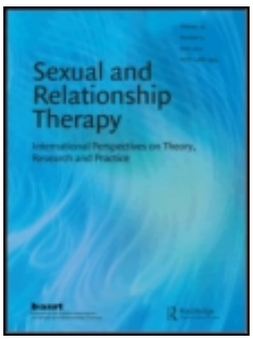

Routledge
Taylor & Francis Group

Sexual and Relationship Therapy

ISSN: 1468-1994 (Print) 1468-1749 (Online) Journal homepage: http://tandfonline.com/loi/csmt20

Sexual function in women with a history of intrafamilial childhood sexual abuse

Ellids Kristensen & Marianne Lau

To cite this article: Ellids Kristensen & Marianne Lau (2011) Sexual function in women with a history of intrafamilial childhood sexual abuse, Sexual and Relationship Therapy, 26:3, 229-241, DOI: 10.1080/14681994.2011.622264

To link to this article: http://dx.doi.org/10.1080/14681994.2011.622264

Sexual and Relationship Therapy
Vol. 26, No. 3, August 2011, 229–241

Routledge
Taylor & Francis Group

Sexual function in women with a history of intrafamilial childhood sexual abuse

Ellids Kristensen[a,b]* and Marianne Lau[c]

[a]*Psychiatric Clinic Copenhagen, Department of Sexological Research, Copenhagen, Denmark;* [b]*Department of Neurology, Psychiatry and Sensory Sciences, Faculty of Health Sciences, University of Copenhagen, Copenhagen, Denmark;* [c]*Mental Health Services Copenhagen, Stolpegaard Psychotherapy Centre, Copenhagen, Denmark*

(*Received 11 November 2010; final version received 4 April 2011*)

This study investigated sexual function in women with a history of severe intrafamilial childhood sexual abuse (CSA) and the correlation between sexual problems and the severity of CSA, adult support during childhood and current psychiatric symptoms. The sample consisted of 158 women who subsequently began specialized group psychotherapy for CSA sequellae. Clinical interview and questionnaires (Present Sexual Function, Sexual and Body Satisfaction, Symptom Check List 90-R) were used for data collection in a cross sectional study design. Non-parametric analysis, linear and logistic regression analysis were applied. Of the women, 63% were unsatisfied with their current sexual life, 39% felt uncomfortable with physical endearments and 71% were unsatisfied with their body. Only 82% had an active sexual life and, of these, 73% reported at least one sexual problem, 48% orgasmic problems and 45% dyspareunia. The occurrence of sexual problems was significantly correlated to childhood physical violence, current psychological distress, flashbacks in sexual situations and discomfort with physical endearment. The prevalence of sexual pain disorders were also positively correlated to "no adult support" in childhood. The present study finds that psychiatric patients in terms of women with a history of intrafamilial CSA have wide-ranging sexual problems. It is crucial to screen for sexual problems and address them during treatment.

Keywords: child sexual abuse; dyspareunia; female; sexuality; sexual satisfaction

Introduction

Women exposed to childhood sexual abuse (CSA) often, but not always report sexual problems and dissatisfaction with sexual life (De Silva, 2001; Leonard, Iverson, & Follette, 2008; Nazareth, Boynton, & King, 2003; Öberg, Fugl-Meyer, & Fugl-Meyer, 2002). In a random community study, 40% of women with a history of CSA lacked interest in sex during the preceding year (Laumann, Michael, & Gagnon, 1994). Kinzl, Traweger and Biebl (1995) investigated 202 Australian university women and found that 22% reported exposure to CSA and that women with a history of abuse had a greater risk of sexual pain, sexual desire/arousal disorder and orgasm disorder. Courtois (1997) describes that flashback and body concerns occur frequently in conjunction with sexual problems.

*Corresponding author. Email: ellids.kristensen@regionh.dk

ISSN 1468-1994 print/ISSN 1468-1749 online

http://dx.doi.org/10.1080/14681994.2011.622264
http://www.tandfonline.com

Among women seeking psychotherapy, women with a history of CSA have been found to have more severe sexual problems than women without. Lundqvist, Svedin and Hansson (2004) studied a group of 45 women with a history of sexual abuse referred to group therapy and found that 80% reported sexual problems. In an Australian random community study, Mullen, Martin, Anderson, Romans and Herbison (1994) found that about half the women with history of CSA who were seeking therapy reported sexual problems, whereas sexual problems were less often reported (about every forth) in the control group of women with no CSA.

