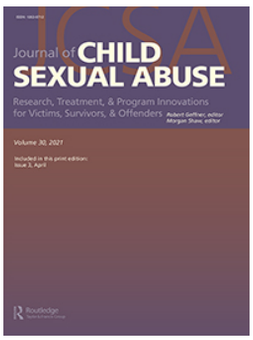

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Associations between Childhood Sexual Abuse and Sexual Well-being in Adulthood: A Systematic Literature Review

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ABSTRACT

Child sexual abuse (CSA) tends to occur in close relationships and involves sexual acts and betrayal. Thus, it is thought to affect sexual well-being in adulthood more so than any other form of childhood trauma. Research conducted over the last decade resulted in an impressive diversity of evidence reporting that CSA may be related to greater sexual dysfunction and lower sexual satisfaction as an adult, but also to higher levels of sexual compulsivity and sexual risk behaviors. Some studies also found no significant association between CSA and adult sexual well-being. Faced with these mixed results, understanding how CSA may affect sexual well-being in adulthood remains challenging for clinicians and researchers. The aim of this comprehensive literature review was to synthesize the empirical studies published in the last five years documenting the associations between CSA and several indicators of sexual well-being in adults excluding risky sexual behaviors. The literature search yielded 18 eligible studies which mainly examined five domains of sexual outcomes of CSA: sexual function, sexual satisfaction, sex-related cognitions, sexual behaviors and affective components of sexuality. Findings suggest that CSA is not unanimously related to all domains of sexual well-being, but rather, that associations are largely a function of the presence of other comorbidities or nature of the sample. Moreover, men are still significantly underrepresented in reviewed studies. Implications of the findings will be discussed in light of their relevance for clinicians and for researchers about gaps in current literature need to be filled.

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Child sexual abuse; sexual function; sexual satisfaction; sexual cognitions; sexual behaviors; sex-related affects

Introduction

Child sexual abuse (CSA) is an endemic social issue with a worldwide prevalence estimated at 18% for women and 8% for men (Stoltenborgh et al., 2011). These rates are even more alarming when we take into account that CSA is associated with a wide range of negative psychosocial and health outcomes in adulthood including substance use, posttraumatic stress disorder, depression and anxiety disorders as well as chronic pain (Fergusson et al.,

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2013; Hailes et al., 2019). Given CSA tends to occur in close relationships and involves sexual acts, violation of the victim's sexual boundaries, and betrayal (Freyd, 1996; Herman, 1992), it is thought to affect sexual wellbeing in adulthood more so than any other form of childhood trauma (e.g., physical abuse, neglect). Indeed, CSA often occurs at the hand of a significant attachment figure, in situations where intense negative feelings such as fear, betrayal, abandonment, and loss (Bernstein & Freyd, 2014; Freyd, 1996) are experienced, carried throughout life, and potentially triggered or re-evoked in sexual activities, thus potentially affecting sexual well-being. According to the World Health Organization (2010), sexual well-being is defined as self-perceived sexual health based on a balance of emotional, physical, mental, and social wellbeing in relation to sexuality and incorporates both positive elements of sexual health and negative ones.

Two relevant theoretical models support the long-term associations between CSA and sexual well-being in adulthood. Finkelhor and Browne's model (Finkelhor & Browne, 1985) suggests that the conjunction of four traumagenic dynamics–sexual traumatization, betrayal, powerlessness, and stigmatization–are the core of difficulties CSA survivors might experience. By being introduced to sexuality while not developmentally equipped to deal with the abuse, sexual traumatization might occur, but the child might also experience a sense of betrayal as well as powerlessness as his needs and desires have been ignored, and body invaded. Moreover, the child might also have internalized a sense of blame, rejection, and of being different, as if something was wrong with him. The four dynamics then act as a lens through which the child, with his distorted representations of himself, grows up attempting to adjust to the world, relationships, and.

The Self-Trauma Model (Briere, 2002; Briere & Scott, 2014) offers a developmental perspective concerning the mechanisms through which CSA may lead to challenges in adulthood, including difficulties in the sexual realm. First, CSA might induce altered expectations and assumptions about relationships, including in relation to the safety and trust that are required in sexual activities. Second, the context in which CSA occurs is likely to distract the child's attention from his internal states to the outside, leaving little room for the construction of a coherent sense of identity which in turn, may eventually lead to a feeling of emptiness and a vulnerability to external norms and judgments of others (Briere & Rickards, 2007). Third, CSA can lead to distorted cognitions in which the survivor perceives himself as inadequate or flawed and that can persist in adulthood, embedded in the survivor's sense of self. These effects on the survivor's identity and sense of self may alter sexual wellbeing by generating negative sexual self-schemas about oneself or adopting indiscriminate or compulsive sexual behaviors. Finally, the traumatic context of CSA may not have provided survivors with the resources needed to develop adequate emotion regulation skills, particularly with trauma-related ones such as fear, betrayal, abandonment, and loss (Bernstein &

Freyd, 2014; Freyd, 1996). Emotion dysregulation has been related to sexual difficulties including sexual dissatisfaction and risky sexual behaviors (Garofalo et al., 2015; Rellini et al., 2010).

