping theory and research: Past, present and future. *Psychosomatic Medicine*, *55*(3), 234–247.

Leipold, B., & Greve, W. (2009). Resilience: A conceptual bridge between coping and development. *European Psychologist*, *14*(1), 40–50.

Leitenberg, H., Gibson, L.E., & Novy, P.L. (2004). Individual differences among undergraduate women in methods of coping with stressful events: The impact of cumulative childhood stressors and abuse. *Child Abuse & Neglect*, *28*(2), 181–192.

Leonard, L.M., & Follette, V.M. (2002). Sexual functioning in women reporting a history of child sexual abuse: Review of the empirical literature and clinical implications. *Annual of Sex Research*, *13*, 346–388.

Lesserman, J. (2005). Sexual abuse history: Prevalence, health effects, mediators and psychological adjustment. *Psychosomatic Medicine*, *67*, 906–915.

Loeb, T.B., Williams, J.K., Carmona, J.V., Rivkin, I., Wyatt, G.E., Chin, D. et al. (2002). Child sexual abuse: Associations with the sexual functioning of adolescents and adults. *Annual of Sex Research*, *13*, 307–345.

Maikovich-Fong, A.K., & Jaffee, S.R. (2010). Sex differences in childhood sexual abuse characteristics and victims' emotional and behavioral problems: Findings from a national sample of youth. *Child Abuse & Neglect*, *34*(6), 429–437.

Maltz, W. (2001). *The sexual healing journey: A guide for survivors of sexual abuse* (rev. ed.). New York: HarperCollins.

Mackey, T.F., Hacker, S.S., Weissfeld, L.A., Ambrose, N.C., Fisher, M.G., & Zobel, D. (1991). Comparative effects of sexual assault on sexual functioning of child sexual abuse survivors and others. *Issues in Mental Health Nursing*, *12*(1), 89–112.

Merrill, L.L., Guimond, J.M., Thomsen, C.J., & Milner, J.S. (2003). Child sexual abuse and number of sexual partners in young women: The role of abuse severity, coping style, and sexual functioning. *Journal of Consulting and Clinical Psychology*, *71*(6), 987–996.

Merrill, L.L., Thomsen, C.J., Sinclair, B.B., Gold, S.R., & Milner, J.S. (2001). Predicting the impact of child sexual abuse on women: The role of abuse severity, parental support and coping strategies. *Journal of Consulting and Clinical Psychology*, *69*(6), 992–1006.

Meston, C.M., Heiman, J.R., & Trapnell, P.D. (1999). The relation between early abuse and adult sexuality. *Journal of Sex Research*, *36*(4), 385–395.

Meston, C.M., & Heiman, J.R. (2000). Sexual abuse and sexual function: An examination of sexually relevant cognitive processes. *Journal of Consulting and Clinical Psychology*, *68*(3), 399–406.

Meston, C.M., Rellini, A.H., & Heiman, J.R. (2006). Women's history of sexual abuse, their sexuality and sexual self-schemas. *Journal of Consulting and Clinical Psychology*, *74*(2), 229–236.

Montejo, A.L., Llorca, G., Izquierdo, J.A., & Rico-Villademoros, F. (2001). Incidence or sexual dysfunction associated with antidepressant agents: A prospective multicenter study of 1022 outpatients. *Journal of Clinical Psychiatry*, *62*(Suppl. 3), 10–21.

Moore, E.E., Romaniuk, H., Olsson, C.A., Jayasinghe, Y., Carlin, J.B., & Patton, G.C. (2010). The prevalence of childhood sexual abuse and adolescent unwanted sexual contact among boys and girls living in Victoria, Australia. *Child Abuse & Neglect*, *34*(5), 379–385.

Murthi, M., & Espelage, D.L. (2005). Childhood sexual abuse, social support and psychological outcomes: A loss framework. *Child Abuse & Neglect*, *29*(11), 1215–1231.

Najman, J.M., Dunne, M.P., Purdie, D.M., Boyle, F.M., & Coxeter, P.D. (2005). Sexual abuse in childhood and sexual dysfunction in adulthood: An Australian population-based study. *Archives of Sexual Behaviour*, *34*(5), 517–526.