Many studies show that women exposed to serious CSA (including touching or penetration) reported a more disrupted adult sexual life than women exposed to mild or no CSA (Loeb et al., 2002). Penetration during the CSA seems to be an important factor in developing sexual problems. Two thirds of women reporting penetration as part of the CSA also reported sexual problems (Mullen et al., 1994) and in a later study (Mullen, Martin, Anderson, Romans, & Herbison, 1996) it was found that women exposed to contact CSA (touching or penetration) were significantly more likely to report sexual problems (OR: 4.0), than women who had not been abused. Whether there had been more than one perpetrator and violence in conjunction with the CSA also affected the women's adult sexual function (Loeb et al., 2002).

Knowledge about other upbringing factors with impact on later sexual problems in women sexually abused as children is sparse. Positive maternal support and having at least one caring and stable parent figure has been shown to affect the degree of symptoms in the child (Kendall-Tackett, Williams, & Finkelhor, 1993; Spaccarelli & Kim, 1995) and family environment seems to be more important than specific characteristics of a CSA experience for predicting long-term outcomes (Fassler, Amodeo, Griffin, Clay, & Ellis, 2005).

Sexuality, sexual relationships and sexual functioning involve enjoyment of physical endearment and intimacy (Kleinplatz & Mènard, 2007) as well as a complex interplay of thoughts, feelings, physical processes and behaviours (Wiederman, 2002). Women with a history of CSA experience significantly low scores on positive feelings for partners (Dennerstein, Guthrie, & Alford, 2004) and frequently describe a lack of intimacy in relationships with both men and women (Mullen et al., 1994). These problems may derive from body dissatisfaction, bodily concerns and feelings of a lack of control over their own bodies and thereby contribute to the development of sexual problems (Svedin, Back, & Soderback, 2002; Wenninger & Heiman, 2005).

Although there have been several studies on sexual function in women with a history of CSA, there is still sparse knowledge on the factors influencing sexual function in clinical samples – knowledge potentially important for the treatment offered. We hypothesize that the severity of sexual abuse and neglect in childhood are positively correlated to the severity of problems in the adult women's sexual function and that flashback, impaired psychological wellbeing and body concerns are mediating factors between CSA and later sexual function.

Aims

The aim of this study was to describe sexual function, symptomatology, sexual satisfaction and body satisfaction in a clinical sample of women that reported primary intrafamilial CSA. Furthermore we wanted to investigate whether sexual function and satisfaction were correlated to (1) factors in upbringing environment (supportive adult relationships and physical abuse), (2) specific factors related to the CSA and (3) general psychological function, body concerns and flashbacks.

Methods

The sample

A total of 161 women starting treatment in specialized psychotherapy groups for women with a history of intrafamilial CSA were selectable (Kristensen & Lau, 2007; Lau & Kristensen, 2010). All women were referred by a medical doctor and diagnosed by a specialist in psychiatry as victims of sexual abuse within the family. The women reported exposure to at least one intrafamilial CSA experience with physical contact (see below for definition). Exclusion criteria were: no clear recollection of the sexual abuse, pregnancy, current diagnosis of psychosis, mental or organic impairment, active drug or alcohol abuse and active suicidal behaviour. Three failed to complete the data on sexual function leaving 158 women for evaluation.

Measures

Data was collected from self-administered questionnaires completed in conjunction with a clinical interview. The main measures were:

Present Sexual Function (PSF)

For the purpose of this study, a self-rating questionnaire with five questions was constructed. The first four questions were scored on a Likert-type scale from 0–4: never (0), seldom (1), regular (2), often (3) or always (4). These included *physical arousal* (''Is your vagina sufficiently lubricated during sexual activity?'' (reversed coded), *vaginismus* (''Do you experience muscle spasms in your vagina, so that the penis can't be inserted and coitus is impossible?''), *dyspareunia* (''Do you have pain in your genitals or lower abdomen in connection with coitus or other sexual stimulation?'') and *orgasmic function* (''Are you able to get an orgasm when you want it?''). The fifth question regarding *low sexual interest and pleasure* (''How much where you troubled by lack of sexual interest or pleasure?'') was also scored on a 0–4 scale, but with slightly different options: not at all (0), a little (1), some (2), quite a lot (3) and very much (4). The women were able to mark ''Not sexually active'' in the questionnaire. Women with an active sexual life, with partner or alone are asked to answer the questionnaire based on their sexual life during the last four weeks. The total score ranged from 0 to 20; higher scores indicate more impaired sexual function.

Factor analyses were performed on the PSF. The statistics on the five items in the PSF were acceptable (Appendix 1). The screen plot showed one major factor. The internal consistency using Cronbach's standardized item alpha was 0.66. All items correlated with the total and none were above $\alpha = 0.66$.