These two conceptual models propose relevant pathways to understand the complexity of CSA's sexual repercussions and their entanglement in the survivor's profound representations of himself, others and the world, that may alter sexual well-being. However, they were not specifically developed to explain the sexual repercussions of CSA and empirical evidence examining the associations between CSA and sexual well-being reported mixed findings.

Research conducted over the last decade resulted in an impressive diversity of studies reporting a wide range of CSA sexual outcomes in adulthood. For example, in some studies using samples of men and women, CSA was associated with sexual dysfunction and dissatisfaction, but also with higher levels of sexual compulsivity and sexual risk behaviors (Bigras et al., 2015; Najman et al., 2005; Vaillancourt-Morel et al., 2015). Some studies also found no significant associations between CSA and women's sexual function (Rellini & Meston, 2007), whereas others reported that women with CSA histories that included genital penetration experienced more adverse sexual outcomes, such as lower sexual self-esteem, than women with non-penetrative CSA histories (Lemieux & Byers, 2008). Other studies ranged from examining associations between CSA and sexual revictimization in college women (Filipas & Ullman, 2006; Messman-Moore & Long, 2003) to sexual offending in incarcerated adults or sexual coercion in men (Drury et al., 2019; Pedneault et al., 2020). Faced with such mixed and conflicting findings, it is difficult to draw a general picture of the potential effects of CSA on sexual well-being in adulthood to inform health professionals and clinicians.

Past researchers have already underlined the need to review and synthesize these complex results (Kilimnik et al., 2018; Pulverman et al., 2018). Yet, most reviews on the associations between CSA and sexual well-being published to date present several shortcomings that make it challenging for both clinicians and researchers to understand how CSA may affect sexuality in adulthood. First, a series of published reviews on CSA and various components of sexuality are becoming dated, as this research area has grown rapidly in the last five years (Aaron, 2012; Colangelo & Keefe-Cooperman, 2012; Leonard & Folette, 2002; Rellini, 2008; Schwartz & Galperin, 2002; Zwickl & Merriman, 2011). Second, recent reviews focused exclusively on women's sexuality, disregarding the reality of men CSA survivors. Indeed, the recent review documenting the association between CSA and sexuality by Pulverman et al. (2018) or Pulverman and Creech (2019) are limited by their inclusion of women only or very specific samples, such as women veterans, as well as restricted studied outcomes (i.e., sexual dysfunction). Other recent reviews or meta-analyses on CSA and sexual outcomes also targeted a very specific category of sexuality: risky sexual behaviors, including early age at first sexual

activity, inconsistent condom use, lifetime number of sexual partners or sex with strangers, and compulsive sexual behavior (Abajobir et al., 2018; Slavin et al., 2020; Wang et al., 2019). Thus, reviews on complaints concerning sexual function, satisfaction and distress – the most common presenting problems in clinical practice for sex and couple therapists – remain scarce or suffer from important limitations, focusing only on women or on only one specific sexual outcome (e.g., sexual function; Pulverman et al., 2018). The dearth of recent and more comprehensive reviews leaves clinicians unaware of recent data on which they can rely to inform their assessment of sexual difficulties and related interventions that can apply to a wide range of sexual difficulties in both men and women survivors of CSA. Therefore, considering the heterogeneity of results in published studies on CSA and sexual outcomes, and that reviews aim to appraise heterogenous results by synthetizing them (Jahan et al., 2016), a different approach from what was done previously was chosen for the present review. Providing a unique contribution to the literature, we report how recent studies are still very diverse and fragmented in their examination of sexual outcomes following CSA.

As risky sexual behaviors have received more attention in the last decade, being the focus of recent reviews and meta-analyses (Abajobir et al., 2018; Wang et al., 2019), the present review will adopt a more inclusive and non-pathological lens concerning how men and women survivors of CSA navigate their sexuality in adulthood, excluding risky sexual behaviors.

Method

The literature search followed the preferred reporting items for systematic reviews and meta-analyses for Protocols 2015 statement (PRISMA-P; Moher et al., 2015). Following previous search protocols from systematic literature reviews, potential articles were identified by searching PsycINFO and PubMed with the search term ((“child sexual abuse” OR “childhood sexual abuse”) AND (“sexual*” OR “sexual function*” OR “sexual satisfaction” OR “sexual health” OR “sexual behavior” OR “sexual dysfunction”)). We searched for quantitative studies that examined the association between childhood sexual abuse (i.e., prior to 18 years of age) and sexual outcomes in adult participants (samples over 18 years of age) that were published in peer-reviewed journals in the past five years (deadline: September 20, 2019) in English. We excluded studies that examined the association with sexuality in children or adolescents or those focusing on risky sexual behaviors. The selection and screening process is presented in Figure 1. Our search resulted in 215 articles in PsycINFO and 378 articles in PubMed. The bibliographies of previous literature reviews and meta-analyses published in the last five years were also examined for additional relevant studies, which resulted in nine other studies. In consultation with the first author, the third author reviewed the resulting 602 titles and abstracts for

