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Child sexual abuse and persistence of risky sexual behaviors and negative sexual outcomes over adulthood: Findings from a birth cohort☆

Thea van Roode*, Nigel Dickson, Peter Herbison, Charlotte Paul

Department of Preventive and Social Medicine, University of Otago, PO Box 913, Dunedin, 9054, New Zealand

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ABSTRACT

Objectives: To determine the impact of child sexual abuse (CSA) on adult sexual behaviors and outcomes over three age periods.
Methods: A longitudinal study of a birth cohort born in Dunedin, New Zealand in 1972/1973 was used. Information on CSA was sought at age 26, and on sexual behaviors and outcomes at ages 21, 26, and 32. Comparisons were over the whole period from age 18 to 32, then for the three age periods from age 18 to 21, 21 to 26, and 26 to 32, adjusting for measures of family environment.
Results: Overall, 465 women and 471 men (91.9% of the surviving cohort) answered questions about CSA. Contact CSA was reported by 30.3% of women and 9.1% of men. For abused women, significantly increased rates were observed for number of sexual partners, unhappy pregnancies, abortion, and sexually transmitted infections from age 18 to 21; with rates approaching those of nonabused over time. Conversely, for abused men rates were not significantly elevated in the youngest age period, but were for number of partners from age 26 to 32 and acquisition of herpes simplex virus type 2 from age 21 to 32.
Conclusions: Gender and age are critical when considering the effect of CSA. While the profound early impact of CSA demonstrated for women appears to lessen with age, abused men appear to carry increased risks into adulthood.
Practice implications: CSA is common and should be considered when young women present with unwanted conceptions or seek multiple terminations, and when men continue to have high risk sexual behavior into adulthood. Furthermore, if CSA is disclosed, sexual risks in adulthood need to be considered.

Introduction

A large body of research in the last two decades into the effects of child sexual abuse (CSA) on adult functioning has revealed extensive associations between early abuse and later disorder. A wide range of psychosocial and interpersonal problems, including sexual revictimization and sexual problems, have been shown to be more common among those who suffered sexual abuse as children (Andrews, Corry, Slade, Issakids, & Swanston, 2004; Briere & Elliott, 1994; Polusny & Follette, 1995; Wyatt, Newcomb, & Riederle, 1993). Engagement in sexual risk taking behaviors has been proposed as a mechanism for emotional avoidance of distress resulting from abuse in childhood (Briere & Elliott, 1994; Herman, 1981; Polusny & Follette,

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* Corresponding author.

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1995). Despite this growing knowledge of the outcomes of CSA, the long-term effects on sexual health and development and the relationship with adult sexuality are yet to be fully clarified.

Sexual health and development encompasses aspects such as sexual functioning, satisfaction, and behavior, reproduction, and those health outcomes which are direct consequences of sexual behavior. A range of theories have been suggested to explain the impact of CSA. There is wide support and empirical evidence for the idea that CSA leads to age inappropriate sexualized behavior in youth (Putnam, 2003). However, the longer term impact, and the underlying mechanisms, remain in dispute. To understand the effects of CSA on these various aspects of sexual health and development, it is necessary to identify precisely sexual outcomes which are affected over the life course (Heiman & Heard-Davison, 2004). Those sexual outcomes relating to reproduction and sexual behavior or which are sexual consequences of behavior are considered here.

Research that has investigated the effect of CSA on subsequent sexuality has focused on adolescent outcomes or considered adults over a wide age range—with little data available on men—and varying definitions of what constitutes abuse (Mullen, Martin, Anderson, Romans, & Herbison, 1996; Romano & De Luca, 2001). In adolescence (up to and including age 18), CSA has been linked to sexual risk taking behaviors and negative sexual outcomes. For instance, CSA has been associated with early onset consensual sexual activity and unprotected intercourse, multiple sexual partnerships, teenage pregnancy, and sexually transmitted infections (STIs) for adolescent women (Boyer & Fine, 1992; Fergusson, Horwood, & Lynskey, 1997; Mason, Zimmerman, & Evans, 1998; Putnam, 2003; Stock, Bell, Boyer, & Connell, 1997). Similar associations have been suggested for adolescent men but data are limited (Loeb et al., 2002; Mason et al., 1998; Romano & De Luca, 2001). Nevertheless, evaluation of the effects of CSA on adolescent sexual development is complicated by the inclusion of outcomes which may have directly resulted from abuse episodes. While evidence supports increased risk for abused adolescents, it is possible this risk is directly related to ongoing abuse rather than the consequent altered behavior of the individual.