Sexual functioning

Questions concerning *sexual function* were constructed for the study. The question about satisfaction with current sex life (''How satisfying is your current sex life?'') was rated as: very unsatisfied, unsatisfied, satisfied, very satisfied. The question regarding sexual desire (''Are the dimension of your sexual desire as you want it to be?'') was rated as: much too low, too low, appropriate, too extensive, much too extensive. *Body satisfaction* – the women's attitude toward her body (''How satisfied are you with your body (your appearance, bodily shape and function)?'' – was rated as: very unsatisfied,

unsatisfied, satisfied, very satisfied. *Physical endearment* (''Do you enjoy physical endearment?'') was rated as: never, seldom, regular, often or always.

Childhood sexual abuse questions

The questionnaire, created for the study, included several detailed questions describing the relationship between the child and the offender, the sex of the offender, the severity and duration of the CSA.

The Symptom Checklist-90-R (SCL-90-R)

The *SCL-90-R* (Derogatis, 1994, 2000) is a self-report inventory with 90 questions measuring general psychiatric symptomatology in nine primary dimensions. The SCL-90-R Global Severity Index (GSI) is the mean of all scores and provides a measure of the current overall level of psychological distress. Adequate internal consistency, test-retest reliability and construct validity have been previously established for this inventory. Internal consistency ranges from .77 to .90 for the subscales. Test–retest coefficients, at a 1-week interval, range from .80 to .90 for the subscales (Derogatis, 1994, 2000). The mean GSI in a random sample of Danish women was 0.5 ± 0.5 (Olsen, Mortensen, & Bech, 2006).

Supportive adult in childhood

This is a ''yes'' or ''no'' response to the question: ''During childhood were there one or more adults that you trusted, and who helped you when you needed it?''

Flashback registration in sexual situations (FBR-S)

Flashback registration in sexual situations was defined as recurrent and intrusive distressing recollections of the CSA during sexual situations. It was scored on a 6-point scale ranging from every day to never.

Definitions

Intrafamilial CSA was defined as at least one reported incidence of sexual abuse with physical contact experienced before the age of 16, committed by a biological relative or non-biological family member. *Orgasmic problems* were defined as never or seldom attaining orgasm during sexual activity. *Physical arousal problems* were defined as never or seldom producing sufficient lubrication during sexual activity. *Dyspareunia* was defined as always, often or regularly experiencing genital pain during sexual activity. *Vaginismus* was defined as always, often or regularly experiencing an involuntary spasm of the musculature of the vagina that interfered with coitus during sexual activity.

Statistical methods

Sociodemographic data and categorical symptoms were analysed using the chi-square test. Mann-Whitney U-test was applied to analysis of SCL-90-R and PSF. Spearman's R correlation coefficient was selected for the correlation analyses. Linear regression

was used to determine the relative contribution of GSI, body satisfaction, physical endearment discomfort and flashbacks to PSF. Logistic regression was used to determine the influence of upbringing factors on sexual dysfunction. All tests were performed as two-sided with a 5% level of significance. All statistics were computed using the SPSS 15.0.

Ethics

The study was approved by The Ethics Committees in Denmark. All participants gave written consent for participation after receiving complete written and oral descriptions of the study.

Results

The socio-demographic and psychiatric data on the sample are shown in Table 1. Table 2 shows the characteristics on the sexual abuse and upbringing.

Sexual function and satisfaction

Table 3 shows sexual function in the sample. Almost half (45%) of the 95 currently sexually active women with a sexual problem were unsatisfied with their current sexual life. The mean age for women not sexually active (40.1, SD = 10.1) differed from women who were sexually active (32.0, SD = 9.0) (Mann-Whitney U = 1013, $p < .001$). Sexual pain disorder (vaginismus and/or dyspareunia) were described by 49% (64) of the sexual active women. Psychological function is shown in Table 3. The mean GSI score was more than 2 SD over the mean GSI of a general Danish female population sample (Olsen et al., 2006).

Body appreciation

Women who were dissatisfied with their bodies were significantly more dissatisfied with their sexual life (76% versus 36%) ($\chi^2 = 22{,}031$, $p = .000$) and had a higher GSI than women who were satisfied with their bodies (1.75 ± 0.65 versus 1.31 ± 0.48) (Mann-Whitney U = 3607.0, $p < .001$). However, they did not have more sexual dysfunctions.