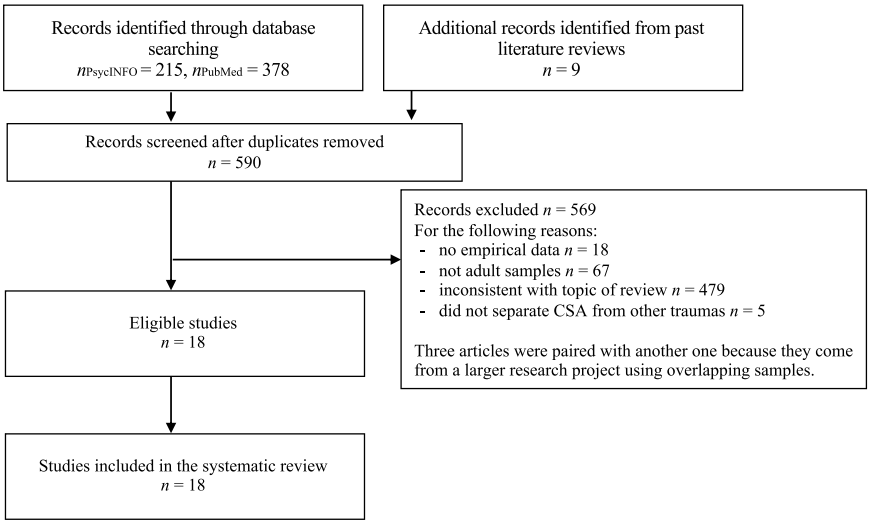

Figure 1. Flow diagram of the inclusion and exclusion of the studies in the systematic review.

inclusion and exclusion criteria and excluded 581 articles for the following reasons: no empirical data (18), sample did not include adults (67), inconsistent with topic (479), and did not separate CSA from other types of child maltreatment (5). Duplicate studies were also removed (12). The evaluation of abstracts was reviewed with the second author in weekly consultation meetings to ensure accuracy of classification, and any articles with questionable relevance were discussed until a consensus was reached among authors. The authors identified a total of 18 articles for inclusion (see PRISMA diagram; Figure 1). In terms of the choice of the five domains of sexual outcomes, the first three authors were included in the selection and review process. Once the third author had highlighted the main outcomes of each paper, the first author suggested a way to prioritize outcomes' presentation which was reviewed by the second author. In case of disagreement, the third author was consulted in order to reach agreement among authors about categories of outcomes.

After titles, abstracts, and then complete articles were screened for eligibility, 21 studies met the requirements to be included in this literature review. However, three articles were paired with another one because they come from a larger research project using overlapping samples. We chose to keep only the study with the larger sample size. Thus, in the present literature review, 18 studies examining sexual well-being of adults in association with CSA in adult samples will be discussed. The details of the included studies are presented in Table 1.

Table 1. Description of reviewed articles.

First author	Sample	CSA definition	Sexual outcomes	Main results
1. Ağaçhanlı et al. (2018)	51 outpatient women with opioid use disorder and 48 women without substance user disorders	Sexual contact or conduct between a child younger than 18 years of age and an adult or older person	Sexual function Sexual avoidance	In the women with opioid use disorder, CSA was significantly correlated with higher sexual dysfunction and avoidance. In the control group, CSA was unrelated to sexual dysfunction and avoidance.
2. Bigras et al. (2015)	257 women and 45 men recruited in the community aged 18 years and older.	Unwanted sexual contact in childhood/ adolescence OR sexual contact with an adult, someone in authority, or someone five years older	Sexual satisfaction Sexual anxiety	CSA was unrelated to sexual satisfaction and sexual anxiety, but they were indirectly negatively associated via higher levels of interpersonal conflicts and identity impairment.
3. Bornefeld-Ettmann et al. (2018)	32 women with PTSD who experienced CSA, 32 women without PTSD who experienced CSA and/or childhood physical abuse, and 32 women without PTSD and without CSA	Sexual abuse before the age of 18 years	Sexual satisfaction Sexual function Sexual aversion	Women with PTSD who experienced CSA had significantly lower scores of aversion, satisfaction, and higher pain indicating lower sexual functioning than women without PTSD and CSA and women without PSTD who experienced CSA and/or childhood physical abuse. There was no significant between groups in arousal or orgasm.
4. Cohen and Byers (2015)	596 women 18 years of age or older and in a same-sex relationship	Attempted and/or completed vaginal, oral, or anal intercourse with an adult or someone older before the age of 14.	Sexual satisfaction Sexual esteem Sexual anxiety Negative automatic thoughts during sexual activity Dyadic desire Nongenital sexual frequency Genital sexual frequency	CSA was positively related to negative thoughts during sexual activity, but unrelated to sexual satisfaction, sexual esteem, sexual anxiety, sexual desire, and nongenital and genital sexual frequency. Controlling for adult sexual victimization or relationship satisfaction, CSA was unrelated to negative sexual thoughts.
5. Dunlop et al. (2015)	808 adult outpatients (452 women) with major depression	Sexual contact or conduct between a child younger than 18 years of age and an adult or older person	Sexual function	CSA was related with all components of current sexual dysfunction (sex drive, arousal, erection/lubrification, ease of orgasm, and satisfaction of orgasm) in women, but not in men.
6. Kelley and Gidycz (2015)	710 college women	Sexual contact or conduct that occurred before the age of 14 perpetrated by an adult/older adolescent	Sexual self-schema Sexual self-esteem Erotophobia/erotophilia	CSA was related to lower control sexual self-esteem. CSA was unrelated to all sexual self-schemas (romantic/passionate, open/direct, embarrassed/conservative), to four of the five subscales of sexual self-esteem (skill/ experience, attractiveness, adaptiveness, and moral/judgment) and to erotophobia/ erotophilia.