Noll, J.G., Trickett, P.K., & Putman, F.W. (2003). A prospective investigation of the impact of childhood sexual abuse on the development of sexuality. *Journal of Consulting and Clinical Psychology*, *71*(3), 575–586.

Osuch, E.A., Noll, J.G., & Putnam, F.W. (1999). The motivations for self-injury in psychiatric patients. *Psychiatry*, *62*, 334–346.

Parillo, K.M., Freeman, R.C., Collier, K., & Young, P. (2001). Association between early sexual abuse and adult HIV-risky sexual behaviors among community-recruited women. *Child Abuse & Neglect*, *25*(3), 335–346.

Pereda, N., Guilera, G., Forns, M., & Gomez-Benito, J. (2009). The prevalence of child sexual abuse in community and student samples: A meta-analysis. *Clinical Psychology Review*, *29*(4), 328–338.

Pistorello, J., & Follette, V.M. (1998). Childhood sexual abuse and couples' relationships: Female survivors' reports in therapy groups. *Journal of Marital & Family Therapy*, *24*(4), 473–485.

Proulx, J., Koverola, C., Fedorowicz, A., & Kral, M. (1995). Coping strategies as predictors of distress in survivors of single and multiple sexual victimization and non-victimized controls. *Journal of Applied Social Psychology*, *25*(16), 1464–1483.

Rathus, S.A., Nevid, J.S., & Fichner-Rathus, L. (2008). *Human sexuality in a world of diversity* (7th ed.). Boston: Pearson.

Rellini, A.H. (2006). Sexual abuse. In I. Goldstein, A.M. Traish, C.M. Meston, & S.R. Davis (Eds.), *Women's sexual function and dysfunction: Study, diagnosis and treatment* (pp. 98–102). London: Taylor & Francis.

Rellini, A.H. (2008). Review of the empirical evidence for a theoretical model to understand the sexual problems of women with a history of CSA. *Journal of Sexual Medicine*, *5*, 31–46.

Rellini, A.H., & Meston, C.M. (2007). Sexual desire and linguistic analysis: A comparison of sexually abused and non-abused women. *Archives of Sexual Behaviour*, *36*, 67–77.

Rind, B., & Tromovitch, P. (1997). A meta-analytic review of findings from national samples on psychological correlates of child sexual abuse. *Journal of Sex Research*, *34*(3), 237–255.

Rind, B., & Tromovitch, P. (2007). National samples, sexual abuse in childhood and adjustment in adulthood: A commentary on Najman, Dunne, Purdie, Boyle, and Coxeter (2005). *Archives of Sexual Behavior*, *36*(1), 101–106.

Rodriguez-Srednicki, O. (2001). Childhood sexual abuse, dissociation and adult self-destructive behavior. *Journal of Child Sexual Abuse: Research, Treatment, & Program Innovations for Victims, Survivors, & Offenders*, *10*(3), 75–90.

Runtz, M.G., & Schallow, J.R. (1997). Social support and coping strategies as mediators of adult adjustment following childhood maltreatment. *Child Abuse & Neglect*, *21*(2), 211–226.

Schloredt, K.A., & Heiman, J.R. (2003). Perceptions of sexuality as related to sexual functioning and sexual risk in women with different types of childhood abuse histories. *Journal of Traumatic Stress*, *16*(3), 275–284.

Schnurr, P.P., Lunney, C.A., Forshay, E., Thurston, V.L., Chow, B.K., Resick, P.A., et al. (2009). Sexual function outcomes in women treated for post-traumatic stress disorder. *Journal of Women's Health*, *18*(10), 1549–1557.

Schweitzer, I., Maguire, K., & Ng, C. (2009). Sexual side-effects of contemporary antidepressants: Review. *Australian and New Zealand Journal of Psychiatry*, *43*(9), 795–808.

Senn, T.E., Carey, M.P., Vanable, P.A., Coury-Doniger, P., & Urban, M.A. (2006). Childhood sexual abuse and sexual risk behavior among men and women attending a sexually transmitted disease clinic. *Journal of Consulting and Clinical Psychology*, *74*(4), 720–731.