Table 1. Characteristics of the sample of 158 women with a history of sexual abuse.

	n	%
School or vocational training under 10 years	36	22.8
No formal education	61	38.6
University education	27	17.1
Employed	65	41.1
In process of training	30	19.0
Unemployed	61	38.6
Part or full-time sick leave	50	31.7
Married or cohabiting	66	41.8
Had at least one child	66	41.8
Out-of-home care during childhood	41	25.9
Current psychopharmacological treatment	44	27.8

Table 2. Characteristics on the sexual abuse and upbringing.

	n	%
Relationship between child and abusive persons*		
Biological father	75	47.5
Stepfather	32	20.3
Stepbrother/biological/adoptive brother	25	15.8
Uncle	26	16.5
Grandfather	19	12.0
Biological mother	4	2.5
Adoptive or foster father	7	4.4
Exposed to both intra- and extra-familial offenders	45	28.5
At least one female offender	7	4.4
No male offenders	2	1.2
Penetration (vaginal, oral and/or anal)	102	64.6
Abused by more than one offender	62	39.2
Violence in conjunction with CSA (actual or threatened)	75	47.5
Physical abuse in childhood not in conjunction with the CSA	69	43.7
Raped as teenager or adult	56	35.4
Average age of onset of CSA, mean (SD)	6.3 (3.5)	
Duration of CSA, mean (SD)	6.7 (4.3)	

Note: *A number of people were exposed to several abusive persons.

Table 3. Sexual function described by the women.

	All women $n = 158$		Sexually active women $n = 130$	
	n	%	*n*	%
Perceived low sexual desire	98	62.0	80	61.5
Physical endearment discomfort	61	38.6	43	33.1
Unsatisfied with body	112	70.9	89	68.5
Unsatisfied with current sexual life	99	62.7	76	58.5
No current sexual activity	28	17.7		
Any sexual problem	95	60.1	95	73.1
Orgasmic problem	62	39.2	62	47.7
Arousal problem	29	18.4	29	22.3
Dyspareunia	59	37.3	50	45.4
Vaginismus	19	12.0	19	14.6
Number of sexual problems, mean (SD)			1.3 (1.1)	
No adult support during childhood	92	58.2	76	58.5
Low sexual interest or pleasure	105	66.5	89	68.5
Flashback in sexual situations	57	36.1	57	43.8
at least monthly				
never	19	12.0	19	14.6
Psychological function GSI, mean (SD)	1.62 (0.64)		1.62 (0.64)	
Age, mean (SD)	33.4 (9.7)		32.0 (9.0)	

Women who were uncomfortable with physical endearment were significantly more dissatisfied with their sexual life (90% versus 48%), ($\chi^2 = 27{,}819$, $p < .001$), had more sexual problems (1.76 ± 1.28 versus 1.01 ± 0.92) (Mann-Whitney $U = 2769.5$, $p = .013$) and had a higher GSI (1.76 ± 0.62 versus 1.55 ± 0.63)

(Mann-Whitney U = 4344.5, $p < .001$) than women who were comfortable with physical endearment.

Present Sexual Function

The correlation analyses showed that the PSF score was statistical significant correlated with GSI ($r = 0.25$, $p = .002$), FBR-S ($r = 0.24$, $p = .007$), low body satisfaction ($r = 0.19$, $p = .018$) and physical endearment discomfort ($r = 0.16$, $p = .041$). Present Sexual Function was also statistically significantly correlated to two of the commonly known factors that influence sexuality: age ($r = -0.24$, $p = .003$) and level of education ($r = -0.18$, $p = .023$), but not correlated to currently employed, marital status, number of children or use of psychopharmaceuticals.

Linear regression analysis was performed with PSF as the dependent variable and GSI, FBR-S, low body satisfaction and physical endearment discomfort as covariates, adjusted for age and level of education. Global Severity Index, FBR-S and physical endearment discomfort showed statistical significance (Table 4). Findings suggest that distress, flashback symptoms and comfort with physical endearment predict variance in overall sexual functioning in women with a history of CSA.

With respect to factors in relation to upbringing and other abuse incidents than CSA there was a statistically significant correlation between PSF and not having a trusting adult relationship during childhood ($r = 0.16$, $p = .043$), but not to later rape or childhood physical abuse. Present Sexual Function correlated at a borderline level to having had more than one offender ($r = 0.16$, $p = .051$). No correlations were found between PSF and other CSA-related factors (age of onset, duration of the abuse, offender types, violence in conjunction with the abuse and penetration).

Sexual problems

Having at least one sexual problem was correlated to ''not having a trusted adult during childhood'' ($r = 0.21$, $p = .018$) and to childhood physical abuse ($r = 0.29$, $p = .005$). No correlations were found for CSA-related factors (age of onset, duration of the abuse, offender types, more than one offender and penetration).

A logistic regression with sexual dysfunction as the dependent variable and two upbringing characteristics (no adult support and physical abuse) as covariates showed that physical abuse in itself was a significant factor, with an OR of 2.7

Table 4. Linear regression analysis of relationships between Present Sexual Function as dependent variable and Global Severity Index (GSI), flashback registration during sexual situations (FBR-S), not satisfied with body and physical endearment discomfort (adjusted for age and education).