(*Continued*)

Table 1. (Continued).

First author	Sample	CSA definition	Sexual outcomes	Main results
7. Kelley and Gidycz (2017)	501 college women	Sexual contact or conduct that occurred before the age of 14 perpetrated by an adult or an adolescent at least 5 years older.	Sexual function	CSA was positively correlated with sexual pain, but it was unrelated to sexual desire, arousal, lubrication and orgasm both directly and indirectly via trauma-related symptomatology.
8. Kelley and Gidycz (2019)	108 college women with a history of adult sexual assault	Sexual contact or conduct before the age of 14 perpetrated by a caregiver, an older adult, an authority figure, someone at least 5 years older or the perpetrator used some form of force or coercion	Sexual function Sexual distress	CSA was unrelated to sexual desire, arousal, lubrication, orgasm and pain as well as to sexual distress.
9. Kilimnik and Meston (2016)	139 women with a history of CSA and 83 women without a history of CSA	Involuntary sexual experiences (unwanted oral, anal, or vaginal penetration or genital touching or fondling) before 18 years of age	Sexual excitation Sexual inhibition	CSA history was significantly related to sexual inhibition, but not to sexual excitation.
10. Kilimnik and Meston (2018)	334 women without any nonconsensual sexual experience history and 227 women with nonconsensual sexual experience before age 16	Any sexual experience that occurred against someone's will before age 16	Sexual function including sexual satisfaction Sexual self-schema Sexual excitation Sexual inhibition	No significative differences were found between women with nonconsensual sexual experience before age 16 and women without nonconsensual sexual experience histories on all sexual function subscales (desire, arousal, lubrification, orgasm, satisfaction, pain), on sexual self-schema (passionate-romantic, open-direct, and embarrassed-conservative), and on sexual excitation or inhibition.
11. Maseroli et al. (2018)	200 heterosexual women attending a sexual medicine outpatient clinic for female sexual dysfunction	Any unwanted sexual experiences (both contact and noncontact acts) in childhood (under 14 years of age) or in adolescence (14 to 17 years of age)	Sexual function including sexual satisfaction Sexual distress Sexual inactivity during the previous three months	Sexual abuse in childhood was unrelated to sexual function (arousal, orgasm, satisfaction) and distress when compared with women without any CSA. Sexual abuse in adolescence was related to lower levels of arousal, orgasm, and satisfaction and higher levels of sexual distress compared to women without any CSA. Sexual abuse in adolescence was related to higher odds of sexual inactivity compared with women with a history of CSA.
12. Meyer et al. (2017)	812 individuals (504 women)	Sexual abuse before the age of 18	Sexual compulsive behaviors	CSA was related to higher sexually compulsive behaviors for both men and women, with this increase being greatest for men.

(*Continued*)

Table 1. (Continued).

First author	Sample	CSA definition	Sexual outcomes	Main results
13. Miron and Orcutt (2014)	541 sexually active college women	Being touched or fondled in a sexual way or being asked to touch or fondle someone else before the age of 13 (CSA) or between 13 and 18 years (adolescent sexual abuse)	Likelihood to have sex with a poorly known partner Sex to reduce negative affect	CSA and adolescent sexual abuse were not associated with the likeliness to have sex at first encounter and CSA was unrelated to having sex to reduce negative affect. Adolescent sexual abuse was positively related to having sex to reduce negative affect.
14. Moyano and Sierra (2015)	561 spanish adults in a heterosexual relationship (333 women)	Sexual victimization experienced before the age of 13 years.	Positive and negative sexual cognitions (intimate, exploratory, dominance, submission and impersonal sexual cognitions)	For men and women, CSA was not associated with significative differences in both positive and negative sexual cognitions compared with men and women without CSA history.
15. Pulverman and Meston (2019)	120 adult women from the local community	Unwanted sexual contact before the age of 16	Sexual function Sexual shame Dissociation during sex	CSA was related to higher sexual shame, higher dissociation during sex, and lower sexual function.
16. Scheim and Bauer (2019)	173 transfeminine adults (16 years or older)	Any unwanted sexual contact before age 16	Sexual inactivity (no oral, genital, or anal sex)	CSA was related to higher odds of sexual inactivity in the past year.
17. Tekin et al. (2016)	113 patients (55 women) with a diagnosis of social anxiety disorder	Sexual contact with a family member before the age of 18 or with a stranger of five years older than themselves or more	Sexual function	History of CSA was significantly higher in patients who had sexual dysfunction than in patients who did not have it.
18. Vaillancourt-Morel (2016 c)	1,033 adults (760 women)	Any sexual act between a child under 16 years of age and a person five or more years older, or in a position of authority.	Sexual avoidance Sexual compulsion	Women CSA survivors reported more sexual compulsivity and sexual avoidance than women without CSA history, but men reported only more sexual compulsivity with no significant difference for sexual avoidance.