Siegel, J.A., & Williams, L.M. (2003). The relationship between child sexual abuse and female delinquency and crime: A prospective study. *Journal of Research in Crime and Delinquency*, *40*(1), 71–94.

Sigmon, S.T., Greene, M.P., Rohan, K.J., & Nichols, J.E. (1996). Coping and adjustment in male and female survivors of childhood sexual abuse. *Journal of Child Sexual Abuse: Research, Treatment, & Program Innovations for Victims, Survivors, & Offenders*, *5*(3), 57–76.

Soloman, Z., & Mikulincer, M. (2006). Trajectories of PTSD: A 20-year longitudinal study. *American Journal of Phychiatry*, *163*(4), 659–666.

Spaccarelli, S. (1994). Stress, appraisal and coping in child sexual abuse: A theoretical and empirical review. *Psychological Bulletin*, *116*(2), 340–362.

Spataro, J., Mullen, P.E., Burgess, P.M., Well, D.L., & Moss, S.A. (2004). Impact of child sexual abuse on mental health: Prospective study in males and females. *British Journal of Clinical Psychiatry*, *184*, 416–421.

Steel, J., Sanna, L., Hammond, B., Whipple, J., & Cross, H. (2004). Psychological sequelae of childhood sexual abuse: Abuse-related characteristics, coping strategies and attributional style. *Child Abuse & Neglect*, *28*(7), 785–801.

Swanston, H.Y., Parkinson, P.N., O'Toole, B.I., Plunkett, A.M., Shrimpton, S., & Oates, R.K. (2003). Juvenile crime, aggression and delinquency after sexual abuse: A longitudinal study. *British Journal of Criminology*, *43*, 729–749.

Tiefer, L., Hall, M., & Tavris, C. (2002). Beyond dysfunction: A new view of women's sexual problems. *Journal of Sex & Marital Therapy*, *28*(1), 225–232.

Tremblay, C., Hebert, M., & Piche, C. (1999). Coping strategies and social support as mediators of consequences in child sexual abuse victims. *Child Abuse & Neglect*, *23*(9), 929–945.

Tsai, M., Feldman-Summers, S., & Edgar, M. (1979). Childhood molestation: Variables related to differential impacts on psychosexual functioning in adult women. *Journal of Abnormal Psychology*, *88*(4), 407–417.

Ullman, S.E. (2007). Relationship to perpetrator, disclosure, social reactions and PTSD symptoms in child sexual abuse survivors. *Journal of Child Sexual Abuse: Research, Treatment, & Program Innovations for Victims, Survivors, & Offenders*, *16*(1), 19–36.

Walsh, K., Blaustein, M., Knight, W.G., Spinazzola, J., & van der Kolk, B.A. (2007). Resiliency factors in the relation between childhood sexual abuse and adulthood sexual assault in college-age women. *Journal of Child Sexual Abuse: Research, Treatment, & Program Innovations for Victims, Survivors, & Offenders*, *16*(1), 1–17.

Wenninger, K., & Heiman, J.R. (1998). Relating body image to psychological and sexual functioning in child sexual abuse survivors. *Journal of Traumatic Stress*, *11*(3), 543–562.

Wonderlich, S.A., Brewerton, T.D., Jocic, Z., Dansky, B.S., et al. (1997). Relationship of childhood sexual abuse and eating disorders. *Journal of the American Academy of Child & Adolescent Psychiatry*, *36*(8), 1107–1115.

Wright, M.O.D., Crawford, E., & Sebastian, K. (2007). Positive resolution of childhood sexual abuse experiences: The role of coping, benefit-finding and meaning-making. *Journal of Family Violence*, *22*(7), 597–608.

Wyatt, G.E., & Newcomb, M.D. (1990). Internal and external mediators of women's sexual abuse in childhood. *Journal of Consulting and Clinical Psychology*, *58*(6), 758–767.

Wyatt, G.E., & Peters, S.D. (1986). Issues in the definition of child sexual abuse in prevalence research. *Child Abuse & Neglect*, *10*(2), 231–240.