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The Pathways of Problematic Sexual Behavior: A Literature Review of Factors Affecting Adult Sexual Behavior in Survivors of Childhood Sexual Abuse

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Research shows that many adult sexual behaviors may be related to childhood sexual abuse (CSA), ranging from withdrawal and dysfunction on one end of the spectrum to hypersexuality and compulsion on the other, but it is unclear why some individuals respond to CSA by withdrawal, fear and anxiety, while others respond with impulsiveness and acting-out behavior. This literature review finds that there are two distinct factors which account for differences in sexual behavior among adult survivors of CSA: (a) the gender of the victim, and (b) the age at onset of victimization. Based on this data, an integrative framework is proposed, incorporating elements of social learning theory and psychoanalytic concepts, to explain the etiology of problematic adult sexual behaviors, as well as corresponding implications for clinical treatment.

There has been a great deal of research in the past 20 years documenting the harmful effects of childhood sexual abuse (CSA) on adult mental health, and specifically on adult sexual functioning (Easton, Coohey, O'Leary, Zhang, & Hua, 2011). The literature shows that there are many possible sexual responses to CSA, ranging from withdrawal and dysfunction on one end of the spectrum to hypersexuality and compulsion on the other (Easton et al., 2011; Kendall-Tackett, Williams, & Finkelhor, 1993). With so many wide-ranging and disparate responses, it is unclear why some individuals respond to CSA by withdrawal, fear and anxiety, while others respond with impulsiveness and acting-out behavior. Much research exists on the relation between CSA and adult sexual dysfunction (Najman, Dunne, Purdie, Boyle, & Coxeter,

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2005) as well as CSA and adult hypersexuality and sex addiction (Senn, Carey, Vanable, Coury-Doniger, & Urban, 2007), but very little research on why one individual may go down one pathway rather than another. It was not until 2011 that a comprehensive research study was conducted to further understand variability in sexual functioning among adults who were sexually abused as children (Eaton et al., 2011). Understanding the variables that impact adult sexual response in victims of CSA may have a significant impact on the theoretical understanding as well as clinical implications of working with individuals who present with sexual difficulties.

There are various possibilities for the paucity of research in this realm. First, there are many variables that must be accounted for: individual factors, such as temperament and vulnerability to dissociation and traumatization; environmental factors such as messages to the child from caretakers in response to the abuse, and overall family environment; and particulars of the abuse itself, such as type of abuse, duration, amount of coercion and violence, and relation of perpetrator to child (Kendall-Tackett et al., 1993; Walker, Holman, & Busby, 2009). Compounding the difficulty are the inconsistent definitions and measurements of dysfunction and hypersexuality, and often terms such as hypersexuality and sex addiction may be used interchangeably (Easton et al., 2011).

The research suggests that outside factors such as quality of home life and responsiveness of adult caretakers are mitigating factors in preventing a child from exhibiting traumatic responses to CSA (Nash, Hulsey, Sexton, Harralson, & Lambert, 1993; Rind, Tromovitch, & Bauserman, 1998). Other factors such as whether the abuser was known by the child, the extent and duration of the abuse, the force employed, and negative messages and shaming activities by persons in the child's environment are all risk factors in exacerbating the trauma suffered by the child (Kendall-Tackett et al., 1993; Senn et al., 2007). However, none of these factors, although adequately explaining the severity of the adaptive response of the child, are able to differentiate among the subsequent sexual behaviors of the child, and eventually the adult (Easton et al., 2011; Kendall-Tackett et al., 1993).

Only two distinct factors show a strong correlation between the variable response of sexual inhibition vs. sexual hyperactivity to CSA: (a) the gender of the victim; and (b) the age at onset of victimization (Kendall-Tackett et al., 1993). Specifically, boys are more likely to externalize their behavior through aggression, sexualized behavior, and compulsive behaviors, while girls are more likely to internalize their behavior through depressive and anxiety-related symptoms (Heath, Bean, & Feinauer, 1996; Najman et al., 2007). In this way, boys who are victims of CSA are more likely to become hypersexual while girls tend towards the other end of the spectrum (Najman et al., 2005). The literature suggests that men are much more prone towards sexually compulsive behavior than women (Perera, Reece, Monahan, Billingham, &

Finn, 2009), whereas women are far more likely to suffer from some form of sexual dysfunction (Easton et al., 2011; Najman et al., 2005).

In addition, the age of the victim seems to significantly impact the eventual adult sexual behavior of the victim. The younger the child at victimization, the more likely he or she is to respond to the abuse with sexualized external behavior (Kendall-Tackett et al., 1993). Children below the age of 6 are especially prone to enact their abuse through inappropriate and aggressive sexualized behavior. The older the child, specifically if over the age of 12, the more likely the child is to react with internalizing behavior and to become inhibited and fearful of sex (Easton et al., 2011; Kendall-Tackett et al., 1993).