						95%CI for Exp(B)	
	B	*SE*	Beta	*t*	*p*	Lower	Upper
GSI	1.064	0.531	0.180	2.006	0.047	0.014	2.115
FBR-S	0.419	0.207	0.165	2.023	0.045	0.009	0.830
Not satisfied with body	0.228	0.399	0.052	0.571	0.569	−0.563	1.019
Physical endearment discomfort	1.384	0.309	0.377	4.479	0.000	0.772	1.996

(Table 5), and no adult support showed borderline significance. Logistic regression with each of the four sexual problems as dependent variables showed that no supportive adult influenced prevalence of vaginismus (OR: 3.8) and dyspareunia (OR: 2.6) (Table 5) to a statistical significant degree but not orgasmic or arousal problems. The analysis including desire and orgasmic function showed no statistic significance.

Discussion

To our knowledge this is one of the first studies that has tried to correlate sexual dysfunction in women who have been exposed to intrafamilial CSA with the perception of having a supportive adult during childhood. A major finding of this investigation was that women with a history of CSA who did not have a trustful adult during childhood had more sexual problems than the rest of the women and the frequency of dyspareunia and vaginismus (sexual pain disorder) was correlated to not having a supportive adult in childhood. This is in agreement with the finding that positive extrafamilial relationships and adequate social support (Kinzl et al., 1995) and having at least one caring and stable parent figure (Spaccarelli & Kim, 1995) may be protective factors and prevent negative long-term sexual consequences.

Other major findings were that women who had been exposed to childhood physical abuse had more sexual problems than the rest of the women and that not being comfortable with physical endearment as well as general psychological distress and flashbacks in sexual situations were predictive for having a problematic sexual life.

The present study showed that adult women in psychotherapy due to psychiatric sequela of intrafamilial CSA had a high frequency of sexual dysfunctions and low sexual contentment. Nearly two thirds were dissatisfied with their current sexual life. Of the sexually active women, three quarters had at least one sexual problem, nearly half had orgasmic problems and nearly half had sexual pain disorder (dyspareunia and/or vaginismus). This is in accordance with other studies, including Harlow and Stewart (2005), who found that vulvar pain was strongly associated with childhood sexual abuse and, in accordance with earlier clinical studies that showed high frequencies of sexual dysfunctions in subjects with a history of CSA (Heiman, Verhulst, & Heard-Davison, 2003). It also agreed with the findings that more women

Table 5. Odds Ratios for the influence of childhood conditions (no adult support and physical abuse not in conjunction with CSA) on symptomatology.

							95%CI for Exp(B)	
	B	*SE*	Wald	*df*	*p*	Exp(B)	Lower	Upper
A. Any sexual problem								
No adult support	0.793	0.423	3.513	1	0.061	2.209	0.964	5.061
Physical abuse	1.001	0.453	4.889	1	0.021	2.720	1.120	6.602
B. Vaginismus								
No adult support	1.334	0.674	3.922	1	0.048	3.797	1.014	14.222
Physical abuse	0.654	0.535	1.494	1	0.222	1.924	0.674	5.493
C. Dyspareunia								
Adult support	0.964	0.396	5.940	1	0.015	2.623	1.208	5.695
Physical abuse	0.304	0.381	0.638	1	0.425	1.356	0.642	2.862

with vaginismus reported childhood sexual interference (Ressing, Binik, Khalife, Cohen, & Amsel, 2003) and that early experiences with sexuality in a context where confidence in adults is betrayed may have a substantial influence on mature sexual life (Ahmad, 2006).

Studies comparing women who have been exposed to different degrees of CSA found that the severity of the abuse related to later problems in sexual functioning. Rellini (2007) studied 699 female college students and found that sexual distress was strongly associated with reports of multiple abuses, the presence of vaginal penetration during abuse and a familial relationship with the perpetrator. We did not find that the severity of sexual dysfunction was correlated to penetration, number of offenders or age at initiation or duration of the abuse. This may be understood from the perspective that the women in this study were fairly homogenous, all being exposed to serious sexual abuse with physical contact and mostly to CSA with penetration. But we did find that women, who had been exposed to childhood physical abuse also had more sexual problems than the rest of the women. Nearly three quarters of the women were unsatisfied with their body and two fifths did not enjoy physical endearment. Not being comfortable with physical endearment turned out to be predictive for having a problematic sexual life. Sexuality is a bio-psychosocial development normally connected with positive bodily experiences. It may be easier and more enjoyable for a woman to participate in sexual activities when she is satisfied with her body. A high incidence of a negative body satisfaction has been reported in women who have experienced CSA (Wenninger & Ehlers, 1998) and a negative body satisfaction can lead to body self-consciousness (spectatoring) and reduce arousability. Sanchez and Kiefer (2007) found that body dissatisfaction and body shame were significantly related to reduction in the ability to be sexual aroused and Fredrickson and Roberts (1997) found that body dissatisfaction undermined sexual pleasure. Shame and negative feelings during sexual arousal make it difficult to enjoy sexual desire and excitement and may promote problems with lubrication, dyspareunia and orgasm. Thus, sexuality may become an area of uncertainty and difficulty rather than pleasure and satisfaction Sanchez and Kiefer (2007). To our knowledge it has not previously been shown that physical endearment discomfort is highly predictive for a problematic sexual life. This finding is supported by the theory that sexual problems are best solved by a therapy involving the body (Westerlund, 1992).

