SEXUAL MEDICINE REVIEWS

The Impact of Childhood Sexual Abuse on Women's Sexual Health: A Comprehensive Review

Carey S. Pulverman, PhD,[1] Chelsea D. Kilimnik, MSc,[2] and Cindy M. Meston, PhD[2]

ABSTRACT

Introduction: Childhood sexual abuse (CSA) has been identified as a potent risk factor for sexual dysfunction. Certain characteristics of the abuse experience, such as repeated abuse, appear to affect the risk of developing sexual dysfunction. Despite the robust findings that CSA can be detrimental to sexual function, there is little consensus on the exact mechanisms that lead to these difficulties.

Aim: To summarize the most up-to-date research on the relation between CSA and women's sexual function.

Methods: The published literature examining the prevalence of sexual dysfunction among women with CSA histories, various types of sexual dysfunctions, and mechanisms proposed to explain the relation between CSA and later sexual difficulties was reviewed.

Main Outcome Measures: Review of peer-reviewed literature.

Results: Women with abuse histories report higher rates of sexual dysfunction compared with their non-abused peers. The sexual concerns most commonly reported by women with abuse histories include problems with sexual desire and sexual arousal. Mechanisms that have been proposed to explain the relation between CSA and sexual dysfunction include cognitive associations with sexuality, sexual self-schemas, sympathetic nervous system activation, body image and esteem, and shame and guilt.

Conclusion: Women with CSA histories represent a unique population in the sexual health literature. Review of mechanisms proposed to account for the relation between CSA and sexual health suggests that a *lack of positive* emotions related to sexuality, rather than greater negative emotions, appears to be more relevant to the sexual health of women with CSA histories. Treatment research has indicated that mindfulness-based sex therapy and expressive writing treatments are particularly effective for this group. Further research is needed to clarify the mechanisms that lead to sexual dysfunction for women with abuse histories to provide more targeted treatments for sexual dysfunction among women with abuse histories. **Pulverman CS, Kilimnik CD, Meston CM. The Impact of Childhood Sexual Abuse on Women's Sexual Health: A Comprehensive Review. Sex Med Rev 2018;X:XXX–XXX.**

Key Words: Childhood Sexual Abuse; Sexual Abuse; Sexual Trauma; Sexual Dysfunction; Sexual Health; Women's Sexual Health

INTRODUCTION

Childhood sexual abuse (CSA) is generally defined as unwanted sexual contact between a child and an adult and can include oral, vaginal, and/or anal penetration with a penis, digits, or foreign objects, forced sexual touching, and non-contact sexual abuse (eg, exposure to another's genitals). Experiencing sexual abuse in childhood has been identified as one of the most salient risk factors for the development of sexual dysfunction in adulthood, including problems with sexual desire, arousal, orgasm, and sexual pain.[1,2] Unfortunately, CSA is a common experience for women. According to a recent meta-analysis of studies from 22 countries that defined CSA as contact and non-contact sexual abuse before 18 years of age, approximately 20% of women have experienced CSA.[3] In studies from the United States, using the same definition of CSA, 17% to 51% of women reported CSA histories.[4] The present review focused on the relation between sexual function and CSA specifically, because research has indicated that women with histories of CSA *and* adulthood sexual abuse experience sexual dysfunction at the same rates as women abused solely in childhood.[5,6]

Received September 18, 2017. Accepted December 3, 2017.

[1]VISN 17 Center of Excellence for Research on Returning War Veterans, Waco, TX, USA;

[2]Department of Psychology, The University of Texas at Austin, Austin, TX, USA

https://doi.org/10.1016/j.sxmr.2017.12.002

In this review, we examined meta-analyses, literature reviews, and empirical studies obtained through keyword searches in the PsychInfo and PubMed databases. The keywords included child(hood) sex(ual) abuse + sexual (ity; function, functioning, health, behaviors, mechanisms, schemas). The bibliographies of previous literature reviews and meta-analyses were examined for additional relevant studies. Inclusion criteria included measurement of CSA and sexual health variables, an all or primarily female sample, and written in English. Review of the articles showed 4 primary topics of interest that became the focus for this review: prevalence of sexual dysfunction among women with CSA histories, types of sexual dysfunction among women with CSA histories, characteristics of abuse that increase the risk of sexual dysfunction, and mechanisms related to the development of sexual dysfunction among women with CSA histories. Because previous reviews on this topic focused on research before 2000,[1,2] the present review gave priority to research conducted since 2000; however, for certain areas (eg, prevalence rates) in which there was little new research or few large studies, older studies were included to provide a comprehensive summary of the current state of knowledge on this topic.