Results

From the 18 selected studies, we identified five domains of sexual outcomes of CSA. The first one includes an objective and body-oriented outcome, sexual function. The second was a subjective component of sexuality, sexual satisfaction. The others were organized around a cognitive-behavioral-affective structure, namely sex-related cognitions, sexual behaviors, and affective components of sexuality.

Methodological issues

Before interpreting the results of the reviewed studies according to these five domains of sexuality, some methodological shortcomings should be underscored. First, given the lack of consensus about the definition of CSA in the scientific community, it makes it difficult to compare studies, in addition to producing confusing results. For example, as presented in Table 1, some studies included a vague definition of all sexual acts involving contact (Tekin et al., 2016) whereas others used a more detailed definition ranging from invitation or exposure to a sexual activity to oral, vaginal, or anal penetration (Kelley & Gidycz, 2017). Second, all studies used a cross-sectional design without controlling for important covariates (e.g., other childhood traumas, prior family and peer environments). Based on such methodological limitations, causality cannot be established, as CSA often occurs in deficient family environments, delinquent peer environments, or in co-occurrence with other childhood interpersonal traumas. Thus, based on the current research, we can only conclude that CSA is correlated with, rather than causative of, adult sexual well-being. Finally, the totality of the studies used self-report measures that are likely to induce some biases in participants' responses. These limitations are important to keep in mind when trying to make general assumptions about the association between CSA and sexual well-being, as they considerably limit the conclusions that can be drawn.

Sexual (dys) function

Sexual function is defined based on the different stages of the sexual response cycle (i.e., sexual desire, arousal, orgasm). Sexual dysfunction corresponds to a problem at a specific domain of sexual function: sexual desire/interest disorder, sexual pain, and orgasmic disorder. Of the 18 studies reviewed, ten examined the associations between CSA and sexual function. The interest in sexual function is particularly apparent in clinical samples presenting other comorbid disorders frequently related to sexual difficulties. For example, the association between CSA and sexual function was examined in 113 men and women diagnosed with social anxiety disorder (Tekin et al., 2016), in 200

heterosexual women consulting for sexual dysfunction (Maseroli et al., 2018), in 51 outpatient women with opioid use disorder (Ağaçhanlı et al., 2018), and in 808 chronically depressed adults (Dunlop et al., 2015). Of the ten reviewed studies, only two used mixed-sex samples and only one provided results separately by sex/gender (Dunlop et al., 2015; Tekin et al., 2016).

Although at first glance and based on past reviews focusing on women only (Pulverman et al., 2018) there seems to be a consensus about the negative effects of CSA on adult sexual function, a meticulous examination of the ten studies reviewed focusing on this association reveals rather divergent or inconsistent results. Four studies, three in clinical samples and one in women from the community, indicated an association between CSA women and lower global sexual function, a score combining all stages of the sexual response (Ağaçhanlı et al., 2018; Dunlop et al., 2015; Pulverman & Meston, 2019; Tekin et al., 2016). The only study reporting results separately between men and women reported that CSA severity was negatively related to sexual function (total score combining sexual desire, arousal, and orgasm) for women but not for men (Dunlop et al., 2015). Three studies reported that CSA was unrelated to the total score of sexual function in different samples of women (sexually active college women, Kelley & Gidycz, 2017, 2019; women from the community, Kilimnik & Meston, 2018). Three other studies examined only specific stages of the sexual response that are affected by CSA. In a sample of 200 heterosexual women attending a female sexual dysfunction clinic, patients reporting sexual abuse in adolescence, compared with women without sexual abuse, showed a diminished ability to be aroused and reach orgasm when controlling for age, diagnosis of psychiatric diseases and current use of psychiatric medications (Maseroli et al., 2018). Another study using a sample of 96 women with or without CSA and posttraumatic stress disorder (PTSD) found that women who reported CSA and PTSD reported higher pain during intercourse than healthy women without CSA and women without PTSD, but similar levels of sexual arousal and orgasmic function (Bornefeld-Ettmann et al., 2018). In their sample of 596 women in long-term same-sex relationships, Cohen and Byers (2015) only examined dyadic sexual desire and found no significant relationship with CSA.

These mixed findings make it difficult to conclude whether CSA might affect sexual function in adult women. The small effect sizes observed in studies reporting significant results in women might explain that these sexual dysfunctions are not reported by all CSA survivors and that some risk or protective factors might help to understand in which context they emerged. For example, nonsignificant results were mostly reported in studies using nonclinical samples, which might suggest that these women developed a resilient functioning, including in the sexual realm. Finally, it is impossible to make any conclusion regarding the association between CSA and sexual function in men, even if one study reported nonsignificant results, given the very specific nature of this sample (depressed adults).

Sexual satisfaction

Five studies examining the link between CSA and sexual satisfaction in adulthood were identified. Only one of them included a mixed-sex sample of 257 women and 45 men and there was no significant association between CSA and sexual satisfaction (Bigras et al., 2015). Two studies conducted among women from the community support this finding as they reported a nonsignificant link between CSA and sexual satisfaction (Cohen & Byers, 2015; Kilimnik & Meston, 2018). Another study reported that sexual abuse before 14 years old was unrelated to women's sexual satisfaction, but sexual abuse in adolescence (between 14 and 17 year old) was related to lower levels of women's sexual satisfaction compared to women without any sexual abuse (Maseroli et al., 2018). One study also found that women with CSA and PTSD reported significantly lower sexual satisfaction than healthy women without CSA and without PTSD (Bornefeld-Ettmann et al., 2018).