Also, the occurrence of flashbacks in sexual situations and general psychological distress were correlated to problems in sexual function; earlier it has been documented that both elements may be indicative for sexual problems (Buehler, 2008; Maltz, 2002). In conjunction with our results the occurrence and frequency of flashbacks appear to be a good clinical predictor of sexual problems and their magnitude (especially when flashbacks occur in sexual situations). Future studies must show whether it is the flashbacks that cause the sexual problems.

Flashbacks during which the sexual abuse is vividly relived may cause various problems. One aspect is that during sex it can be difficult or even impossible for the women to distinguish between her partner and the offender. Therefore she may try to avoid sex, have low sexual desire or try to control the sexual act by being restrictive and avoiding in terms of touching and sexual contact that might trigger a flashback. We put forward the hypothesis that sexual problems, flashbacks and physical endearment discomfort is knitted together in a pattern still to be explored. Sexual problems are more the rule than the exception in clinical samples of women with

a history of child sexual abuse. Therefore both screening and assessment for sexual problems and sex therapy are important tasks for clinicians treating survivors of CSA. In the attempt to screen for sexual problems, questions about flashbacks can be recommended. The treatment of sexual after-effects is most efficaciously undertaken later in treatment, after the bulk of the trauma resolution work is completed. Standard sex therapy techniques need to be modified for survivors, to include a heavy emphasis on psycho-education and cognitive mastery before moving on to sexual exercises (Courtois, 1997).

Limitations

There are several limitations to this study. The participants are a clinical sample of women seeking group psychotherapy in a psychiatric setting. They all report rather serious hands-on intrafamilial CSA, which means that the results cannot be generalized neither to other psychiatric patients exposed to other types of sexual abuse nor to a general population. There were no questions on sexual orientation included in the study, which would have been meaningful since differences in sexual function between heterosexual and homosexual women have been found (Laumann et al., 1994). It is also a limitation that a control group was not included in the study. Finally, the sexual abuse scale and the PSF scale (questions concerning sexuality) were constructed for this study. We performed a reliability and factor analysis on the PSF, but its validity needs to be tested.

Conclusion

Intrafamilial CSA might have a major influence on the adult women's sexual scripts. The majority of women in the present study, all starting psychotherapy because of serious CSA, were dissatisfied with their sex life, had low sexual desire and had sexual dysfunctions, many had physical endearment discomfort. The fact that sexual problems were correlated to frequency of flashbacks in sexual situations might be indicative of how important it might be to focus on flashback management in psychotherapy.

Most women were dissatisfied with their body and many felt uncomfortable with physical endearment. It might be important to include body therapy in the treatment since the bodily discomfort is correlated to having sexual dysfunctions.

The findings that childhood physical abuse and not having adult support during childhood were correlated to sexual dysfunction and, especially, sexual pain disorders, might be indicative for the importance of putting forward questions on childhood physical abuse and adult support as part of the assessment, as they may be indicative for sexual problems.

Our results emphasize the significance of screening for and addressing sexuality in therapy.

Acknowledgements

This study was supported by the Eastern Danish Research Forum for Health Sciences; Butcher Wørzner and Wife Inger Wørzner's Memorial Grant in Favour of Research in Mental Disorders. The funding sources had no involvement in study design; in the collection, analysis, and interpretation of data; in the writing of the report; and in the decision to submit the paper for publication. We are most grateful to Bent Rosenbaum and Jette LaBianca for their

inspiration and comments during the project planning phase. For their assistance in data collection, we wish to thank the following: Stolpegaard Psychotherapy Centre: Mogens Holme, Pia Rubin, Marianne Hemicke, Linda Kronsted, Rie Luxhøi, Anne Treppendahl, Hanne Lønstrup, Kirsten Rosenkrantz and Dina Wildt. Psychiatric Department, Bispebjerg Hospital H:S: Eva Castberg, Jytte Lykkegaard and Martin Lotz. Fjorden County Hospital, Roskilde County: Karin Førslev, Ellen Galatius and Pia Monsted. Ørsted Neurosis Clinic, Aarhus County: Torben Arngrim, Lene Brønnum, Birgit Lund Jacobsen, Ulla Just, Ellen Marie Lauridsen. Helsingør Psychiatric Day Unit, Hillerød Hospital, Frederiksborg County: Peder Terpager Rasmussen, Karin Borum, Dorrit Krogh.