Research on CSA is complicated by inconsistencies in the operationalization of this construct. Indeed, the definitions of *childhood* and *abuse* have varied greatly among studies, and these methodologic issues have been previously reviewed in detail elsewhere.[7–9] Briefly, researchers have typically defined *childhood* with an age cutoff, such that sexual abuse experiences before a certain age are classified as CSA and abuse after that age is classified as adulthood sexual abuse. However, the age cutoff for childhood has varied from 12 to 18 years old,[8] and some researchers have suggested that developmental events such as age at menarche might be more relevant markers for distinguishing childhood from adulthood.[10] Some definitions of CSA also require a specific age difference between the victim and the perpetrator. The definition of *abuse* has included a range of experiences, including noncontact experiences (ie, propositions and exposure to another's genitals) and contact experiences (genital touching or fondling and oral, vaginal, or anal rape).[3] Specific characteristics of the abuse experience, including relationship to perpetrator, use of force, and chronicity of the abuse, also are sometimes included as additional criteria in CSA operationalization. Abuse characteristics are relevant to the present review because research has indicated that certain characteristics can place women at greater risk for sexual dysfunction than others. Typically, broader definitions of CSA that include more types of experiences and less specific criteria tend to yield higher prevalence rates than narrower definitions of abuse that include specific criteria. These methodologic issues likely contribute to the variation in CSA prevalence rates observed among studies.[4] To address these methodologic concerns, we provide detailed information on the methods used in the prevalence studies cited in this review.

In contrast to the methodologic issues present in operationalizing CSA, female sexual dysfunction has been more consistently defined in the literature. The *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* (*DSM-5*)[11] and the *International Statistical Classification of Diseases and Related Health Problems, 10th Revision*[12] define specific criteria for female sexual dysfunctions, including problems with desire, sexual arousal, orgasm, and sexual pain. In the 2 classification systems, the exact criteria for each sexual dysfunction have evolved over the various editions, with controversy arising over the distinction between sexual desire and subjective sexual arousal[13,14] and the distinction between different types of sexual pain.[15] In addition to the specific sexual symptoms, the *DSM-5* requires that the sexual symptoms are accompanied by "clinically significant distress," meaning that the patient reports increased distress associated with her sexual symptoms.[11] The "distress criterion" can affect prevalence rates. For example, in the general population of women, approximately 43% report sexual difficulties,[16,17] yet when including the distress criterion, only 12% of women report clinically significant sexual dysfunction.[17] Unfortunately, not all studies assess for the distress criterion; however, both subclinical sexual difficulties and clinically significant sexual dysfunction have been associated with lower quality of life in women,[18] and thus the 2 types of sexual sequela are included in this review.

SEXUAL DYSFUNCTION AMONG WOMEN WITH CSA HISTORIES

CSA has been identified as an important risk factor for sexual dysfunction in adulthood because the rates of sexual dysfunction among women with CSA histories are significantly higher than the rates of dysfunction among non-abused women.[1,2,19] We review the prevalence of sexual dysfunction from different types of studies, characteristics of abuse that affect the risk of sexual dysfunction, and the prevalence of the various types of sexual dysfunctions reported by women with CSA histories.

Prevalence Rates

The prevalence of sexual dysfunction among women with CSA histories has been examined in random probability, clinical, community, and college samples (Table 1).* To determine the *average* rate of sexual dysfunction in women with CSA histories, we turn to the research on random probability samples. Using data from the National Health and Life Survey of 1,749 women, Laumann et al[20] found that 17% reported CSA histories, and that 59% of those women reported sexual difficulties. Mullen et al[21] surveyed 1,376 women and found a CSA prevalence of 32%, and 47% of women with abuse histories reported at least 1 sexual problem, constituting an odds ratio of 2.44 for the risk of sexual dysfunction after CSA. In a study with 898 women, the prevalence of CSA was 35%, and 25% of women with nonpenetrative CSA histories developed sexual problems and 32% of women with penetrative CSA histories developed sexual problems.[22] In summary, the rates of sexual dysfunction among

* When studies reported effect sizes, these statistics are included in the review.