In adulthood, much of the research has focused on adult sexual satisfaction and sexual function (such as arousal disorder and lubrication difficulties for women and erectile dysfunction, premature ejaculation, and low sexual desire for men) where significant associations have been found (Browning & Laumann, 1994; Fleming, Mullen, Sibthorpe, & Bammer, 1999; Loeb et al., 2002; Mullen, Martin, Anderson, Romans, & Herbison, 1994; Polusny & Follette, 1995). In addition, sexual risk behaviors and negative sexual outcomes, as found in adolescence, have been documented for adults though not with consistency across studies (Heiman & Heard-Davison, 2004). Associations include unprotected intercourse, multiple sexual partnerships, unintended pregnancy, abortion, and STIs including HIV (Browning & Laumann, 1994; Fleming et al., 1999; Greenberg, 2001; Holmes & Slap, 1998; Polusny & Follette, 1995; Wyatt et al., 1993; Zeirler et al., 1991). These suggest that the risks seen in adolescence are not limited to the direct results of abuse incidents; however, ongoing risk for specific negative sexual outcomes during the reproductive years needs to be confirmed for adults. The wide age range used in these studies may be contributing to the lack of consistency if some ages are more vulnerable.

Determining the extent to which these risk behaviors and negative outcomes are separate from abuse episodes, whether they persist at later ages, and whether they affect men in a similar way to women, will help clarify the role of CSA in sexual health and development.

The family context in which abuse occurs is an important factor when considering outcomes of abuse. Children from disadvantaged backgrounds characterized by less cohesive, less adaptable families where there may be parental conflict, separation, poor health or substance abuse are more likely to have been abused (Andrews et al., 2004; Fergusson, Lynskey, & Horwood, 1996; Mullen et al., 1994; Woodward, Fergusson, & Horwood, 2001). The family context itself may also affect sexual development (Paul, Fitzjohn, Herbison, & Dickson, 2000). Thus family environment may confound or modify any relationship between early abuse and adult functioning.

Longitudinal studies with a representative community sample that include information on both women and men are well placed to address the above issues (Loeb et al., 2002; Romano & De Luca, 2001; Wyatt et al., 1993). Although such studies necessarily rely on retrospective data regarding any CSA, the availability of prospectively collected information about the childhood family environment and related information about sexual health and behavior are invaluable.

A birth cohort was used to examine the relationship between CSA and *persistence* of risky sexual behaviors and negative sexual outcomes in adulthood, with data on women and men, and after adjustment for measures of family environment. Behaviors and outcomes examined were number of sexual partnerships, pregnancies where the person reported their reaction was unhappy, abortions, and STIs including seropositivity for herpes simplex virus type 2 (HSV-2). First the age period 18–32 was examined, and then three age periods: that immediately following adolescence (from 18 to 21), young adulthood (from 21 to 26), and adulthood (from 26 to 32), to better understand how CSA influences sexual development free of the direct effects of the abuse itself, and how this may differ by gender.

Methods

The study

The sample was enrolled in the Dunedin Multidisciplinary Health and Development Study, a longitudinal study of a cohort born in Dunedin, New Zealand between 1 April 1972 and 31 March 1973. The history of the sample has been described by Silva and Stanton (1996). Briefly, the sample was comprised of 1,037 of 1,139 eligible children who were first followed up at 3 years of age. Following that, the sample was seen every 2 years until 15 years, then at 18, 21, 26, and 32 years. Ethics