It seems that examining a subjective sexual outcome such as sexual satisfaction does not allow to say that CSA has negative sexual repercussions in women excepting in specific population or when abuse occurred in a specific context. Indeed, if the abuse occurred in adolescence or if these women also present significant psychological difficulties such as PTSD, then CSA could be related to lower sexual satisfaction. However, it is impossible to disentangle the role of PTSD from that of CSA. As sexual self-concept develops during adolescence, an abuse during this specific period might particularly affect the development of women's sexual needs and desires and thus, sexual satisfaction. These results do not provide enough information about sexual satisfaction in men survivors of CSA, as only one study included them without examining the differential association between men and women.

Sex-related cognitions

Sexual cognitions can be positive or negative and have been measured using different, but related, constructs across studies. Five studies documented cognitive aspects of sexuality through sexual cognitions, sexual self-schemas, sexual esteem, and sexual excitatory and sexual inhibitory cognitive processes. One study examined sexual cognitions in a mixed-sex sample of 561 Spanish adults (Moyano & Sierra, 2015) whereas other samples included women only (Cohen & Byers, 2015; Kelley & Gidycz, 2015; Kilimnik & Meston, 2016, 2018). Moyano and Sierra (2015) did not find any significant differences between CSA survivors and non-survivors on four domains of sexual cognitions (intimate, exploratory, sadomasochistic, and impersonal cognitions), suggesting that CSA was not related to a more negative appraisal of sexual cognitions for men and women. Using a sample of 596 women in long-term same-sex relationships, Cohen and Byers (2015) found that at a bivariate level, meaning that no other variables were taken into account, CSA

was related to more negative thoughts and images during sexual activity but not with sexual self-esteem. However, at a multivariate level, considering other factors such as adult sexual victimization or relationship satisfaction, no significant associations between CSA and sexual thoughts and images were found. In their sample of 701 college women, Kelley and Gidycz (2015) found that, controlling for other childhood traumas and adult sexual abuse, CSA was unrelated to all sexual self-schemas (i.e., romantic/passionate, open/direct, and embarrassed/conservative) and to approach/avoidance tendencies toward sexual stimuli (i.e., erotophilia and erotophobia), but was related to one specific subscale of sexual self-esteem, i.e., to lower control sexual self-esteem. More specifically, CSA was related to less satisfaction with one's own ability to manage sexuality or sexual thoughts, feelings, and interactions (control subscale), suggesting that women survivors of CSA may generalize the perceptions of inability to control the experience of abuse in childhood to a difficulty controlling future sexual experiences in adulthood. Kilimnik and Meston (2016) examined excitatory/inhibitory sexual processes in a sample of 222 women from the community, which refer to the propensity to respond with sexual excitation or sexual inhibition to a variety of situations. They found that women with a CSA history had significantly more sexual inhibition than women without a CSA history, but there was no significant difference on sexual excitation. However, this result was not confirmed in another study using women from the community, as CSA was unrelated to excitatory/inhibitory sexual responses as well as unrelated to sexual self-schemas defined as the individuals' cognitive representations of themselves as sexual beings (Kilimnik & Meston, 2018).

With the exception of two studies that found significant associations between greater CSA severity and lower control sexual self-esteem and between CSA and more sexual inhibition, no other significant result was found. These inconsistent findings might imply that long term effects of CSA on sex-related cognitions are difficult to capture and are likely to be influenced by a plethora of other factors in the survivor's developmental trajectory. Indeed, the presence of more recent traumatic experiences such as adult sexual assault or even a satisfying relationship might weaken the initial contribution CSA could have on those outcomes, also suggesting a small and multifaceted association. Based on the current findings, it is also not possible to draw any conclusion concerning whether CSA is related to men's sexual cognitions, as only one study included them and found no significant result.

Sexual behaviors

Eight studies examined the link between CSA and adult sexual behaviors; six of them used community samples (e.g., Cohen & Byers, 2015; Miron & Orcutt, 2014; Vaillancourt-Morel et al., 2016) and two were conducted in clinical samples (Ağaçhanlı et al., 2018; Maseroli et al., 2018). One study in a mixed-sex community sample found associations between CSA and sexual compulsivity and