Based on these data, some conclusions will be drawn out in the discussion, which will tie in the factors of gender and age to create an integrative theory, incorporating elements of social learning theory and psychoanalytic concepts, to shed light on the etiological basis of problematic adult sexual behaviors, along with implications for corresponding clinical interventions.

REVIEW OF THE LITERATURE

Epidemiology of CSA

Studies on this topic have shown a broad range of data regarding the epidemiology of CSA. For example, surveys of CSA in nonclinical populations have shown ranges from 3% to 29% (Kinzl, Traweger, & Biebl, 1995). Overall, estimates of prevalence rates have ranged anywhere from 10% to 62% (Heath et al., 1996). Because these numbers are so inconsistent, it is difficult to gain a clear understanding of the prevalence of CSA. Perhaps these discrepancies could be accounted for by problems in the methodology and data collection of the studies.

In a landmark study, the Los Angeles Catchment Area Study conducted by Finkelhor in 1984, 6.25% of the women experienced some form of CSA (Heath et al., 1996). In another major study of college-age females, 21.8% reported an incident of CSA (Kinzl et al., 1995). A recent survey, incorporating data from 15,831 individuals, seemed to corroborate the Kinzl study, showing that 22% of both males and females self-reported a history of CSA (Walker et al., 2009). Most studies show that females are 2–4 times more likely to be victimized than males (Heath et al., 1996; Hunt & Kraus, 2009). In a representative sample of 1793 individuals in Australia, more than one-third of women and about one-sixth of men reported a history of CSA (Najman et al., 2005). In an American study of 1528 randomly selected college students, 6% of females reported "childhood unwanted sexual contact" by someone at least 5 years older and 5% reported childhood unwanted sexual contact by someone less than 5 years older; 2% of males reported affirmative for both

variables (Frazier et al., 2009). Perhaps the actual rates are somewhere in between the data collected in these two studies. Although there is no clear answer regarding the actual rate of CSA, it is clear that CSA is a public scourge whose rates of incidence are far higher than most people realize.

Prevalence of Sexual Disorders

For the purposes of this review, sexual disorders will be defined as all problem sexual behaviors on the continuum from dysfunction and hypoactive sexuality to compulsions and hyperactive sexual behavior. Exact rates of prevalence of sexual disorders in the general population are not exactly known, but may be inferred from a variety of studies. Kinzl et al., (1995) estimate that about 20% of the entire population has hypoactive sexual disorders, such as lack of interest in sex, while a staggering 30% of the female population has some sort of orgasm disturbance. Additionally, lifetime prevalence reported by the women in the study were 36% fear of sex, 32% diminished sexual interest, and 36% less than desirable sexual pleasure (Kinzl et al., 1995). Sarwer and Durlak (1996) suggest that some form of sexual dysfunction afflicts up to 35% of females in the general population. These data, however do not explain the etiology of the dysfunction, nor differentiate between psychological and medical reasons.

In a study of a male community sample, 26% reported persistent or recurrent avoidance of sexual activities, 26% reported sexual arousal disorders (such as erectile dysfunction), and 12% reported a range of orgasm disorders (from premature ejaculation to delayed ejaculation) (Kinzl, Mangweth, Traweger, & Biebl, 1996). Another community study reported a lower prevalence of hypoactive sexual desire disorder (lack of interest, avoidance of sex) among men, 16%, still a relatively high number (Kinzl et al., 1996).

Regarding sexual pain disorders, prevalence rates appear to be high especially for women, with studies showing rates up to 33.5% (Kinzl et al., 1995). Overall, it appears that women suffer from some form of sexual dysfunction more frequently than men. This conclusion is echoed by a survey of 1,749 women and 1,410 men, in which 43% of the women and 31% of the men reported some degree of sexual dysfunction (Hunt & Kraus, 2009). Clearly, the rates of sexual dysfunction in the general population are alarmingly high, the etiology of which will be explored in greater detail.

The literature review demonstrates that incidence rates of hypersexual behavior are lower, 3%–6% (Ragan & Martin, 2000). However, it is not clear how these data were collected. According to a 1998 estimate by the National Council on Sexual Addiction and Compulsivity, now known as the Society for the Advancement of Sexual Health (SASH), 6%–8% of Americans are "sex addicts" (Cooper, Putnam, Planchon, & Boies, 1999). A large survey of 9,265 respondents regarding their online sexual usage habits determined that 17% scored positively for sexual compulsivity (Cooper, Delmonico, & Burg, 2000).

Research also indicates hypersexuality occurs far more often in males than females. According to Carnes (1996; 1998), hypersexual males outnumber females 3–4:1.Again, how he came up with this figure is unclear. In a study of 539 young adults attending a Midwestern university, males scored significantly higher than females for sexual compulsivity (Perera et al., 2009). According to a 2003 study by Raymond, Coleman and Miner (as cited in Kaplan & Kreuger, 2010), only 8% of respondents recruited were female. According to a 1996 study by Carnes and Delmonico of 290 self-identified sexual addicts (as cited in Kaplan & Kreuger, 2010), 80% were male and 20% female. This was corroborated in a 2007 study by Briken, Habermann, Berner, and Hill (as cited in Kaplan & Kreuger, 2010), in which only 20% of patients with sexual addiction symptoms were female.