Notes on contributors

Ellids Kristensen, MD, Associate Professor, is a psychiatrist and has since 1998 been head of department at the Sexological Clinic Rigshospitalet, Copenhagen University Hospital. She is a skilled psychotherapist, supervisor, teacher and researcher. Since 1997 she has been coordinator of the Danish national network for treatment of sexual offenders.

Marianne Lau, MD, D.Sci., is a psychiatrist and has since 1993 been employed as a senior consultant at Mental Health Services, Capital Region of Denmark, Psychotherapy Centre Stolpegaard. She is a skilled psychotherapist, supervisor and researcher.

References

Ahmad, S. (2006). Adult psychosexual dysfunction as a sequela of child sexual abuse. *Sexual & Relationship Therapy*, *21*, 405–418.

Buehler, S. (2008). Childhood sexual abuse: Effects on female sexual function and its treatment. *Current Sexual Health Reports*, *5*, 154–158.

Courtois, C.A. (1997). Treating the sexual concerns of adult incest survivors and their partners. *Journal of Aggression, Maltreatment & Trauma*, *1*, 293–310.

De Silva, P. (2001). Impact of trauma on sexual functioning and sexual relationships. *Sexual & Relationship Therapy*, *16*, 269–278.

Dennerstein, L., Guthrie, J.R., & Alford, S. (2004). Childhood abuse and its association with mid-aged women's sexual functioning. *Journal of Sex & Marital Therapy*, *30*, 225–234.

Derogatis, L.R. (1994). *Symptom Checklist-90-R (SCL-90-R): Administration, scoring and procedures manual* (3rd ed.). Minneapolis, MN: National Computer Systems.

Derogatis, L.R. (2000). Symptom Checklist-90-Revised (SCL-90-R). In American Psychiatric Association (Ed.), *Handbook of psychiatric measures* (pp. 81–84). Washington, DC: American Psychiatric Association.

Fassler, I.R., Amodeo, M., Griffin, M.L., Clay, C.M., & Ellis, M.A. (2005). Predicting long-term outcomes for women sexually abused in childhood: Contribution of abuse severity versus family environment. *Child Abuse & Neglect*, *29*, 269–284.

Fredrickson, B.L., & Roberts, T.-A. (1997). Objectification theory: Toward understanding women's lived experiences and mental health risks. *Psychology of Women Quarterly*, *21*, 173–206.

Harlow, B.L., & Stewart, E.G. (2005). Adult onset vulvodynia in relation to childhood violence victimization. *America Journal of Epidemiology*, *161*, 871–880.

Heiman, J.R., Verhulst, J., & Heard-Davison, A.R. (2003). Childhood sexuality and adult sexual relationships. In J. Bancroft (Ed.), *Sexual development in childhood* (pp. 405–420). Blooomington: Indiana University Press.

Kendall-Tackett, K.A., Williams, L.M., & Finkelhor, D. (1993). Impact of sexual abuse on children: A review and synthesis of recent empirical studies. *Psychological Bulletin*, *113*, 164–180.

Kinzl, J.F., Traweger, C., & Biebl, W. (1995). Sexual dysfunctions: Relationship to childhood sexual abuse and early family experiences in a nonclinical sample. *Child Abuse & Neglect*, *19*, 785–792.

Kleinplatz, P.J., & Ménard, A.D. (2007). Building blocks toward optimal sexuality: Constructing a conceptual model. *Family Journal*, *15*, 72–78.

Kristensen, E., & Lau, M. (2007). Women with a history of child sexual abuse. Long-term social and psychiatric aspects. *Nordic Journal of Psychiatry*, *61*, 115–120.