avoidance in addition to specifying conditions under which those associations emerge (Vaillancourt-Morel et al., 2016). Indeed, they reported that CSA was related to sexual compulsivity in single and cohabiting survivors and with sexual avoidance in married ones. They also found that women survivors reported more sexual compulsivity and sexual avoidance than nonabused women, and that men survivors reported more sexual compulsivity than nonabused men, but similar levels of sexual avoidance. In a sample of 173 sexually active transfeminine participants (individuals assigned a male sex at birth who identify as female, feminine or other than male), CSA was associated with higher odds of sexual inactivity in the last 12 months (Scheim & Bauer, 2019). Bornefeld-Ettmann et al. (2018) also reported that women with CSA and PTSD reported higher levels of sexual aversion than healthy women without CSA or PTSD. A similar result was found among women with opioid use disorder, in which CSA was correlated with higher levels of sexual avoidance, which was not the case in the control group (Ağaçhanlı et al., 2018). In a sample of 200 heterosexual women attending a female sexual dysfunction clinic, Maseroli et al. (2018) found that women with a history of sexual abuse during adolescence were more likely to report sexual inactivity during the previous three months than women with a history of CSA. No significant association between CSA and frequency of both nongenital and genital sexual activity was found in a sample of women in same-sex long-term relationships (Cohen & Byers, 2015). In a sample of 541 sexually active college women, CSA was not related to the use of sex to reduce negative emotional states (Miron & Orcutt, 2014). To conclude, Meyer et al. (2017) examined uncontrollable sexual behaviors in 812 men and women from the community. Their results highlighted that both men and women without CSA had lower sexually compulsive behavior scores than men and women with a history of CSA, with a stronger association in sexual compulsive behaviors for men.

Although these results suggest that CSA is related to both sexual avoidance and compulsivity in men and women, a more nuanced examination of the findings indicates that sexual compulsivity and avoidance manifest themselves according to specific conditions (e.g., relationship status; Vaillancourt-Morel et al., 2016) as well as in samples presenting other comorbidities such as PTSD (Bornefeld-Ettmann et al., 2018) or opioid use disorder (Ağaçhanlı et al., 2018). Even if clinical observations and theoretical propositions have asserted that avoidance would be more characteristic of women, whereas sexual compulsivity would be more characteristic of men (e.g., Aaron, 2012), compulsivity has been documented in both men and women following CSA whereas only one study examined sexual avoidance in men limiting the conclusions that can be drawn. Indeed, it is interesting to notice how most studies using women only samples seem to be oriented toward a specific sexual reaction to CSA, that is, sexual aversion or avoidance. Thus, the study of sexual behaviors in adult survivors of CSA still seems biased in how CSA might affect sexuality according to the traditional sexual double standard.

Affective components of sexuality

Of all the studies reviewed, five examined the associations between CSA and several affective components of sexuality in diverse samples. Two studies examined sexual anxiety, one in a mixed-sex sample (Bigras et al., 2015) and the other in women only (Cohen & Byers, 2015). Although they used different measures of sexual anxiety, both studies found no significant association between CSA and anxiety during sexual interactions or when thinking about the sexual aspects of one's life. Two studies assessed the link between CSA and sexual distress in women from the community (Kelley & Gidycz, 2019) and heterosexual women attending a clinic for female sexual dysfunction (Maseroli et al., 2018). Both studies found that sexual abuse in childhood was unrelated to sexual distress, but Maseroli et al. (2018) also indicated that women who reported sexual abuse during adolescence reported higher sexual distress than women without a history of sexual abuse. Lastly, in a sample of women from the community, Pulverman and Meston (2019) found a strong and significant relationship between CSA and sexual shame, defined as shame related to one's past sexual experiences and behaviors.

The results on how CSA might be related to sex-related affect in adult women are inconsistent, with two studies revealing significant associations between CSA and sexual distress and sexual shame. The only study that found a significant association between CSA and sexual distress, only when sexual abuse occurred in adolescence, used the widely validated Female Sexual Distress Scale which assesses feelings such as guilt, embarrassment, inadequacy or inferiority related to sexuality. These emotions align very well with Finkelhor and Browne (1985) dynamic of stigmatization. The other study, which found a significant link between CSA and sexual shame, also reflected an association with strong negative feelings related to sexual behaviors the survivors might have engaged in, also reinforcing the idea that the survivors hold a view of themselves that is negative or distorted, and could be easily triggered in the sexual context. Given the limited number of studies including men (only one used a mixed-sex sample), it is, again, impossible to draw any conclusions about how they are affected by CSA from an affective standpoint.

Suggestions for future research

Our review of recent studies highlighted some important considerations that require further scrutiny. Sexuality is usually a relational activity, increasingly known to fluctuate according to intimacy and relationship features (Dewitte & Mayer, 2018). Despite the fact that one study examined how relationship commitment might moderate the association between CSA and sexual behaviors, all recent research on CSA and sexual well-being included samples of individuals regardless of their current relationship status. This caveat limits

our understanding of how sexual repercussions of CSA might unfold in the context of a romantic relationship, where the combination of intimacy and sexuality might represent a specific challenge for CSA survivors. Moreover, as none of the reviewed studies involved samples of couples (including both partners), none have examined how an individual's CSA might be associated with the partner's sexual well-being. Therefore, studies using dyadic designs are needed to better understand the interplay between relational dynamics and sexual well-being in CSA survivors. The overrepresentation of studies using a cross-sectional design underscores the need to examine longitudinally how – and if – some specific repercussions of CSA might emerge over time, at specific critical life periods (e.g., first romantic relationship, pregnancy, first child) and how these sexual repercussions evolve over longer periods of time.

Some efforts to examine multiple adverse experiences in life (e.g., childhood physical abuse; Tekin et al., 2016) or different developmental stages of sexual abuse (e.g., sexual abuse in childhood versus sexual abuse in adolescence or adulthood; Maseroli et al., 2018) must be acknowledged. However, most studies focused only on CSA while this trauma rarely occurs alone and is rather known to happen in conjunction with other types of maltreatment (Bigras et al., 2017). Studying a single type of trauma such as CSA over multiples types overlooks the co-occurrence of these adverse events and may confound results. Future studies should assess multiple forms of childhood traumas (abuse and neglect) to clarify whether CSA is uniquely associated with sexual outcomes when compared with the effect of other forms of traumas or their cumulative effect.