Based on the literature review, it appears that overall, there is a paucity of research on the frequency of hypersexual disorders in the general population and much of the research seems to lack rigorous methodological controls for accuracy. In addition, it is often unclear how the authors define hypersexuality, as such terms as "hyperphilia," "hypersexual disorder," "sexual addiction," and "compulsive sexual behavior" are often used interchangeably (Kaplan & Kreuger, 2010). It appears that compulsive masturbation, dependence on pornography, and protracted promiscuity are the most noted behaviors used to define hypersexuality (Cooper et al., 1999; Kafka & Hennen, 1999). However, much of the data seem to be compiled from individuals who already self-identify as hypersexual (Kafka & Hennen, 1999). In this way, hypersexuality, as measured in much of the literature, appears to be more of a subjective variable. Most recently, the Hypersexual Behavior Inventory (HBI) has been utilized to validate criteria for hypersexuality as a diagnosis (Reid, Carpenter, & Loyd, 2009).

Hypersexual behavior appears to be a growing concern among men. The data suggest that sexual dysfunction disorders such as performance, orgasm, or pain dysfunctions are more prevalent in females, whereas hypersexuality is far more common in males.

Relationship Between CSA and Sexual Disorders

As stated, it appears that females are more likely to suffer from sexual dysfunction as a result of CSA than men. According to research done on Jamaican adult survivors of CSA, 60% of female respondents (both abused and nonabused respondents) suffered from some type of sexual dysfunction, as did only a third of the abused men (Swaby & Morgan, 2009). A study of 301 men in a community sample found that only 1–3% suffered from sexual dysfunctions such as erectile disorder or sexual pain disorder, whereas only about 10% reported problems with sexual desire or premature ejaculation (Kinzl et al., 1996).

However, no difference was found between survivors of CSA and non-victims, so the authors of the Kinzl study concluded that CSA may not have a significant correlation to male sexual dysfunction. Instead, the research indicated a significant correlation between sexual dysfunction in men and an "adverse" family environment characterized by emotional neglect (Kinzl et al., 1996). In fact, a negative family background had a high correlation for sexual dysfunction in both genders (Kinzl et al., 1995). This was corroborated by a meta-analysis that concluded the correlation between CSA and sexual dysfunction to be weak, or even absent, among men (Holmes & Slap, 1998).

Additionally, the same researchers studied the effects of CSA on female sexual dysfunction and, in contrast to men, found a very strong correlation between the two (Kinzl et al., 1995). In fact, another study suggests that 75% to 94% of women with a sexual dysfunction could be accurately identified based on a history of CSA (Sarwer & Durlak, 1996). One study determined that more than 50% of female survivors of CSA suffer from subsequent sexual dysfunction (Sarwer & Durlak, 1996). In a study of 73 women who experienced CSA, 73% suffered from a current sexual dysfunction (Sarwer & Durlak, 1996). Among a sample of 57 women who were survivors of CSA, 56% experienced physical discomfort during sex and 36% indicated that they needed "sex therapy" (Feinauer, 1989).

The greatest variable of CSA that was correlated with subsequent sexual dysfunction was penetration in the act (Sarwer & Durlak, 1996). Additionally, and perhaps of key importance, women suffering from a sexual dysfunction were more likely to report inadequate sexual education than did women with no dysfunctions (Kinzl et al., 1995).

Among men, in contrast to the lack of correlation between CSA and sexual dysfunction, there appears to be a significant correlation between CSA and sexually compulsive behavior. In a study of prevalence of CSA among men who have sex with men (MSM), 20% reported experiences with CSA, primarily by non-family members (Paul, Catania, Pollack, & Stall, 2001). These men were more likely to engage in high-risk sex than the non-abused men. In addition, the men in the study who had survived CSA were more likely to exhibit sexualized behaviors and behave in aggressive and hostile ways than their female counterparts (Paul et al., 2001). Overall, the men in the Paul et al. study (2001) were more likely to have suffered penetration and physical force. These results were corroborated by a study of 1177 participants, in which those men who were subject to CSA involving force reported more adult sexual risk behavior, including more partners and STD diagnoses (Senn et al., 2007).

According to a meta-analysis of 166 studies regarding CSA samples of boys, men who were victims of CSA were much more likely to engage in frequent high-risk sexual behavior, such as prostitution and unprotected sex, have more lifetime sexual partners, and have higher rates of STDs (Holmes & Slap, 1998). In a qualitative study of 14 men self-identified as sexually

addicted, 13 described experiences of CSA (Guigliano, 2006). Further, nine of the men described their behavior as "reminiscent" of their CSA experiences; men who experienced forcefulness or rape reported their own similar adult behaviors of aggressive or coercive sex. In addition, those who had memories of locations such as dark closets and public places reported similar behavior in adulthood (Guigliano, 2006). This lends credence to support theories of traumatic re-enactment in the etiology of hypersexuality. Interestingly, a majority of these individuals remembered their sexual experiences as occurring prior to age 7, with a significantly older individual (Guigliano, 2006). The significance of age will be examined in greater detail further in this review.

