A Review of the Literature Regarding a History of Sexual Abuse as a Risk Factor for Risky Sexual Behavior in Females

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Abstract

Objective: This paper seeks to answer the questions: "Does a history of sexual abuse predict risky sexual behavior for females? If so, by what mechanisms does this correlation occur?"
Method: A literature review was conducted to identify research articles that investigated the correlation between sexual abuse and sexual behavior. Cumulative Index of Nursing and Allied Health (CINAHL), Medline and PsychInfo databases were searched. Medline and CINAHL databases were searched using the terms "sexual abuse" and "risky sexual behaviors." PsychInfo was searched using the terms "sexual abuse," "risky sexual behaviors," and "risk taking behaviors." Studies examined multiple or single incidents of abuse and both childhood and adult victimization. Only abstracts published in English from 1997 and later were considered. Ultimately, 12 articles were reviewed and discussed.
Results: There is a correlation between child and adolescent sexual abuse and risky sexual behaviors but the mechanisms by which this correlation exists are not fully understood. The mechanisms may be dependent on the interplay of pre-victimization, victimization, and post-victimization factors.
Implications: This review indicates that it is important to conduct more prospective studies with various samples and sample sizes in order to clarify the mechanisms by which a victim of sexual abuse is at an increased risk for becoming involved in risky sexual behaviors.

Introduction

Background and Significance

The questions being reviewed, "Does a history of sexual abuse predict risky sexual behavior for females? If so, by what mechanisms does this correlation occur?" are important to society because risky sexual behaviors can increase a person's risk for sexually transmitted diseases (STDs) (Kahn, Huang, Rosenthal, Tissot, & Burk, 2005). STD prevention is necessary because many are not curable. Additionally, STDs have the potential to affect not only the infected individuals, but their offspring and the general population.

STDs are prevalent among American women. According to the Centers for Disease Control (CDC) in 2004, the rate of chlamydia infections in women was 485.0 per 100,000 females and cases of gonorrhea were 116.5 per 100,000 women. An estimated 96,978 women are living with AIDS (CDC, 2006c). Effects of STD infection vary by disease and can be either short or long-term. For infected women, STDs may cause: pelvic inflammatory disease (PID) which can lead to pelvic pain, infertility, and ectopic pregnancies; arthritis; an increased risk of HIV transmission to her partner; an increased susceptibility for other STDs- including HIV; cervical cancer; and an increased risk for developing cirrhosis of the liver, liver cancer, and liver failure. (CDC, 2006a; CDC 2006b; CDC, 2004a; CDC, 2004b; CDC, 2004c). For newborns of infected mothers, STDs may cause: premature delivery; stillbirth; chlamydia infection in the eyes and/or respiratory tract; early infant pneumonia; conjunctivitis; low birth weight; neonatal sepsis; neurologic damage; blindness; deafness; acute hepatitis; meningitis; chronic liver disease; and cirrhosis (CDC, 2004e).

The CDC reports that high-risk heterosexual contact was the source of 80% of the 9,893 newly diagnosed HIV infections in 2005 (CDC, 2007). Heterosexually acquired HIV infections represented 35% of all new HIV cases and of these cases, 64% of heterosexually acquired HIV infections occurred in females (CDC, 2004d). Another concern is that the CDC estimates 6,000 to 7,000 HIV-infected women give birth each year in the United States, resulting in 280 to 370 new perinatal infections. The background research of Tarakeshwar et al. (2005) estimates that between 32% and 76% of HIV-infected women report childhood sexual abuse. This correlation is important because HIV positive women who have experienced sexual abuse may continue to suffer from psychological distress related to their sexual trauma while also encountering a decreased ability to adhere to HIV secondary transmission treatment (Tarakeshwar et al., 2005).

In this review, first the association between a history of sexual abuse and risky sexual behaviors is summarized. This review also summarizes the various studies which have attempted to untangle the web of factors which determine the path from sexual abuse to risky sexual behaviors. There are previctimization factors, victimization factors, and postvictimization factors which researchers believe contribute to the likelihood of victimization, characteristics of victimization, and risk for revictimization.

Methods

A literature review was conducted to identify research articles that investigated the correlation between sexual abuse and sexual behavior. Cumulative Index of Nursing and Allied Health (CINAHL), Medline and PsychInfo databases were searched. Medline and CINAHL databases were searched using the terms "sexual abuse" and "risky sexual behaviors." PsychInfo was searched using the terms "sexual abuse," "risky sexual behaviors," and "risk taking behaviors." Studies examined multiple or single incidents of abuse and both childhood and adult victimization. Only abstracts published in English from 1997 and later were considered. Ultimately, 12 articles were reviewed and discussed.