Lau, M., & Kristensen, E. (2010). Sexual revictimization in a clinical sample of women reporting childhood sexual abuse. *Nordic Journal of Psychiatry*, *64*, 4–10.
Laumann, E.O., Michael, R.T., & Gagnon, J.H. (1994). A political history of the national sex survey of adults. *Family Planning Perspectives*, *26*, 34–38.
Leonard, L.M., Iverson, K.M., & Follette, V.M. (2008). Sexual functioning and sexual satisfaction among women who report a history of childhood and/or adolescent sexual abuse. *Journal of Sex & Marital Therapy*, *34*, 375–384.
Loeb, T.B., Williams, J.K., Carmona, J.V., Rivkin, I., Wyatt, G.E., Chin, D., & Asuan-O'Brian, A. (2002). Child sexual abuse: Associations with the sexual functioning of adolescents and adults. *Annual Review of Sex Research*, *13*, 307–345.
Lundqvist, G., Svedin, C.G., & Hansson, K. (2004). Childhood sexual abuse: Women's health when starting in group therapy. *Nordic Journal of Psychiatry*, *58*, 25–32.
Maltz, W. (2002). Treating the sexual intimacy concerns of sexual abuse survivors. *Sexual & Relationship Therapy*, *17*, 321–327.
Meston, C.M., Heiman, J.R., Trapnell, P.D., & Carlin, A.S. (1999). Ethnicity, desirable responding, and self-reports of abuse: A comparison of European- and Asian-ancestry undergraduates. *Journal of Consultant Clinical Psychology*, *67*, 139–144.
Mullen, P.E., Martin, J.L., Anderson, J.C., Romans, S.E., & Herbison, G.P. (1994). The effect of child sexual abuse on social, interpersonal and sexual function in adult life. *British Journal of Psychiatry*, *7*, 35–47.
Mullen, P.E., Martin, J.L., Anderson, J.C., Romans, S.E., & Herbison, G.P. (1996). The long-term impact of the physical, emotional and sexual abuse of children: A community study. *Child Abuse & Neglect*, *20*, 7–21.
Nazareth, I., Boynton, P., & King, M. (2003). Problems with sexual function in people attending London general practitioners: Cross sectional study. *British Medical Journal*, *327*, 423–426.
Öberg, K., Fugl-Meyer, K.S., & Fugl-Meyer, A.R. (2002). On sexual well-being in sexually abused Swedish women: Epidemiological aspects. *Sexual & Relationship Therapy*, *17*, 329–341.
Olsen, L.R., Mortensen, E.L., & Bech, P. (2006). Mental distress in the Danish general population. *Acta Psychiatrica Scandinavica*, *113*, 477–484.
Rellini, A. (2007). Review of the empirical evidence for a theoretical model to understand the sexual problems of women with a history of CSA. *Journal of Sex Medicine*, *5*, 31–46.
Ressing, E.D., Binik, Y.D., Khalife, S., Cohen, D., & Amsel, R. (2003). Etiological correlates of vaginismus: Sexual and physical abuse, sexual knowledge, sexual self-schema and relationship adjustment. *Journal of Sex & Marital Therapy*, *29*, 47–59.
Sanchez, D.T., & Kiefer, A.K. (2007). Body concerns in and out of the bedroom: Implications for sexual pleasure and problems. *Archives of Sexual Behaviour*, *36*, 808–820.
Spaccarelli, S., & Kim, S. (1995). Resilience criteria and factors associated with resilience in sexually abused girls. *Child Abuse & Neglect*, *19*, 1171–1182.
Svedin, C.G., Back, C., & Soderback, S.B. (2002). Family relations, family climate and sexual abuse. *Nordic Journal of Psychiatry*, *56*, 355–362.
Wenninger, K., & Ehlers, A. (1998). Dysfunctional cognitions and adult psychological functioning in child sexual abuse survivors. *Journal of Traumatic Stress*, *2*, 281–300.
Wenninger, K., & Heiman, J.R. (2005). Relating body image to psychological and sexual functioning in child sexual abuse survivors. *Journal of Traumatic Stress*, *11*, 543–562.
Westerlund, E. (1992). *Women's sexuality after childhood incest*. New York: WW Norton.
Wiederman, M.W. (2002). Body image and sexual functioning. In T.F. Cash & T. Pruzinsky (Eds.), *Body image: A handbook of theory, research and clinical practice* (pp. 287–294). New York: Guilford Press.

Appendix

Apendix 1. Factor analysis of present sexual function.

Statistics for scale	*N*	Mean	Variance	*SD*	
	5	8.22	14.59	3.82	
	Mean	Minimum	Maximum	Range	Max/Min	Variance
Item means	1.64	0.66	2.27	1.61	3.44	0.42
Item variances	1.40	1.00	1.94	0.94	1.94	0.12
Inter-item Correlations	0.28	0.16	0.44	0.29	2.85	0.01
Item total statistics	Scale mean if item deleted	Scale variance if item deleted	Corrected item total correlation	Squared multiple correlation	Alpha if item deleted
Arousal	6.78	9.71	0.50	0.29	0.55
Orgasm	5.95	10.23	0.41	0.23	0.60
Dyspareunia	6.59	10.55	0.34	0.19	0.63
Vaginismus	7.56	10.69	0.44	0.24	0.59
Sexual interest	6.03	9.60	0.35	0.16	0.63
		Alpha		Standardized item Alpha	
Reliability coefficients for PSF		0.65		0.66	