CSA seems to be highly correlated to sexually compulsive behavior in both genders. Of individuals described as sex addicts, 39% of males and 63% of females were survivors of CSA, according to Carnes (1989) (Perera et al., 2009). In a cohort of self-identified sex addicts, 78% reported CSA (Perera et al., 2009). However, in the Perera et al. (2009) study of 539 young adults, the men did score significantly higher than the women for scales of sexual compulsivity, which perhaps indicates that women are far less likely to suffer from hypersexual behavior, but of those that do, a history of CSA might be a highly correlated variable.

In summary, these studies indicate that CSA is highly correlated with sexual dysfunction primarily in women, while emotional neglect and lack of sex education is correlated with dysfunction in both genders. Perhaps this neglect and absence of information about sex is indicative of an overall negative attitude toward sexuality, a key factor that will be explored in great detail below. CSA appears to be highly correlated to hypersexual behavior in both men and women. However, men are far more likely to engage in such behavior, an issue of key relevance.

Factors Influencing Severity of Post-CSA Response

It is important to remember that CSA does not, in itself, necessarily guarantee a traumatic response from the child. According to a meta-analysis of 45 studies of the effects of CSA, approximately one-third of the children reported no adverse symptoms (Kendall-Tackett et al., 1993). Further, another meta-analysis concluded that family environment was a much greater factor in traumatic response than the CSA itself (Rind et al., 1998). In a more recent study, only 13% of those who had suffered sexual assault and regarded it as their worst traumatic event suffered from PTSD symptoms (Frazier et al., 2009). Therefore, CSA on its own is not the only factor determining the traumatization of the child. Factors in the environment may be just as, if not more important, to the subsequent traumatization of the child as the abuse itself (Bhandari, Winter, Messer, & Metcalfe, 2011). In fact, the abuse

itself accounted for only 15–45% of the variance in subsequent behavior (Kendall-Tackett et al., 1993).

There are two categories of variables that seem to affect severity of symptoms: the nature of the abuse itself and the response the child received about the abuse from his or her environment (Easton et al., 2011; Heath et al., 1996; Kendall-Tackett et al., 1993). Regarding the abuse itself, research shows that the relationship between the child and the perpetrator was highly correlated to traumatic symptoms. Specifically, the closer the perpetrator was to the victim, the more serious the effects of trauma (Kendall-Tackett et al., 1993). Other factors that increased severity of traumatization included the amount of force, frequency and duration of the attacks, and severity of the abuse. If physical force was used to restrain the victim, if the abuse was prolonged and frequent, and if penetration occurred during the abuse, then the child was more likely to suffer from more negative and severe symptoms (Heath et al., 1996; Kendall-Tackett et al, 1993; Senn et al., 2007).

Perhaps the most important factor related to the traumatization of the child, however, is the response to the abuse from the child's environment (Bhandari et al., 2011; Finkelhor & Browne, 1985; Kinzl et al., 1995; Nash et al., 1993). Lack of support from caretakers is a key variable that is correlated with negative outcomes (Kendall-Tackett et al., 1993). Maternal support was the most crucial factor in a child's successful recovery, according to several research studies (Kendall-Tackett et al., 1993). This maternal support was most often demonstrated by believing in the child's story and acting in a protective, nurturing way to the child. Interestingly, two separate studies demonstrated that disclosure by the child regarding its abuse led to greater symptoms, than if the child did not disclose (Easton et al., 2011; O'Leary, Coohey, & Easton, 2010). This may be due to negative reactions of individuals in the environment to the disclosure (Easton et al., 2011; O'Leary et al., 2010). If so, this would lend further credence to the importance of the family environment in the severity of symptoms (Bhandari et al., 2011).

The systemic nature of the family is a key variable. Those families which have less strain and less internal conflict and allow for expressions of anger tend to provide an environment more conducive to the child's recovery (Kendall-Tackett et al., 1993). One research study demonstrated that children whose mothers were most supportive and whose families had less conflict and enmeshment were most likely to be asymptomatic 5 years following disclosure of abuse (Kendall-Tackett et al., 1993).