Definitions

The research describes sexual abuse in various ways but more often defines it as being kissed, hugged, touched, fondled or penetrated in an unwanted way. Childhood sexual abuse (CSA) is often described as any unwanted sexual contact before puberty or the child's 12th birthday (Merrill, Guimond, Thomsen & Milner, 2003; Noell, Rohde, Seeley & Ochs, 2001; Testa, VanZile-Tamsen &Livingston, 2005; Parillo, Freeman, Collier & Young, 2001). Some studies distinguished between childhood sexual abuse and adolescent sexual abuse (Merrill, et.al, 2003; Noell et.al., 2001; Parillo et.al., 2001) while other studies gathered data about abuse at any age (Davis, Combs-Lane & Jackson, 2002; Green, et.al., 2005; Kahn, et.al, 2005; Lang, et.al., 2003; Smith, Davis, & Fricker-Elhai, 2004). The twelve studies examined any combination of CSA, adolescent sexual abuse, and adult sexual abuse.

"Risky sexual behaviors" have been described in this body of research as: sex without protection from unwanted pregnancy, having sex without knowing a partner's sexual history, sex without a condom if partner's STD status is unknown, trading sex for money or drugs, high number of sexual partners (in a certain amount of time or lifetime), and/or high frequency of penile-vaginal intercourse.

Results

Studies used in this review varied in composition. Sample sizes ranged from 28-1052 subjects. All studies were retrospective and most studied mostly Caucasian women. Five studies drew from college-age samples and two focused on adolescents. Several studies included subjects with a mean age in the late teens or of 40 years old and greater and one study recruited subjects in the 18 to 30 years old range.

Findings from all twelve studies included in this review supported an association between sexual abuse history and greater sexual risk factors, behaviors or outcomes. A history of sexual abuse was correlated with: younger age at first sex (Lang et al, 2003; Rodgers et al, 2004); greater number of sexual partners (Lang et al, 2003; Noell, et.al., 2001; Parillo, et.al., 2001; Testa, et,al., 2005); having sex without knowing partner's sexual history (Lang et.al, 2003); and trading sex for money or drugs (Parillo et. al.,2001). Furthermore, Smith, Davis & Fricker-Elhai, (2004) found those with a history of sexual abuse reported higher expected involvement in risky sexual behaviors than those without such histories. In addition, some studies reported associations with sexual abuse and increase rates of STD acquisition (Kahn, et al.,2005; Noell et. al. 2001; Testa et. al., 2005).

Although these findings suggest there is a strong correlation between sexual abuse and risky sexual behaviors, not all women who have been sexually abused exhibit risky sexual behaviors. The results indicate that it is not simply the experience of sexual abuse that predisposes one to risky sexual behavior, the characteristics of the experience(s) and the individual's response to the (those) experience(s) are much stronger determining factors in later behaviors. Characteristics which increase sexual risk include: more incidents of abuse (sexual and physical), history of multiple kinds of abuse (sexual, physical, emotional), closer relationship to the perpetrator (father, brother or neighbor versus stranger), and the coping mechanisms that the victim uses (avoidant, self-destructive). The results on a whole suggest that sexual abuse results in disrupted cognitive processes, which causes an altered ability to judge the risks and benefits of a behavior combined with an altered relationship to sex and interpersonal relationships in general, that may result in increased engagement in risky sexual behaviors.

Previctimization factors

Previctimization factors are factors that predispose one to be victimized, such as substance abuse, which impairs judgment and diminishes the ability to protect oneself (Smith et.al., 2004); abnormal behaviors and cognitive processes such as a diminished awareness of danger and sensation-seeking traits which exist prior to the abuse increase the risk for victimization (Davis et.al.,

2002) (Smith et,al., 2004); and being female. Tradtional gender norms that support female submissiveness (vs. assertiveness) places women at a greater risk for victimization experiences than men. They are also less likely to feel empowered to take aggressive action after the initial victimization event (Noell et. al., 2001). The strength of this expectation varies with a woman's societal and environmental factors, but should be considered when examining why abuse occurs.

Personality characteristics such as sensation-seeking traits as well as drug and alcohol use are associated with sexual victimization and risky sexual behaviors (Davis et al, 2002). Since most studies are retrospective, it has not been determined whether such traits and drug and alcohol use along with their associations are a result of and/or a precursor trait which increases risk of sexual victimization.