The glaring underrepresentation of men in recent studies as well as a lack of analyses allowing to determine sex/gender differences is striking and emphasizes the urgent need to include men in research protocols. It also indicates how our knowledge of their sexual experiences as CSA survivors is still unknown. Finally, only one study included transfeminine participants (Scheim & Bauer, 2019) and another one included women in same-sex couples (Cohen & Byers, 2015). Both of them showed that sexual and gender minorities seem to experience CSA at higher rates (21% in women involved in same-sex couples using a narrow definition limited to oral, vaginal or anal penetration, Cohen & Byers, 2015; 37% in sexually experienced transfeminine participants using a broader definition including any unwanted sexual contact before age 16; Scheim & Bauer, 2019) than what is observed in heterosexual, cisgender samples and using broader definitions of CSA including oral, vaginal or anal penetration but also sexual noncontacts and contacts (e.g., 20% of women and 19% of men, Vaillancourt-Morel et al., 2015) or worldwide meta-analyses (e.g., 12%, Stoltenborgh et al., 2011). Future studies should therefore be more inclusive of sexual and gender minorities in order to be more representative of the diversity of sexual experiences following CSA and examining if repercussions differ or not based on gender/sex and sexual orientation.

Clinical implications

Faced with an impressive array of empirical studies reporting a wide range of CSA sexual outcomes in adulthood, we conducted a systematic review of the literature of the last five years in order to guide clinicians concerning what we currently know about the associations between CSA and sexual well-being in adulthood. One general conclusion that seems to stand out from our review is that CSA is related to sexual difficulties in clinical samples, but not necessarily in samples from the community. Thus, it may not be CSA per se, but rather, co-occurring clinical symptomatology (e.g., PTSD) that contributes to the development of sexual difficulties. This finding suggests that, whereas some survivors might report a resilient sexuality, those reporting psychological comorbidities are also those that may report decreased sexual well-being, showing a general altered functioning and distress that is related to CSA, including in the sexual realm. In addition, even if they are not consulting specifically for sexual issues, therapists should be aware that their clients (belonging to clinical samples), might report impaired sexuality that is related to a prior experience of CSA. However, survivors in the general population might not systematically report sexual difficulties related to their CSA history. They may have found a way to cope with their experience of CSA in a resilient manner. In other words, the experience of CSA does not define sexuality in adulthood and fostering hope can be a relevant intervention target in clinical work.

Although therapists should systematically assess all trauma history in order to have a clear picture of all factors contributing to current sexual difficulties, they should not assume that CSA is the unique cause of patients' current sexual difficulties, nor should they generalize that all CSA survivors will report effects on their sexual well-being. Indeed, the divergent findings highlight how unique and personal the experience of CSA can be, as well as how heterogeneous are the portraits of sexual repercussions that can be reported by the survivors. Relationship status, self-definition of CSA, or other psychological comorbidities potentially only represent a fraction of all the features that should be taken into account when assessing how CSA might be associated with sexual well-being in adulthood. The complex nature of those associations emphasizes the importance of an open communication between therapist and survivor in order to find the most suited interventions for the survivors' needs, tailored to their own subjective experience.

Conclusions

Although CSA repercussions have been studied for decades, a systematic review of recent results still reveals significant gaps in the literature and the need for more rigorous research–specifically, using dyadic and longitudinal designs

involving a diversity of couple configurations–into how CSA might be related to sexual well-being. Findings of this review suggest that CSA is not unanimously related to all domains of sexuality, but rather, that associations are largely a function of the presence of other comorbidities, nature of the sample, or when the abuse occurred. Specifically, (1) sexual dysfunction is particularly apparent in clinical samples presenting other psychological disorders that are frequently related to sexual difficulties; (2) sexual satisfaction is not related to CSA except when it occurred in adolescence or in women diagnosed with PTSD; (3) it is difficult to capture how CSA relates to sexual cognitions considering their multidimensional aspects, but lower control sexual self-esteem and sexual inhibition emerged as being more significantly associated with CSA; (4) the study of sexual behaviors in adult survivors of CSA remains biased according to the traditional sexual double standard with an association between CSA and sexual avoidance in women and; (5) examination of sex-related affect shows strong associations between negative feelings related to sexual behaviors the survivors might have engaged in, supporting how survivors might hold negative views of themselves that are easily triggered in the sexual context.

Importantly, it is not possible to draw any conclusions concerning men survivors of CSA, as they are significantly underrepresented in reviewed studies. Sexual well-being forms a whole in which cognitive, behavioral and affective components are all embedded within one another and interact closely. Yet, to date, studies have failed to examine this globality and on the contrary, have dissected it into separate pieces, which makes it a challenge to assert conclusions about the associations between CSA and sexual well-being in adulthood. Research results should be disseminated more widely to professionals and survivors to inform them as accurately as possible about the implications of CSA on sexual well-being in adulthood.

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