Factors Differentiating Different Pathways of Sexual Behavior

According to a previously cited 1993 meta-analysis of 45 studies of CSA, the most common behavioral symptom is sexualized behavior, which can include everything from sexualized play with dolls, to inserting objects into sexual orifices, to public masturbation and other public displays of sexuality,

to generally seductive behavior (Kendall-Tackett et al., 1993). In fact, compared to a nonclinical population, the effect size of sexual abuse accounted for 43% of the variance for acting-out behaviors such as aggression and sexualized behavior. Interestingly, CSA also plays a large part in internalizing behavior such as withdrawal, accounting for 36% of variance compared to nonclinical samples (Kendall-Tackett et al., 1993)., It is clear that CSA has tremendous influence on both externalizing responses such as sexually acting out and internalizing responses such as withdrawal and inhibition. The question still remains: why is one child influenced one way, while another is moved toward the opposite end of the spectrum?

A more thorough investigation of the findings seems to shed light on this question. According to the meta-analysis a striking difference becomes apparent when behaviors are broken down by age groups: For preschoolers (children younger than age 6), the most common symptoms include inappropriate sexual behavior, while adolescents (children older than 12), most commonly have withdrawal and somatic complaints (Kendall-Tackett et al., 1993). If we can safely assume that inappropriate sexualized behavior is a precursor of adult hypersexuality and withdrawal is a precursor of sexual inhibitions, we can begin to grasp the relevance of the data regarding childhood symptoms and subsequent adult sexual behavior.

Regarding age of abuse and symptoms, 35% of preschool children in the study exhibited inappropriate sexualized behavior following sexual abuse, while only 6% of school age children from 6–12 did so, and a surprising 0% of adolescents displayed the same behavior following their abuse (Kendall-Tackett et al., 1993). Conversely, 10% of preschoolers showed withdrawn behavior, which rose to 36% of school children from ages 6–12, and increased even further to 45% of adolescents (Kendall-Tackett et al., 1993). It appears that the younger the child, the more likely he or she is to react to abuse through externalizing in the form of inappropriate sexualized behavior. On the other hand, almost half of adolescents reacted to their abuse by withdrawing, which is almost five times the rate at which preschoolers withdrew. Also, overall the older children were more symptomatic than the younger ones, showing more depression, anxiety, and somatic complaints than their younger peers (Kendall-Tackett et al., 1993). If, as will be argued later, sexual dysfunctions are a combination of anxiety and somatization, it becomes quite apparent why the older the child is at onset of abuse, the more likely that child is to suffer from sexual dysfunctions.

In addition, the gender of the child appears to play a significant role in subsequent sexual behavior. Research from a community sample of adult survivors of CSA indicates that women tend to report much more anxiety (internalizing), while men report greater addictive and antisocial behavior (externalizing) (Heath et al., 1996). Anxiously attached boys also measure higher for rates of aggression and control-seeking than girls (Karen, 1994). These findings were corroborated by an Institute for the Study of Child

Development study, which interviewed 169 adolescents and children within 8 weeks of discovery of CSA (Feiring, Taska, & Lewis, 1999) adolescents and girls were far more likely to suffer from sexual anxiety than younger children and boys.

As stated prior, a 2011 study on 165 adults who were victims of CSA attempted to measure dimensions of adult sexual behavior as it related to specific variables of the CSA incident, isolating for age of onset of abuse, gender, and nature of the abuse itself (Easton et al., 2011). Easton et al. measured fear of sex, guilt during sex, problems with touch, problems with arousal, and dissatisfaction with sex (Easton et al., 2011). Unfortunately, they did not examine hypersexual components of behavior, but only the inhibiting or dysfunctional aspects of sexual performance. Nonetheless, this study completely corroborates the 1993 study regarding the importance of gender and age of onset of abuse in determining subsequent adult sexual response. Specifically, the study determined that 48.1% of the females were afraid of sex, compared to 37.5% of the men; and 37.6% of the females had problems with arousal, compared to only 21.9% of the men (Easton et al., 2011). Isolating for age of abuse, only 29.8% of those abused before age 6 were afraid of sex, while a staggering 52.5% of those abused after age 6 expressed fear of sex. Furthermore, only 23.4% of the younger group felt guilty during sex, compared to 35.6% of the older group; 29.8% of the younger cohort had problems with arousal, compared to 36.4% of the older cohort, and most telling, 23.4% of the younger cohort was dissatisfied with sex, compared to 40.7% of the older cohort (Easton et al., 2011). Controlling for other variables, the odds of being afraid of sex were four times greater for the older cohort and the odds of feeling guilty during sex were two and one-half times greater for the older group. Clearly, this study supports earlier findings regarding the importance of gender and age in adult sexual behavior of victims of CSA.

Specifically, behaviors expressing fear, guilt, anxiety, and somatization were highly correlated to females and older child victims, over the age of 6 (Easton et al., 2011; Kendall-Tackett et al., 1993). Sexualized behavior and aggression were more correlated to males and younger child victims, especially younger than 6 (Kendall-Tackett et al., 1993). The author believes that these results can be significant in understanding and formulating appropriate clinical interventions in working with individuals with sexual difficulties and problematic sexual behavior.