Victimization factors

Victimization factors describe the type of abuse one has experienced which affects the victim's behaviors and cognitive processes later in life. These factors include: the victim's relationship to the abuser (Davis et.al., 2002); duration of the abuse (Green et.al., 2005); number of incidents (Davis et.al., 2002); severity of abuse (Merrill et.al., 2003; Parillo et al., 2001); and age at the first experience of abuse.

According to Van de Kolk (1989), "Traumatization occurs when both internal and external resources are inadequate to cope with external threat," (p.393) and these resources are generally less adequate when the victim is younger. The younger a victim is at first victimization, the fewer emotional and social-cognitive skills they have developed. This lack of development affects one's ability to adapt to current life situations, as well as one's ability to properly progress through later developmental stages (Smith et.al., 2004). Developmental delays and deviations are increased when: multiple incidents and/or multiple types of victimization are experienced by an individual (Rodgers et.al., 2004; Smith, Leve, & Chamberlain, 2006; Davis, et.al., 2002); abuse involves penetration (Merrill et.al., 2003; Parillo et al., 2001); and the abuse is perpetrated by a friend, acquaintance, or family member (Davis, et.al., 2002).

A sexual abuse victim's level and nature of cognitive dysfunction depends on at what age a person has their first experience with abuse. Though, psychosocial and cognitive development is not a precise science, several theories have been developed which may describe the true nature of such development. In 1963, Erickson developed 5 stages of psychosocial development: trust vs. mistrust (birth to 1 year); autonomy vs. shame and doubt (1-3 years); initiative vs. shame (3-6 years); industry vs. inferiority (6-12 years); identity vs. role confusion (12-18 years). The success or failure at each stage results in a decreased ability to properly complete the next stage. So that the earlier in one's life that development is affected, the more negative effects are on following stages and, eventually, one's ability to function fully as an adult (Hockenberry, 2005, p.87-88).

Postvictimization (Revictimization) factors

Postvictimization factors are factors which occur after the first experience of victimization and increase or decrease the risk for revictimization. Postvictimization factors include: coping systems used by the victim; assessments of the risks/benefits ratio of a behavior; sexual partner choices; physical, psychological, social, and moral safety and stability; and traumatic reenactment. According to Terr (1990), "Traumatic events are external, but they quickly become incorporated into the mind." (p.8). The effects one experiences after a traumatic experience are a combination of the external characteristics of traumatization and the internal coping style(s) used and developed, which determines the way in which a victim copes and how well those styles serve them in the short and long term, as well as the safety of the victim's external environment. Bloom (1999) defines a comprehensively safe environment as such:

> "Psychological safety is the ability to be safe with oneself. Social safety is theability to be safe in groups and with other people. Moral safety involves the maintenance of a value system that does not contradict itself and is consistent with healthy human development as well as physical, psychological, and social safety. An environment cannot be truly safe unless all of these levels of safety are addressed." (p.13)

Several factors influence whether the victim experiences a positive or negative adjustment to their abuse, life after abuse, and how many sexual partners they will have. These factors include: avoidant coping systems; self-destructive coping systems; and coping methods such as denial and emotional suppression. (Merrill et al., 2003). Smith, et. al. (2004) found that victims and non-victims differ in their perceptions of risky behaviors and expectations regarding their likely involvement in risky behaviors, and this difference is hypothesized to be a result of the victim's use of denial as a coping method. These differences in perceptions and expectations of risky behavior may explain why avoidant coping systems increase the likelihood that a victim engages in antisocial behavior- behavior associated

with health-risking behavior (Smith, et.al., 2006). Beyond altered risk/benefit ratio assessments, many women use drugs to numb their emotional distress. Substance abuse impairs their judgment and diminishes their ability to protect themselves, increasing the risk for revictimization (Tarakeshwar et al., 2005; Davis, et.al., 2002).

CSA is associated with affiliation with aggressive, antisocial and more sexually risky partners; which resulted in increased rates of STD and lower relationship satisfaction. Lower relationship satisfaction prospectively predicted entering new sexual relationships- a risk factor for both STD and sexual victimization. However, partner sexual risk is not the only risk factor. Women with a history of CSA experiences tend to have higher levels of baseline sexual risk factors such as early age of first intercourse and higher number of previous sexual partners. Higher numbers of sexual partners may be explained by CSA survivors' expression of difficulty in establishing safe and stable relationships. The use of sex to gain control in relationships may also result in an increased number of break-ups and entering into new relationships, ultimately resulting in higher numbers of sexual partners. (Testa et al., 2005; Tarakeshwar et al., 2005). Based on these findings, it seems important for one of the goals of sexual risk interventions should be to improve intimate relationships of CSA survivors.