DISCUSSION

Sex Roles—The Influence of Gender

This literature review supports a significant role for gender in the diverse outcomes of adult sexual behavior. The incidence of compulsive and

hypersexual behavior is more prominent in men, whereas the rates of sexual dysfunction and withdrawal are higher among women. It is not surprising then, that male survivors of CSA tend to skew towards compulsive acting-out behavior and females towards dysfunction and withdrawal (Easton et al., 2011; Kendall-Tackett et al., 1993). Are these differences likely to be genetic in nature or a result of social conditioning?

A Jamaican study by Samms-Vaughan and colleagues (1993) indicated that males are less likely than females to perceive sexual acts in childhood as being traumatic. In fact, only 26.7% of abused males stated that they felt helpless or horrified by the abuse experience, compared with 57.1% of females. This was supported by studies indicating that men tended to see their experience in less negative terms, often expressing indifference or even pleasure, while women tended to react with more fear and embarrassment (Holmes & Slap, 1998; Rind et al., 1998). Clearly, males and females tend to experience their abuse differently, but what could account for these differences in perception?

Several theories have been advanced to explain this. Najman et al. (2005) state that women are more likely to suffer penetrative abuse, which would negatively affect their perception of the event. Senn et al. (2007) take a more sociological approach and argue that women in heterosexual relationships often have less power and control than men over their own sexual encounters, which would increase their sense of victimization. In this way, social roles and expectations serve to impact internal perceptions of health and well-being.

Social learning theory holds that individuals learn to behave by imitating those around them and adopt belief patterns by absorbing the messages and beliefs of those in their environment (Bandura, 1969). It can easily be inferred that children pick up messages about what it means to be a male or female from their caretakers, peers and media. In this way, the idea of masculinity or femininity is largely a social construction.

One doesn't have to look far to see the variance in messages directed at boys and girls regarding sexuality. For example, a man who engages in sex with lots of other people, usually women (using our culture's heteronormative template) is considered a "stud," while a woman who engages in the same behavior is portrayed as a "slut" or a "whore" (Brekhus, 1996). Boys grow up idolizing successful and famous men such as rock stars, rappers, movie stars, and athletes, who presumably use their status and recognition to bed a harem of beautiful women (Brooks, 2001). Male celebrities, such as Gene Simmons from the rock band KISS and basketball player Wilt Chamberlain are on the television or publishing gossipy books bragging about their voluminous sexual exploits (Brooks, 2001). Boys may get messages from their fathers and the culture at large about macho ideas of what it means to be a man that portray sexual virility as a highly desired masculine trait (Philaretou & Allen, 2001).

On the other hand, female celebrities who have slept with many men are portrayed in the media as "loose" and "skanky" and are often reduced to mere uni-dimensional sex objects, rather than celebrated (Levy, 2006). Very few women publicly describe in minute detail the intricacies of their sexual escapades. Girls, in contrast to boys, may get messages from their mothers that portray sexuality often in very negative terms (Tanenbaum, 2000). They may hear about the importance of prudence and modesty, about how sexuality is something that may be given to a man as a reward, rather than something to explore and embrace, and even that only "sluts" enjoy sex and that good girls don't (Tanenbaum, 2000).

To illustrate this large difference in sex roles between the two genders, in a study of 2500 college age men and women, 65% of men said they would not take a girl seriously who had slept with more than 10 men in the previous year, but only 5% said that they would lose respect for a man who did the same (Tanenbaum, 2000).

It is clear that a meta-message is created and understood differently by both genders. The message to boys is that sex is desirable, that sex is "good," while the message to girls is that sex is "dirty," that sex is "bad." The author believes that these differing messages play a key role in the subsequent way that children respond to their abuse, which will be explored further below.

The "Bad Self"

To further understand the ways in which CSA affects the pathways of adult sexual behavior, we must take a close look at the other key variable affecting the different behavioral outcomes—age of child at onset of abuse. As detailed above, the younger the child, the more likely the child is to respond to CSA through externalizing behavior, such as inappropriate sexualized behavior, and the older the child, especially if the child is an adolescent, the more likely the child is to respond through internalizing behavior such as withdrawal and somatization (Kendall-Tackett et al., 1993). Clearly, it appears there is something about the age of the child which affects traumatic response to CSA. Perhaps the best way to understand this is to review some of the key theoretic literature regarding childhood development. Perhaps some seminal psychoanalytic concepts will help to shed light on this issue.

According to object relations theory, a child develops through his or her relationships with the external environment ("objects"), specifically caretakers (Mitchell & Black, 1994). At a very young age, the child is not yet able to differentiate between complex aspects of the objects in his environment. For example, according to Melanie Klein (1932, as cited in Mitchell & Black, 1994), an infant who is happily sucking at his mother's breast and as a result, feels a sense of warmth and security, envisions the breast he is

sucking as a "good breast"; however, when the baby is hungry and wants his mother's milk, the breast that is not there, that is denying him, is the "bad breast". In this way, the baby is either satisfied by the "good breast" or denied by the "bad breast," but cannot see that both breasts are both part of and different aspects of the same mother. Klein calls this the "paranoid-schizoid" position because the infant is not yet able to step outside of his internal "schizoid" world and understand the objects in his environment to be integrated, capable of both good and bad (Mitchell & Black, 1994).

Only once the child has matured more fully and is able to understand that his caregiver is both capable of good and bad is the child more capable of integrating this duality within himself, something that Klein called the "depressive" position (Mitchell & Black, 1994). Many individuals who have suffered trauma at a very early age are incapable of understanding themselves and others in this kind of complex, dualistic way and so engage in "splitting" behavior, viewing themselves and others as either purely good or evil, a trait commonly associated with individuals diagnosed with borderline personality disorder (Mitchell & Black, 1994). This concept of splitting and goodness vs. badness is crucial in understanding the way in which a child reacts to abuse.

W.R.D Fairbairn (1944, as cited in Borden, 2009), a prominent object relations theorist, described the mechanisms in which a child responds to abusive caretakers. Because the child is not yet mature enough to understand that his caregiver is capable of both acts of kindness and cruelty, the cruelty that the child experiences can only mean that the caregiver is "bad." However, because the idea that the person(s) that he depends on is purely bad is so frightening, the child instead, in order to justify the cruelty he suffers, decides that he must be bad instead (Borden, 2009). Hence, the child who is experiencing abuse concludes that it must surely be because he deserves it, and the only way that he deserves it is if he is bad (Borden, 2009). In this way, the child experiences himself as a "bad self" in order to make sense of the abuse he suffers.

From this, it is not a stretch to imagine that if a child is bad, he must behave badly to justify his internal representations. Hence, a child who is being abused, and then justifies the abuse through "bad" internal representations of self, then proceeds to behave badly; after all, that is what bad children do. This kind of bad behavior is externalized through actions that are visible, such as aggressiveness, violence, and oppositional and even inappropriate sexualized behavior. And here is the main concept which may hold the key to understanding differences in sexual responses to CSA—internal concepts of badness are expressed through externalizing behavior, while the opposite is also true in that external concepts of badness are expressed through internalizing behavior. In effect, this highlights the often paradoxical nature of behavior.

The Paradoxical Nature of Behavior—Locating the Badness

We saw that boys tend to receive positive messages regarding sex, whereas girls receive negative messages, and that this can be directly tied into the concept of "badness." Because boys view sex in positive terms, if something sexually traumatic occurs to them, it's not the sexual act itself that's bad, so it must be the boy himself who is bad. In support of this, research indicates that low self-esteem and feelings of worthlessness are associated with sexually compulsive behavior (Guigliano, 2006; Reece et al., 2009). A study of 147 adult male survivors of CSA demonstrated that the male coping mechanism of internalization was highly likely to produce negative clinical outcomes, concluding that internalization and disengagement were the most damaging reactions in male victims (O'Leary, 2009).

Conversely, since girls are bombarded with negative sexual messages, if something sexually traumatic happens to them, they are much more likely to locate the badness in the perpetrator or in the sexual act itself. In support of this, numerous studies have shown that women exposed to CSA are more likely to develop a fear of sex during their lifetimes (Merrill, Guimond, Thomsen, & Milner, 2003). Indeed, Swaby & Morgan (2009) suggest that research supports that sexual dysfunctions are often a result of anxiety.

When something in the environment is perceived to be bad or threatening or scary, that leads to a phobic reaction. As a metaphor, if one is bitten by a spider, a creature known to be physically repulsive and frightening, then one could easily develop a specific phobia of spiders. However, if spiders were portrayed by our society as cute and cuddly creatures, and if someone were bitten by a spider, it is much more likely that that individual would find fault in him or herself, because after all, our culture dictates that spiders are nothing to be feared. The author theorizes that that person may be more likely to compulsively re-enact his or her experience with spiders—after all the individual is not afraid of spiders, but is trying to gain mastery of the traumatic event experienced with spiders.

This highlights the control-mastery aspect of Freud's repetition theory (McWilliams, 1999), according to which a person may compulsively re-enact an experience of trauma in order to attempt to gain a greater sense of control during the experience—to "master" the trauma. This approach is corroborated by Guigliano's (2006) study in which over 63% of subjects described a re-enactment aspect of their sexual behavior. In line with this thinking, Finkelhor and Browne (1985) believe that male victims of CSA, because of their socialized male sex roles, may have compulsive needs to control or dominate as a reaction to their powerlessness during their victimization.

In this way a positive view of something, whether one's abusive caregivers or sexuality or spiders, leads to internal representations of badness if something bad happens, which leads to externalizing behavior. Conversely, negative views of the same, would lead to externalizing representations

of the trauma (locating the badness outside of oneself), which would lead to phobic reactions; in the case of sexuality, dysfunction and withdrawal.