Traumatic reenactment may be another factor that increases the likelihood that sexual victims engage in risky sexual behavior. Freud calls this phenomenon 'the repetition compulsion' and says it occurs because:

"He reproduces it not as a memory but as an action; he repeats it, without, of course, knowing that he is repeating…He cannot escape from his compulsion to repeat; and in the end we understand that this is his way of remembering." (Van der Kolk & Ducey, 1989, p.271)

The theory of traumatic reenactment, aims to explain the altered intimate relationships, as mentioned earlier, that are common for victims of abuse. Since many victims of abuse employ the coping mechanisms of denial and emotional suppression, (Merrill et al., 2003) the victim may reenact sexual behaviors similar to those encountered in their abuse experience(s) in an unconscious effort to be in control of those experiences where they previously had lacked control.

Discussion

A history of sexual abuse does increase a woman's risk of risky sexual behavior; which may increase her risk for STD infection. Knowing this correlation, efforts should be made to develop interventions which prevent risky sexual behavior and ultimately STD infection in women with histories of abuse. The ultimate goal of interventions for sexually abused women should be to reverse or amend the developmental disruption that the abuse caused (Parillo, et al, 2001). Tarakeshwar et al. (2005) found that women who identified a connection between their sexual experiences and their HIV infection were better able to identify aspects of their life that need attention (e.g., increasing self-worth, having relationships with men) and process the ways it has impacted or continues to impact their everyday life. Therefore, it seems that connecting abuse to current behavior is an important factor for improving victim's quality of life, decreasing risk for risky sexual behaviors, and decreasing risk for becoming infected with STDs. In accomplishing this goal of healing, there are typical characteristics of sexually abused women that should be taken into account and amended, such as: learned helplessness; an addiction to the endorphins released from high stress events (Bloom, 1999); involuntary sexual behaviors (Noell, et.al., 2001); high anxiety levels (Smith, et.al., 2004); and the victim's heightened need for physical, psychological, social, and moral safety and stability (Bloom, 1999; Tarakeshwar, et.al., 2005;Testa, et. al., 2005).

Interventions should be based on and incorporate the known or speculated reasons for this correlation which includes previctimization, victimization, and postvictimization factors. The research of Tarakeshwar et al. (2005) implies that if psychological/mental health services and sexual risk/infection services collaborated closely, the efforts of each entity would positively affect the goals of the other. This interdisciplinary collaboration may optimize the efforts of each healing entity and result in a greater offsetting of the victim's physical and emotional effects of sexual abuse.

Unresolved Issues

Nine of the studies reviewed were descriptive and did not have a quasi-experimental and randomized controlled design. Randomizing girls to be in an abused or not abused group is unethical and this is why randomized controlled trials, though more conclusive scientifically, are an impossibility in the field of sexual abuse research. Instead of randomized controlled and quasi-experimental designs, all reviewed studies were retrospective. The reviewed studies did not assess for a uniform type of abuse and may have only assessed for specific kinds of abuse, such as abuse from a male or abuse involving penetration; thereby excluding those who are victims of other types of abuse. Because the reviewed studies are not comprehensive in their description of abuse, certain victims are not being studied and, therefore, the results discussed in this paper may be flawed or incomplete. Additionally, the absence of

prospective studies in the literature indicates that is it not definitively known whether risky behavior or sensation-seeking traits exists prior to first abuse, predisposing the victim for revictimization.

Future Research

Sexual victimization affects all aspects of the victim's life which directly or indirectly increase the likelihood that they will engage in risky sexual behaviors. For this reason, a multitude of factors must be considered when conducting further research on this correlation and when designing intervention strategies for those who engage in or are at an increased risk for engaging in risky sexual behaviors. Research is needed in order to clarify all of the possible mechanisms by which sexual abuse increases incidence of risky sexual behavior. Future research should: include more diverse samples; be prospective; study traumatic reenactment as a mechanism by which sexual abuse is a risk factor for risky sexual behaviors; assess for a lack of married parents, inter-parental conflict, divorce and social class as mediators (Colman & Spatz Widom, 2004); assess how sexual abuse affects attachment issues in future casual and intimate relationships (Lang, Stein, Kennedy & Foy, 2004); evaluate why victims use internalized versus externalized coping styles (Lang, et.al., 2004); and assess effectiveness of available treatments. Prospective studies are particularly important to the research because it has been found that adults are less likely to report histories of abuse when studies are conducted retrospectively (Widom & Morris, 1997).

In conclusion, this literature review has found that abuse occurs as a result of many personal and environmental factors and results in many consequences for the individual and for society (Bloom, 1999). Ultimately, sexual abuse and its resulting behaviors must be viewed in a systemic and comprehensive way.

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