Perhaps this explains why boys, who are more likely to receive positive messages about sex, tend to externalize and re-enact their abuse, while girls, who receive predominantly negative messages about sex, tend to develop phobic reactions such as fear of sex and pain syndromes. Interestingly, a study by Johnson and Shrier (1985) showed that sexual dysfunction among males was more likely if the boy had inadequate masculine identification, such as if the father was absent or the boy was dominated by the mother. This boy may not have received the same kind of messages as other boys regarding sexuality, so may have adopted a more negative stance towards sex. This corroborates the Kinzl et al. (1996) study cited above that correlates sexual dysfunctions in males more with neglect rather than CSA and correlates lack of sex education in childhood with sexual dysfunctions in both males and females.

This may also explain why older adolescents are most likely to respond with internalizing symptoms such as withdrawal and somatization, whereas the youngest children are most likely to respond though externalizing behaviors and sexually acting out. A young child, who has not developed the cohesive ability to integrate good and bad in himself and others is most likely to internalize a sense of badness in oneself and respond through externalizing behavior. A teenager, meanwhile, is more able to understand that his or her perpetrator is bad and hence to locate the badness in the perpetrator and/or the actual act of sex, in this way developing a phobic reaction to sex, leading to withdrawal and dysfunction.

Clinical Implications

Utilizing this theoretical framework can help shed light on appropriate and effective clinical interventions. For adults struggling with sexual dysfunctions, a cognitive-behavioral approach may be most effective in addressing the phobia and anxiety surrounding perceptions and attitudes around sex. However, with individuals displaying hypersexual behavioral traits, the above theoretical framework suggests that perhaps more of a psychodynamic and trauma-focused approach may be most effective in addressing issues such as internalized shame and behaviors displaying compulsive traumatic re-enactments. In this way, the client can begin to integrate split off conceptions of oneself into a more integrated view of self, one that is not polarized or shame-based. By integrating one's sense of self, the client can begin to lessen his or her need to project and re-enact destructive internalized representations of self. Psychosexual education could also be highly effective in either case in helping the client to understand and challenge his or her potentially harmful attitudes and misconceptions about sex.

CONCLUSION

In conclusion, the review of the literature demonstrates that both hypersexual and compulsive sexual behavior on one end of the spectrum and sexual dysfunction and withdrawal on the other are common responses to childhood sexual abuse. A meta-analysis of the research indicates that not all children are symptomatic following their abuse, and that the nature and severity of the abuse itself, particularly whether the child knew the perpetrator and whether force and penetration was employed, as well as the cohesiveness and support, or lack thereof, of the family, are the most important variables in whether the child is symptomatic. Two key variables were found to influence the symptoms—the gender and age of the child—accounting for either sexually aggressive or withdrawing behavior.

The author theorizes that the nature of the cultural messages that boys and girls receive regarding sex and the level of maturational development of the child both contribute to whether the child views him- or herself or something external, such as the perpetrator or the act of sex itself, as bad. That internal schema leads to either the need for compulsive re-enactment if the child is expressing perceived badness, or to a phobic, anxious and somatic reaction if the child is responding to an external fear (or "badness"). These childhood responses manifest themselves in adulthood as either hypersexual or compulsively sexual behavior in the case of the aggressive and re-enacting child or sexual dysfunction and withdrawal in the case of the phobic child.

Overall, age appears to be a more important variable, since in the meta-analysis, no adolescents displayed externalizing sexualized behavior, and the differences in behaviors between the age groups was dramatic (Kendall-Tackett et al., 1993). This may also explain why CSA is more correlated with sexual compulsivity in men—perhaps boys tend to be molested at younger ages, since they are better able to defend themselves in adolescence. Indeed, a study of 262 men with erectile dysfunction and 479 without, indicated that those who had experienced sexual abuse as adolescents or adults, rather than as children, appeared to experience more erectile dysfunction than other men (Tucker, Harris, Simpson, & McKinlay, 2004). Perhaps the Kinzl et al. (1995) study did not find much correlation between CSA in males and sexual dysfunction because boys are more likely to be molested as young children. Unfortunately, that study did not differentiate the ages of onset of abuse in the men who suffered from CSA.

Additional research further isolating the two categories of age and gender would shed more light on this issue. For example, a study of adult survivors of CSA with some form of problematic sexuality, whether compulsivity or dysfunction, that groups the behaviors with the two variables of age of victimization and gender may help create distinct classifications and provide a deeper understanding of the underlying dynamics that mold sexual behavior.

Using the two concepts of social learning theory and psychoanalytic object relations, this article has attempted to create a framework for understanding the mechanisms in which childhood experiences lead to the expression of adult sexuality. Further clinical implications were provided, examining ways that clinicians may approach their work with individuals presenting with various sexual difficulties, utilizing the above theoretical framework. It is the hope that the conclusions reached in this article will be the starting point for further dialogue and spur continued research and inquiry into understanding the deleterious effects of childhood sexual abuse, and the ways that adult sexual behavior are an expression of the events and behavioral patterns formed during the vulnerable and impressionable years of childhood.

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